HEALTH AND WELLBEING BOARD AGENDA

Monday 3 August 2015

at 2.00 pm

in 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, Councillor S Akers-Belcher

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

To confirm the minutes of the meeting held on 22 June 2015.

4. **ITEMS FOR DECISION**

None

5. **ITEMS FOR INFORMATION**

5.1 Improving Clinical Standards – Implications from the Dalton Review – *Chief Officer, NHS Hartlepool and Stockton-on-Tees CCG*

5.2 Local Health and Social Care Plan – *Chief Executive*

5.3 Learning Disability Update – Tees Integrated Commissioning Group (TIC) – *Director of Child and Adult Services*

5.4 Breathlessness Support Programme – *Chief Executive, Hartlepool and District Hospice*

5.5 Director of Public Health Annual Report 2014/15 – *Director of Public Health*

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

Date of next meeting – Friday 11 September 2015 at 10.00 am at the Civic Centre, Hartlepool.

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

22 June 2015

The meeting commenced at 10 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 Paul Thompson and Councillor Ged Hall (as substitute for Councillor 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

Other Members:
Chief Executive, Hartlepool Borough Council – Gill Alexander
Representative of the NHS England – Vacancy
Representative of Hartlepool Voluntary and Community Sector – Tracy Woodhall
Representative of Cleveland Police - Chief Superintendent Gordon Lang as substitute for Assistant Chief Constable Simon Nickless

Also in attendance:- Representatives of Healthwatch – S Thomas, J Gray
Representative of Tees Valley Public Health Shared Service, James O'Donnell, Public Health Intelligence Specialist,
Representative of Mental Health Forum, Zoe Sherry (also representative of Healthwatch)
Elected Member, Hartlepool Borough Council – Councillor Springer

Hartlepool Borough Council Officers: Jill Harrison, Assistant Director (Adult Services)
Neil Harrison, Head of Service
Carol Johnson, Head of Health Improvement
Joan Stevens, Scrutiny Manager
Amanda Whitaker, Democratic Services Team

Prior to the commencement of business, the Chair highlighted that it was the first meeting of the Board to be attended by a representative of Cleveland Police and welcomed the representative to the meeting.

1. Apologies for Absence

Elected Member – Councillor Chris Simmons
Director of Child and Adult Services, Hartlepool Borough Council – Sally Robinson
Director of Regeneration and Neighbourhoods, Hartlepool Borough Council – Denise Ogden
Representatives of Healthwatch – Ruby Marshall
Representative of Tees Esk and Wear Valley NHS Trust – Martin Barkley
Representative of North Tees and Hartlepool NHS Foundation Trust – Alan Foster
Representative of Cleveland Police – Simon Nickless

2. Declarations of interest by Members

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

3. Minutes

The minutes of the meeting held on 2 March 2015 were confirmed.

Referring to minute 50, Minimum Unit Price for Alcohol – Referral from Council, the Director of Public Health confirmed that a letter had been sent to Sefton Council and that BALANCE was reporting to Leaders and Mayors meetings across the North East.

With reference to minute 57, Obesity Conference Feedback, the Director of Public Health assured the Board that the issues arising from the Obesity Conference were being considered and that a further report would be submitted to the September/October meeting of the Board.

Further to minute 54 – COPD Screenings – it was understood from feedback that problems continued to be experienced. The Chief Officer, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group advised that she would address the issue.

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

The approval of the Board was sought for the Joint Mental Health Implementation Plan 2015 -2108. The report also provided an update on a number of key reviews of mental health services.

The Board was advised that the Hartlepool Mental Health Forum had set up a task and finish group involving representatives from Hartlepool Borough Council and Hartlepool & Stockton on Tees Clinical Commissioning Group (CCG) to support the development of a local Mental Health implementation plan. The Chair of the Mental Health Forum was in attendance at the meeting and spoke in support of the Plan.

The Joint Mental Health Implementation Plan for 2015-18, appended to the report, had been co-produced with the CCG and incorporated the key national and local mental health outcomes. An action plan had also been developed which would be refreshed annually to demonstrate progress and reflect any changing national and local priorities. The report set out details of the methodology which had been adopted together with details of public engagement. It was highlighted that the Plan described the national drivers, key deliverables and demographic pressures on the local community and used the outcomes of the public engagement event as the basis to formulate an action plan.

The Board was informed also that as part of Sector Led Improvement within the North East ADASS Region all Councils had agreed to the Local Government Association (LGA) undertaking a Peer Challenge within adult social care over a three year period. Hartlepool Borough Council's Peer Challenge had taken place in November 2014 and was focused on mental health services. The review had focused on 3 key themes; service delivery, working together and vision, strategy and leadership and for each area the team had identified key strengths and areas for consideration as summarised in the report. Key recommendations were highlighted. It was noted that an action plan was being developed with TEWV to address the recommendations. Progress has already been made in a number of areas as detailed in the report.

Members of the Board were informed of details of a CQC Mental Health Act Monitoring Visit to Tees Esk and Wear Valley NHS Foundation Trust in December 2014. The report set out the key developments that were reviewed and the key areas for improvement for the Tees area together with actions to be taken in response to the recommendations.

The report set out details also of the Mental Health Crisis Care Concordat which sets out how organisations should work together better to make sure that people get the help they needed when they are having a mental health crisis. It focused on four main areas as detailed in the report. It was noted that the Mental Health Forum and key strategic partners had signed up to the

principles of the Crisis Care Concordat. An action plan was being monitored through the Tees Crisis Concordat Working Group.

The report informed Board Members also of a national consultation exercise which had taken place on a revised Code of Practice for Mental Health. The main changes were highlighted to the Board. It was acknowledged that work would be required to ensure professionals working under the revised Code of Practice for Mental Health were aware of the changes and remained confident practitioners. Senior managers would ensure that workforce plans were updated to reflect changes to key legislation and would monitor uptake through Continuous Professional Development.

Board Members debated issues arising from the report. It was highlighted that the report identified significant mental health issues in the town and an assurance was provided by the Chief Officer, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group that there had been significant increases in investment in mental health services. The Chief Officer undertook to deal with issues highlighted at the meeting in relation to access to the 111 service and to report back to the board in relation to telephone access to the out of hours services by ethnic minority groups. Issues relating to access to services by those with hearing loss were discussed also and it was noted that the Council's Hearing Loss Strategy was currently being refreshed with consultation planned during July. It was requested that Healthwatch representatives be included in the consultation. The Chair of the Mental Health Forum raised a number of issues relating to crisis intervention including concerns regarding an increase in the number of people self presenting, transport issues in terms of accessing Roseberry Park and access to the Section 136 assessment suite. The Chair of the Forum agreed to take back to the Forum issues highlighted at the meeting relating to the number of people who appeared not to receive treatment for mental health issues.

The Assistant Director advised that a report was being considered at the next meeting of the Council's Adult Services Committee on Section 136 provision. The Chair of the Board requested the involvement of this Board.

Decision

(i) The Board approved the Joint Mental Health Implementation Plan and agreed to receive further reports to monitor progress against the action plan.

(ii) The outcomes of recent reviews and the actions being taken to address the recommendations were noted.

(iii) The revised Code of Practice for Mental Health was noted.

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

Further to consideration by the Board on 2 March 2015, the report provided an update in relation to the Clinical Commissioning Group (CCG) Quality Premium Guidance for 15/16. The report included an overview of the guidance and advised of the approach taken to select local indicators to enable final plans to be submitted to NHS England on the 14th May.

It was noted that the Quality Premium for 2015/16 had been published and was intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvement in health outcomes. The premium would be paid to CCGs in 2016/17, and covered a number of national and local priorities which were addressed in the report. Based on population size, the Quality Premium provided an opportunity to earn £1,428,885 should all measures be achieved.

In terms of local indicators, 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, there had been no opportunity to present the information to the Health and Wellbeing Boards due to meetings not taking place during the election period. The CCG in the absence of a Board meeting had therefore worked with both Local Authority Public Health teams to sight them on the requirement of the quality premium guidance and submission and had agreed relevant indicators to be selected as local measures from the CCG Outcome Indicator set and those that linked with the JSNA. The two local measures discussed and selected for submission for the plans were improving estimated diagnosis rate for people with dementia increasing the planning target from 69% to 72% and a reduction in maternal smoking at delivery from 14/15 to 15/16. It was agreed as both indicators had been selected by the Board and CCG in previous years that these should continue to be an area of focus. It was highlighted that the dementia indicator was a performance measure of BCF plans therefore increasing this target would help achieve not only BCF but the quality premium measure. The Director of Public Health expressed support of the indicators which had been selected.

In response to a question raised at the meeting by an elected member, the Chief Officer advised in relation to the collection of data. The Chair of the Board proposed that consideration be given to the appropriate timescales for submission of data to Board meetings.

Decision

The update was noted and the local indicators as selected by the CCG and Public Health colleagues were ratified.

6. Tees Wide Suicide Prevention Implementation Plan 2014-16 (*Director of Public Health*)

The Board was presented with the Tees Wide Suicide Prevention Implementation Plan, a copy of which was appended to the report. The attention of the Board was brought to the recommendations made by Middlesbrough Borough Council's Health Scrutiny Panel in relation to the Tees Wide Suicide Prevention Implementation Plan, also appended to the report. The Board was requested to consider the referral of the Tees Wide Suicide Prevention Implementation Plan to the Council's Planning Committee.

The Board was advised that the Tees Suicide Prevention Implementation Plan 2014-2016 mirrored the national Suicide Prevention Strategy and was monitored through each of the Health and Wellbeing Boards across the Tees Valley. In July 2014, Middlesbrough Borough Council's Health Scrutiny Panel had explored the link between deprivation across Middlesbrough and levels of suicide and in doing so had requested further information regarding the Tees Suicide Prevention Implementation Plan. This information had been considered on the 21 October 2014, and the Panel had agreed a number of recommendations as set out in the report. 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), was provided in the report. Following consideration of the Plan, the recommendations of the Health Scrutiny and the position in Hartlepool as outlined in the report, the Board was requested 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. The Scrutiny Manager advised the Board that she had been advised by the Council's Planning Services Manager that it would be achievable for the recommendations to be considered in the context set out in the report.

Decision

i) The recommendations of Middlesbrough Borough Council's Health Scrutiny Panel were noted.
ii) It was recommended 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.

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

As a result of the Scrutiny investigation into Dementia, a series of recommendations had been made. To assist the Health and Wellbeing Board in its determination of either approving or rejecting the proposed recommendations an action plan had been produced which was appended to the report together with the Final Report and recommendations of the Working Group.

Decision

(i) The Board approved the proposed recommendations and the action plan in response to the recommendations of the Dementia Working Group's investigation into Dementia: Early Diagnosis.
(ii) It was agreed that a further report be submitted to the Board in six months time.

8. Better Care Fund Performance Reporting (*Director of Child and Adult Services, Hartlepool Borough Council and Chief Officer, NHS Hartlepool and Stockton-on –Tees CCG*)

The report provided an update regarding the performance reporting arrangements for the Better Care Fund (BCF) and the return submitted in relation to Quarter 4 of 2014/15.

The Board was advised that NHS England had issued 'Guidance for the Operationalisation of BCF in 2015/16' in March 2015 which was appended to the report. The guidance included a quarterly performance reporting template which was appended to the report also and had confirmed dates for submission of the templates .The dates for quarterly submissions had been set nationally and involved collation of performance information from a number of sources across health and social care. It was highlighted that the dates would create some challenges in terms of Health & Wellbeing Board sign off prior to submission. It was suggested that this could be addressed through delegating responsibility for sign off, with reports submitted to the Health & Wellbeing Board at the earliest opportunity. On 11 May 2015 a revised and simplified reporting template had been issued specifically for the first submission on 29 May 2015.The revised reporting template for 29 May 2015 had been completed by officers of the Council and CCG and was appended to the report. Although there was no requirement to report on the performance measures for this quarter, information had been collated and indicated that improvements had been seen in a number of areas as set out in the report.

It was highlighted that the one indicator where performance was not shown to have improved was admissions to care homes of people aged 65 and over.

Performance against this indicator had 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 was a 13.8% reduction, which was a significant achievement in the context of demographic pressures and increasing prevalence of dementia. However, the way that this indicator was measured had changed nationally and full cost paying residents were now included within the measure. This figure had not been included in the indicator in previous years, but the change to the national definition meant that the total number of admissions for 2014/15 now had to be reported as 187 for 2014/15.

Board Members were assured that performance against all of the BCF indicators would 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 would inform the quarterly reports.

Decision

(i) The performance reporting process was noted together with the report submitted on 29 May 2015;
(ii) The issues raised in relation to timing of performance reports and Health & Wellbeing Board meetings were noted and authority was delegated 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.

9. Community Based Urgent Care Update – June 2015

(Chief officer, Stockton-on-Tees Clinical Commissioning Group)

The report provided an update following the information which had been presented to the Board in January 2015. The report set out the actions undertaken to date and associated timelines in relation to the integrated urgent care service. Following the previous report to the Board, the CCG had been working with the communications and engagement team within the commissioning support unit to develop a communications and engagement plan. Details of communication and engagement activities were set out in the report.

Board Members were advised that the outputs from the market engagement and public engagement exercises would be reviewed and intelligence gathered from these events would be used to develop the service specification. It was envisaged that the tender for the integrated urgent care service would be published in Mid-July 2015. Evaluation would be undertaken during August and September and a contract subsequently awarded to ensure service commencement for 01 April 2016.

The Board was updated, at the meeting, on issues arising from the feedback received by Healthwatch. The Chief Officer provided assurance that whilst undergoing the process, current services would continue to be monitored to meet needs in the most appropriate manner.

Decision

The Board noted the report.

10. Annual Review Health Status Presentation (*Director of Public Health*)

The Board received a presentation by the Director of Public Health which provided an opportunity for discussion on the current health status of the people of Hartlepool with a view to reaffirming priorities for action and service development.

The presentation included latest statistics, trend analysis, benchmarking and lower level geography. The key factors arising from the presentation were summarised as follows:-

- Hartlepool is more deprived than the national average
- The health of the people in Hartlepool is generally worse than the national average
- Many health indicators in Hartlepool are improving
- The health of people in Hartlepool is similar to Local Authorities with a comparable level of deprivation
- There are health inequalities within Hartlepool
- Life expectancy in Hartlepool is increasing

Following the presentation, the view was expressed that it would be useful for the Board to have a future 'wider conversation' on health determinants including preventative issues.

The Director of Public Health responded to clarification sought on the frequency of updates of ward profiles. It was agreed that the health profiles will be produced on an annual basis to accompany the statutory annual Director Public Health report.

Decision

(i) The content of the presentation, including the key messages regarding the health status of the people of Hartlepool, was noted.
(ii) It was agreed that the health profiles be produced on an annual basis to accompany the statutory annual Director Public Health report.

Meeting concluded at 11.35 a.m.

CHAIR

HEALTH AND WELLBEING BOARD

3 August 2015

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

Subject: IMPROVING CLINICAL STANDARDS – IMPLICATIONS FROM THE DALTON REVIEW

1. PURPOSE OF REPORT

1.1 To appraise the Health and Wellbeing Board on the outcome of the Dalton Review 'Examining new Options and Opportunities for the Providers of NHS Care' and consider local implications in relation to improving clinical standards.

2. BACKGROUND

2.1 The Dalton Review was commissioned by the Secretary of State for health in February 2014 to support providers in strategically considering their future organisational form with the aim of reducing variation in clinical standards, financial performance and patient safety and in helping them respond to the challenges set out in the 5 year forward view to ensure clinical and financial sustainability.

3. PROPOSALS

The review concluded that:

3.1 Alternative organisational forms are required to support sustainable high quality services however, no one organisational model 'fits all' and a number of possible models are described including:

- Collaborative models-Two or more organisations pool resources and achieve better outcomes e.g. federation, joint venture
- Contractual models – formalized agreements with performance and quality standards agreed as part of the arrangement e.g. Service level chains and management contracts
- Consolidation models – Changing the ownership of the organisation and providing different services e.g. integrated care organisations, foundation groups

- Other – buddying, information partnering, clinical/strategic networks, mutual social enterprises

3.2 Quicker transformation and transactional change is required by simplifying the processes.

3.3 Ambitious organisations with a proven track record should be encouraged to expand their reach and have greater impact, becoming 'system architects' and encouraging entrepreneurial spirit.

3.4 Overall sustainability of the provider sector is a priority.

3.5 A dedicated implementation Programme is needed to make change happen – demonstrator sites.

4. LOCAL IMPLICATIONS

4.1 The report goes on to make a series of recommendations to national bodies, Clinical Commissioning Groups, Trust Boards and NHS leaders. There is an expectation that leaders in the NHS with their partners will consider the review recommendations and how these might support solutions that reflect local circumstances. The Health and Wellbeing Board have already for example received reports on the Securing Quality in Health Services (SeQHIS) project, which aims to deliver improved clinical standards across County Durham and Tees Valley, whilst managing some of the very real financial and workforce challenges we are currently facing. The Dalton Review will be helpful in considering the organisational changes required to deliver robust and sustainable services in the future. An update of the progress with SeQUIS will be presented at the meeting.

6. BACKGROUND PAPERS

Appended: Examining new options and opportunities for providers of NHS care: the Dalton Review December 2014

7. CONTACT OFFICER

Ali Wilson
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Examining new options and opportunities for providers of NHS care

The Dalton Review

December 2014

Examining new options and opportunities for providers of NHS care

The Dalton Review

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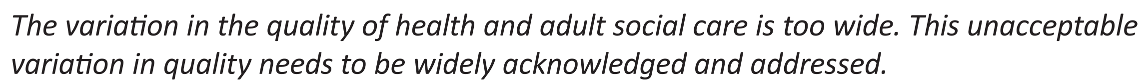

The variation in the quality of health and adult social care is too wide. This unacceptable variation in quality needs to be widely acknowledged and addressed.

That care can be delivered in different ways does not justify poor quality for some people, settings or locations. Everyone should receive good quality care, no matter how or where it is being delivered. This means improving the care that is inadequate or requires improvement, while leaving others to flourish to develop their good and outstanding care.

The state of healthcare and adult social care in England 2013/14

Care Quality Commission, October 2014

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Letter to the Secretary of State

Dear Secretary of State for Health

It was a privilege to be asked by you to lead this review into exploring ways to address the challenges faced by providers of NHS care. I believe that our NHS is the best healthcare system in the world, yet I know that not all of our patients are experiencing the standards they deserve. The recently published *NHS Five Year Forward View* describes the enormous challenges that the NHS faces. It emphasises that new care models are needed to support and care for people. This is the right approach. Yet, describing new care models is different from delivering them. This Report complements the *Forward View* and provides the organisational 'delivery vehicles' that can help translate its ideas into reality. I have confidence that NHS leaders and staff have the will and the capability to deliver what is needed.

We have significant variation in the standards of service provided by our healthcare organisations, and that troubles me. There are some excellent providers and some poor providers – and a lot in the middle. Why should any family have to accept that a relative living in one area can be confident in accessing excellent care whilst another, with the same needs living elsewhere, cannot? We might understand some of the reasons for this variation, but we shouldn't tolerate the extent of it. All of our staff want to provide the best – and we must do our best to ensure that they can.

Whilst some providers have a track record of high performance, it is increasingly clear that, for a significant number of others, their existing organisational model will not deliver financial and clinical sustainability. The tests for Foundation Trust status, which were introduced 10 years ago, enable proper judgement to be made on good organisational governance and viability – and must be retained. Yet, a decade on, 93 NHS Trusts still have not achieved this standard. This must not continue.

The District General Hospital, established by the 1962 Hospital Plan now, in isolation, can struggle to meet the needs of the population. This is well known to those of us who provide and commission healthcare, and we are now at a point where patients and their families are beginning to understand that too. The time is right to change the way we think about the organisation of service provision. Institutions should not be preserved just because they exist. Boards should not pursue self-protectionist strategies, using the 'interests of patients' as camouflage. If an organisation is not able to provide high standards, reliably, to the population it serves, then its continuation in its current form should be called into question. Safeguarding reliable, high quality care to patients is more important than preserving organisations.

There are no 'right' or 'wrong' organisational forms – what matters is what works. This Report does not champion one organisational model over any other but recognises that it is for our system leaders to pursue the models that will deliver the greatest benefits to the populations they serve.

Some models will enable ***collaborative*** solutions: where shared services, working across organisational boundaries, meet standards, seven days a week; or where new integrated governance arrangements for primary and secondary care bring greater coherence to a locality. Other ***contractual*** or ***consolidated*** models will allow opportunities for successful organisations to bring their proven leadership, processes and expertise into organisations which are unable to demonstrate clinical and financial viability.

Leaders of successful organisations should be 'system architects': using their social entrepreneurial spirit to develop innovative solutions to their challenges and to codify and spread their success, so that the best standards of care can be available, reliably, to every locality in the country. I strongly believe that our leaders should be encouraged to be aspirational and to strive for improvement – and that organisational achievement

should be recognised. The Report recommends a system of '*credentialing*' for our best organisations, building on the existing assessment systems of Monitor and CQC and drawing on the evidence of the characteristics of high reliability organisations. This new 'kitemark', beyond FT status, would enable commissioners to identify those organisations with the capability and greatest likelihood of successfully spreading their systems into organisations that are in persistent difficulty.

It is notable that all of the European countries we visited have developed new organisational forms as a response to the challenges they faced. Many have seen the development of hospital groups and the use of management contracts. These new forms have enabled the standardisation of best practice – and the delivery of this at a lower management cost overhead. It is perplexing that these forms have not been pursued in England. This may be due just as much to leadership mindset, as to some of the system impediments and weak incentives. This must be addressed.

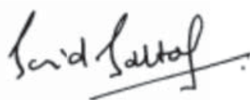
Competition law must not be seen as a barrier to developing innovative organisational solutions. There must be no doubt that patient benefit is and will be the key judgement in progressing new organisational forms. Some have said that it takes too long and costs too much to make changes. I agree – and so this Review makes recommendations to streamline processes, making it easier, quicker and less costly to transact organisational change.

I know that NHS change can be slow, due in part to an institutionally low tolerance to risk. It is important that this time we don't miss the opportunity to act with urgency. I very much hope that boards will now develop an *Enterprise Strategy* – utilising innovative approaches for growth to deliver better care for patients – and develop the internal capacity and capability required to deliver improvement. Significant support for transactions must be made available to help organisations to gear up to deliver change. I am also recommending that national bodies accelerate change by supporting the costs of initial transactions so that we have **demonstrators**, capable of prototyping the new models and transferring their experience and learning to others.

I am indebted to the people who have supported this Review: to my Expert Panel and to the Chairs' Group; to colleagues across Europe and the world who have allowed us to have insight into their systems; to the many people who have taken their time to participate in the numerous engagement events and to provide their views. I have been superbly supported by the Department of Health Review Team.

The Expert Panel has looked at the evidence of what works and presented this as a menu of organisational forms. We have listened and found a widespread appetite for change. We believe successful organisations should be encouraged to develop further and support organisations in persistent difficulty. There will be risks in taking this agenda forward, but I am confident that the NHS is capable of managing these. The prize will be a sustainable NHS, for the long term. We must support our NHS leaders and staff to reduce variation currently experienced and to deliver reliable, high quality care to all.

Yours sincerely



Sir David Dalton
Chief Executive
Salford Royal NHS Foundation Trust

December 2014

Executive summary

The NHS is rightly recognised as a world leading health system, highly valued by the public and those who work in it. There have been a number of remarkable successes over the last decade, but not all NHS providers have improved at the same rate, resulting in an unacceptable extent of variation in quality of care across the country. All patients and carers should expect and receive reliable standards of care, no matter where they live.

It is not only currently challenged providers who should strategically consider their future alongside that of their wider health economy partners. The NHS Five Year Forward View signposts the need for new models of care to respond to the challenges faced by the NHS. Even the best providers will struggle to meet the challenges of the future without looking outside traditional organisational boundaries and considering how their form could better support new clinical models and ways of working. Assuring the clinical and financial sustainability of the provider sector requires a wider range of options for both providers and regulators, and these must be embraced by leaders across the sector.

The evidence of the Review identified a number of organisational forms which could help providers to make these changes, which should be considered by all boards as part of their strategic planning processes. The Review also identified barriers and improvements to the system architecture surrounding these models, and makes recommendations to provider boards and to national bodies accordingly.

The organisational forms considered in this Review have different characteristics, benefits and barriers. Many are already being used in the NHS. It is clear that there should be no national blueprint or one size fits all. Accordingly, this Report does not impose wholesale change. It identifies five themes:

i. One size does not fit all

ii. Quicker transformational and transactional change is required

iii. Ambitious organisations with a proven track record should be encouraged to expand their reach and have greater impact

iv. Overall sustainability for the provider sector is a priority

v. A dedicated implementation programme is needed to make change happen

i. One size does not fit all

Organisational forms should develop to deliver the models of care which best suit local circumstances. They must not be centrally dictated. System leaders understand their own population need and geographies, and therefore need to be enabled and supported to identify and implement the best clinical models for their patients. In doing so, they need to examine their current organisational form to determine whether or not an alternative form would deliver better outcomes for their populations.

Too often, organisations seek to retain the status quo at the expense of operating outside of traditional organisational boundaries and fail to adopt best practice or pursue wider system leadership which could deliver improvements for patients. Shifting the mindset of board members towards one of joint ownership and governance with other organisations should change the unhelpful perception of service change by boards of 'winning or losing' for their organisation to one of 'winning' for their patients and wider community.

The Review considered a number of organisational forms which have the potential for wider adoption across NHS providers: federations, joint ventures, service level chains, management contracts, integrated care

organisations and multi-service chains or Foundation Groups. The Report and its supporting evidence packs explore the potential of each form to offer solutions to local challenges. In the future, it suggests, organisations are likely to operate more than one organisational form for their service portfolio.

Who	Recommendation
Trust boards	As part of the 2015/16 business planning process, trust boards should consider their response to the NHS Five Year Forward View and determine the scale and scope of their service portfolios. They should consider whether a new organisational form may be most suited to support the delivery of safe, reliable, high quality and economically viable services for their populations.
Trust boards	Trust boards of successful and ambitious organisations should develop an enterprise strategy and should consider developing a standard operating model that could be transferred to another organisation or wider system.

ii. Quicker transformational and transactional change is required

System leaders need to collectively own the transformation required across their local health economy. Historically transformation and transaction processes have been lengthy and protracted, particularly the early stages of planning and gaining consensus across the local health economy. Simplifying these processes will both accelerate opportunities for improvements in patient care and reduce the costs of transactions. The 'rules' also need to be explained and understood further as perception of competition and legislative issues can cause organisations to become overly risk averse.

Who	Recommendation
NHS England and Clinical Commissioning Groups	NHS England should require Clinical Commissioning Groups (CCGs) to set out in their five year strategic commissioning plans: a. the future care/service models they wish to support; and, b. how they will use their allocated funds for service transformation to support providers to deliver the agreed transformational and organisational change. Where multiple CCGs and providers are taking forward service transformation across a shared geographical area, NHS England should help broker agreement as to how costs are met between all parties.
Department of Health	A single, unified process with standardised documentation outlining clear criteria should be developed to support future transactions. This should include guidance for all parties including Governors.
Department of Health, Monitor and NHS Trust Development Authority (TDA)	A Tender Prospectus that has the parameters of the transaction clearly laid out should be made available to all potential bidders in the interests of speed and transparency.
Secretary of State for Health	The Secretary of State should set a requirement to the national bodies that, except in exceptional circumstances, all transactions should be completed within one year or less from the time the decision is taken by the board of the NHS Trust Development Authority (TDA) or Monitor.

iii. Ambitious organisations with a proven track record should be encouraged to expand their reach and have greater impact

Transformational change requires strong and capable leadership. There are many successful NHS organisations and individual leaders with a track record of delivering consistently high quality healthcare to patients, but many have not thought beyond their current organisational boundaries. Leaders of successful organisations should become 'system architects', encouraged to use their entrepreneurial spirit to develop innovative organisational models and to codify and spread their success to other localities. Recognising these successful organisations, supporting them to develop enterprise strategies that expand their reach and developing new incentives will encourage more successful organisations to have greater impact with less successful ones.

Who	Recommendation
Monitor and the Care Quality Commission (CQC)	A new credentialing process, to recognise successful organisations capable of spreading their systems and processes to other organisations, should be developed by July 2015. This should build on CQC and Monitor ratings, with a good or outstanding rating a prerequisite. Once agreed, Monitor should be responsible for the process and the first wave of credentialing should be completed by October 2015.
Monitor and the CQC	A list of all credentialed organisations should be published on both Monitor and the CQC websites and made available to every Clinical Commissioning Group.
Clinical Commissioning Groups and providers	CCGs and providers should use this list of credentialed organisations to identify new partner organisations most likely to deliver transformational improvement.
Monitor and the TDA	A procurement framework should be developed which allows interested credentialed organisations the ability to register for management contract and acquisition opportunities. This framework should be live from or before April 2016. Inclusion on this register would mean that an organisation automatically passes the pre-qualification questionnaire (PQQ) stage of any tendering processes. The framework should then be used by the TDA and Monitor to procure support for challenged organisations.
Trust boards	Trust boards should consider new operational and strategic leadership roles required in order to support the new organisational models, and put development plans in place accordingly.
Leadership Academy	The Leadership Academy should support the development of the requisite skills and experience for the new operational and leadership roles and build these into the career paths and leadership and development training of current and future NHS leaders.
Department of Health, Monitor and CQC	The Department of Health, Monitor and the CQC should agree a 'grace period' for acquiring organisation with an agreed trajectory of finance, performance and quality standards improvement for the acquired or contractually managed organisation, separate from the overall performance of the combined organisations. This 'grace period' should take into account historical quality issues and the impact of any agreed financial investment adjustments.
Monitor and the TDA	Monitor and the TDA should ensure that – where appropriate – an acquiring or contractually managed organisation can start to create integrated operational structures, once the Heads of Terms have been agreed, so that these may be run in shadow form prior to the final decision on the transaction being taken.

iv. Overall sustainability for the provider sector is a priority

There are currently 93 NHS Trusts. A proportion of these will become Foundation Trusts, but many will not reach the required standards in their current organisational form. Equally, there are some Foundation Trusts that would not meet the requisite standards for authorisation today and may be significantly challenged both clinically and financially. Long-term solutions need to be identified for these organisations, supported by appropriate governance models, to ensure that all patients can continue to access safe and reliable high quality care.[1]

Who	Recommendation
TDA	The TDA should publish the categorisation of and plans for each of the 93 NHS Trusts in the Foundation Trust pipeline, along with the trajectory and milestones for when and how each organisation will achieve Foundation Trust status or other sustainable organisational form.
Department of Health	The Department of Health should hold the TDA to account for meeting the trajectory and milestones for each of the 93 organisations.
TDA	The TDA should consider accelerating the solutions for patients and communities currently served by organisations in persistent difficulty, by running batched procurements for category B1 and B2[1] NHS Trusts.
Monitor and the TDA	The buddying system should be expanded, beyond the special measures trusts, into a partnering system to allow organisations with the potential to improve early access to support and guidance from credentialed organisations. Arrangements should be developed to identify and remunerate trusts capable of providing support. Should buddying not result in the required improvement within a defined time period, a re-categorisation of the NHS body should be considered so that further action can be enacted quickly.
Monitor	Monitor should consider using their existing categorisation process to drive more rapid interventions. Where Monitor determines that a FT is in 'persistent difficulty', it should require that FT to produce a plan with clear improvement timescales. If the FT is subsequently unable to demonstrate improvement against this plan, Monitor should compel that FT to present a new sustainability plan. This may include adopting a new organisational form or pursuing a transaction with a 'credentialed' organisation.

v. A dedicated implementation programme is needed to make change happen

In order to implement the ideas in this Report, two activities should occur in parallel: firstly, NHS leaders should be supported to develop awareness and knowledge of the available models and implementation approaches through a widespread programme of sharing learning and best practice; secondly, there should be a programme of demonstrator sites that can stimulate and accelerate change. This programme will support providers to develop and test new organisational forms in practice. Particular attention should be given to supporting successful organisations stepping in to improve delivery of high quality services in challenged health economies.

[1] Category B1 are described as organisations that cannot reach FT status in their current form and where an acquisition by another organisation is likely to be the best route to sustainability.

Category B2 are described as organisations that cannot reach FT status on their own and where a franchise, management contract or other innovative organisational form is likely to be the best route to sustainability.

Who	Recommendation
Department of Health	The evidence and findings from the Review should be communicated across the health sector, alongside the business planning round, through a national programme of learning and sharing best practice.
Department of Health, Monitor and the TDA	The national bodies should support a number of demonstrator sites where organisations implement a change to their organisational form. This should be evaluated and the learning shared with the wider sector.

Conclusion

The extent of variation of standards of care across the country and the challenges all providers of NHS services face must be addressed as soon as possible. The NHS Five Year Forward View signposts organisations to consider new and innovative solutions to address quality and financial challenges; the recommendations of this Review complement the NHS Five Year Forward View and support providers to deliver the changes required. The evidence from the Review suggests that addressing these five key themes will accelerate the transformational change that is required to help overcome the challenges facing the NHS. Effective and speedy implementation is now required in order to have the greatest impact for patients. The government, national bodies and patients should have confidence in NHS leaders to make the necessary changes a reality.

Introduction

1. The NHS is precious to both the public and its staff,[2] and is rightly viewed as a world leading healthcare system. People rely on its services to provide safe, high quality healthcare when they need it most.

2. However, whilst the NHS is established as a universal service, people do not experience the same standards of service from each of the organisations providing NHS care. Reliability of clinical standards is affected by issues including governance, leadership and financial viability and the factors driving these are many and varied.

3. Recent reforms have focussed on the regulation, inspection and commissioning elements of the health system. Over a number of years there has been an increased focus on commissioning against common service specifications and in greater public reporting of delivery against those standards, following regulatory inspection. Less attention has been given to the reform of the provider sector.

4. Despite the considerable changes experienced by the NHS, there is widespread consensus that the NHS must continue to transform in order to be able to meet the needs and expectations of patients in the 21st century. This need for change comes at a time of unprecedented financial challenge; 2015/16 will be the fifth consecutive year that providers have been required to meet challenging efficiency targets. Without transformational change, NHS providers will not be able to make the improvements required and will not be able to assure clinical and financial sustainability of services.

Why focus on the provider sector?

5. The provider sector is an integral part of the NHS and for many patients and the public it is what they think of as 'the NHS'. It is highly varied, with NHS commissioned services delivered by a range of organisations spanning the NHS, voluntary, independent sector and social enterprises. In 2012/13, secondary care providers were allocated £70 billion of the £102.6 billion NHS budget[3] making sustainability of this sector significantly important for the overall viability of the NHS.

6. Today, there are 242 secondary care providers of which 149 are Foundation Trusts and 93 remain NHS Trusts. The national policy intention is that all NHS Trusts should ultimately be authorised as Foundation Trusts, or an equivalent sustainable organisational form. While supportive of this aim, this Review is unequivocal in its view that the assessment criteria must remain and that the bar should not be lowered. It should be noted that the Expert Panel was of the view that a number of existing Foundation Trusts would struggle to meet the current assessment standards.

7. This gap between required and actual standards manifests itself in variation of standards across the country; reducing this variation and ensuring uniformly high standards of care across the provider sector is vitally important.

8. As demand and complexity continue to increase, it has become increasingly difficult for providers of all types to navigate the challenges that the NHS faces. The NHS Five Year Forward View identifies that the NHS needs better ways of delivering care at greater scale. It rightly identifies that:

    a. care should be personal, whilst based on population health needs;

    b. there should be a new focus on co-ordinated care systems and networks;

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[2] Ipsos MORI (2014), Public perceptions of the NHS and social care survey

[3] Nuffield Trust (2014), Into the Red; the state of the NHS Finances

c. a greater emphasis should be given to redesigning out-of-hospital care;

d. centralisation should be supported where it demonstrably delivers improvements in quality and safety; and,

e. to achieve greater productivity, new approaches should adopt greater standardisation of processes, use of technology and shared information.

9. The new approaches to developing care models proposed by the NHS Five Year Forward View are welcomed, helping to address some of the key challenges faced by providers:

   i. There are more people living with long term conditions: the number of people with three or more conditions is expected to rise from 1.9 million in 2008 to 2.9 million by 2018.[4] Patients with chronic disease have complex and varied needs, often accessing services across a spectrum of care;

   ii. Between 2011/12 and 2012/13 the number of emergency admissions increased by 1.8%; outpatient appointments by 3.9% and daycase episodes by 2.3% and this demand pattern further increased in 2013/14.[5] Overall demand is predicted to rise to 7% per annum.[6] This is coupled with an aging demographic where the number of patients over the age of 85 is expected to double by 2030,[7] many of whom will have one or more chronic conditions.

10. Establishing models and systems of care which meet the needs of individuals and communities is essential, and it is crucial for local leaders to determine what will work best for their locality. It is for provider organisations and their leadership, governance, structures and workforce to deliver the required transformational change.

11. New models of care require new organisational responses. This Review provides options for providers of NHS care, together with support, to adopt the most appropriate organisational form for their clinical models.

The tightening financial climate

12. Since the inception of the NHS in 1948, health expenditure has increased by an average of 3.8% year on year in real terms.[5] Government spending over the last four years has seen much lower growth, around 1% per year.[5] In order to continue to meet demand within this budget, the NHS secondary care sector has been expected to achieve a 4% efficiency target year on year. The NHS has risen to this challenge and is becoming more productive, but rises in demand have started to outstrip the benefit of this increased efficiency.

13. Sustained financial constraint will continue for the foreseeable future. Many savings achieved in the previous years were non-recurrent and will not be of benefit in future years.[5] A King's Fund report in 2014 suggested that a majority of providers are not confident they will achieve financial balance in 2015/16.[8]

14. The medium term outlook is equally challenging and NHS England have predicted that without reform and efficiency improvement by 2021 the NHS will have a funding shortfall in the region of £30 billion.[9]

15. The greater the financial challenge and uncertainty faced by organisations, the greater the risk to standards of clinical services. The reasons why some trusts are unable to achieve financial stability are

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[4] Department of Health (2012), Long Term Conditions Compendium of Information, 3rd Edition, May 2012

[5] Nuffield Trust (2014), Into the Red; the state of the NHS Finances

[6] Health Education England (2014), Framework 15; Health Education England Strategic Framework 2014-2029

[7] Fairer Care Funding (2011), The report of the Commission on Funding of Care and Support

[8] Appleby J, Thompson J, Jabbal J (2014b). *How is the health and social care system performing?* Quarterly Monitoring Report 11. London: The King's Fund

[9] Monitor (2013), Closing the NHS funding gap: how to get better value healthcare for patients

many and varied. For most it is likely to be that the scale and scope of their service portfolio is unbalanced. This requires trust boards to make clear strategic choices and reach agreement with others on the need for wider system changes. For others, it will be a blend of leadership, cultural and workforce factores, with internal systems being misaligned and unable to meet the service and financial plans of the organisation.

16. The costs of supporting trusts that are persistently unable to demonstrate financial viability is considerable. In 2013/14, 31 NHS bodies were in receipt of interim revenue deficit support (9 Foundation Trusts and 22 NHS Trusts) totalling £509.5 million and 17 NHS bodies (6 Foundation Trusts and 11 NHS Trusts) were in receipt of interim capital deficit support totalling £95.3 million.[10] This circa £600 million funding is spent on ensuring the continuity of services rather than improving patient care and quality standards.

17. Whilst recognising that from time to time it is appropriate to provide short term financial support to organisations whilst they manage change, the extent of long term support denies the NHS the use of resources that could be better utilised to improve care to patients.

18. The time is right for providers to examine their service portfolios, clinical models of care and be clear on the supporting organisational forms that are needed to ensure these are fit for the next five years and beyond to meet the changing needs and expectations of patients.

Increasing evidence of variation in care

19. The NHS has some of the best outcomes in healthcare, but there is also significant variation in outcomes and in both patient and staff experience. Whilst some variation in outcomes will relate to differences in the patients each organisation cares for and the types of treatment they provide, some variations in outcome – and almost all variation in patient and staff experience – will relate to the quality of care provision. This variation is increasingly being reported and should not stay hidden from the public. It should be an aim of our universal NHS that all parts of the service aspire to deliver the standards that the highest performing organisations are able to achieve.

20. The Keogh Review[11] and most recently the Care Quality Commission's State of Care report outlining the results of the Chief Inspector of Hospitals quality inspections,[12] has emphasised the unacceptable variation in care and the need for providers to tackle this in a more systematic way.

21. The NHS Safety Thermometer[13] is a monthly survey of all patients in NHS care in any setting on one day. This data is used to provide information on the presence or absence of four harms – pressure ulcers, falls, urinary tract infections (UTIs) and new venous thromboembolisms (VTEs) – selected not only because they are common but also because there is clinical consensus that they are largely preventable through appropriate care.

22. Yet, for example, in the 12 months up to August 2014 the proportion of patients being treated for pressure ulcers ranged from 2.9% in the highest performing trusts to 6.5% in the lowest performing trusts. If the standards of care were universally brought up to those of the upper decile, each month 2,000 fewer patients would have the pain and distress of a pressure ulcer.[14]

23. Despite a sustained focus on infection control rates within the NHS, there still remains significant variation in the numbers of patients acquiring C-difficile infections. Over the 12 months to August 2014, the best performing trusts had an infection rate of 6.4 per 100,000 bed days with this increasing up to as many as 22.5 per 100,000 bed days for the worst performing trusts.[15] This equates to almost 3,000 fewer patients acquiring C-difficile if all trusts worked to the best standards of care.

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[10] Department of Health (2014), Financial Assistance under section 40 of the National Health Service Act 2006: Report on the exercise of powers under subsection 40 of the National Health Services Act 2006 as amended by the Health and Social Care Act 2012; July 2014

[11] NHS England (2013), Review into the care and treatment provided by 14 hospital trusts in England: overview report

[12] Care Quality Commission (2014), State of health care and adult social care in England 2013/14

[13] The NHS Safety Thermometer, http://www.safetythermometer.nhs.uk/

[14] The extrapolated figure given here is based on NHS Safety Thermometer national data for September 2013 to August 2014.

[15] Public Health England (2013/14), Monthly counts of trust apportioned Clostridium difficile (C. difficile) infections by NHS acute trust, https://www.gov.uk/government/statistics/clostridium-difficile-infection-monthly-data-by-nhs-acute-trust

24. When examining deaths in hospital, characteristics of the population served by the hospital must be taken into account. But even when factors such as age and type of illness are taken into account there is significant variation. For example, the best performing organisations on the Standardised Hospital Mortality Indicator (SHMI) showed 18% fewer deaths in hospital and at 30 days after discharge than would be expected. At the other end of the scale, the worst performing organisations show 16% more deaths than would be expected. This range of 34 percentage points between the best and worst performing organisations is concerning.

25. Over recent years it has become apparent that some organisations struggle to attract the right quality of clinical workforce, which has compounded the issues of clinical variation for trusts that are already challenged. The evidence shows that staff engagement has significant associations with patient satisfaction, patient mortality, infection rates as well as staff absenteeism and turnover.[16]

26. In all five of the NHS Trusts that the CQC has rated inadequate as of October 2014, more than 40% of staff said in the 2013 staff survey that the standard of care provided by the organisation would not be good enough for a friend or relative.[17]

27. In addition, recruitment of enough staff with the right skills to universally meet the seven day working requirements against predicted levels of future demand will prove an ongoing challenge for organisations.[18] Trusts will need to think innovatively about how they redesign services and pool their workforce with neighbouring organisations in order to maintain clinical quality.

28. The recent inspections that the Care Quality Commission has started to undertake demonstrate that leadership and culture have a significant impact on other areas of quality. Its early findings show that being well-led correlates well with the overall rating of quality. As the CQC have stated, the variation they observe cannot be explained by money alone. In many cases money will be a factor, and in a few cases a critical one, but quality improvements can also drive productivity gains. There will be other drivers behind this level of variation, and these need to be fully explored and solutions implemented to ensure everyone gets the good quality care they deserve.[19]

29. This Review suggests that giving organisations greater flexibility in their clinical, service and organisational models and forms will support a reduction in the variation seen in standards of care.

Why focus on organisational form?

30. It is rightly stated that 'form follows function'. Organisational form should always be designed to support the delivery of models and standards of care, and should not be an end in itself. This Review encourages boards to consider fundamentally whether their existing form is best designed to deliver new models of care and ensure the delivery of required standards.

31. Organisational form and design are crucial for enabling organisations to deliver their goals and to create the circumstances in which to address the challenges they face. Changes to organisational form are likely to have an impact on the elements which influence the ability of organisations to improve and deliver services. These elements include:

    i. leadership and culture;

    ii. systems of governance;

    iii. scale and scope of service offerings;

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[16] West and Dawson (2012), Employee engagement and NHS performance

[17] Care Quality Commission (2014), The state of healthcare and adult social care in England 2013/14

[18] Health Education England (2014), Framework 15; Health Education England Strategic Framework 2014-2029 seeks to start to address these challenges

[19] Care Quality Commission (2014), The state of healthcare and adult social care in England 2013/14

iv. systems/processes of service provision;

v. deployment of the workforce; and

vi. stakeholder relationships

32. The NHS Five Year Forward View, published in October 2014, outlined the collective system vision for the NHS. This outlined the *health and wellbeing gap*, the *care and quality gap*, the *funding and efficiency gap* and the transformation required to tackle all three.

33. As organisations respond to the NHS Five Year Forward View they should review their current organisational form to ensure that they understand any changes required to deliver new models of care. In doing so it is expected that trust boards will gain a greater understanding of the organisational form which will be most appropriate to meet the needs of the populations they serve through a range of clinical models.

34. The evidence of this Review has demonstrated that there are a range of different possible organisation forms with a range of associated benefits, but that barriers and confusion stand in the way of their wider adoption. This report makes recommendations for removing some of those barriers and to stimulate leaders to think across traditional organisational boundaries and the wider health system.

35. In addition, this Review intends to encourage all organisations across the sector to think differently about how they might accelerate emerging innovative change, as well as focussing on challenged providers. The engagement and discussions undertaken for the Review generated significant enthusiasm from both inside and outside the sector, and a wealth of additional information was gathered at the events which informed the recommendations set out later in this report.

Findings

36. The Review has shown that whilst there is an appetite for change amongst leaders within the sector, support will be needed to navigate some of the identified 'wicked problems'.[20] The sector must more quickly address its challenges, reduce variation in service standards and do so in more challenging financial circumstances. Those that have had success should be incentivised to support others to achieve clinical and financial sustainability across the whole sector, more quickly than would be possible by organisations working in isolation. There are, however, barriers preventing change from happening quickly and these must be addressed.

37. Throughout the Review there has been clear evidence of innovative practice, particularly in the mental health and community sectors, demonstrating the opportunity offered by strong relationships with a range of partners across the independent, voluntary, social care and social enterprise sectors. These opportunities should be more widely utilised by all types of provider.

38. Overall, the following five key themes have been identified:

    i. **One size does not fit all** – the challenges faced by providers are often multi-factorial and derived from local geography, historical service changes and local demographics. System leaders understand their own population need and geographies, and therefore need to be enabled and supported to identify and implement the best clinical models for their patients. In doing so, they need to examine their current organisational form to determine whether or not an alternative form would deliver better outcomes for their populations.

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[20] Grint, Keith (2008), Wicked Problems and Clumsy solutions: The role of leadership; originally published Clinical Leader Volume I Number II December 2008 – This defined a 'wicked problem' as one that is so complex it cannot be removed from its environment and solved and returned without affecting its environment. It shows no clear relationship between cause and effect and cites the NHS problems of an aging population and demand as an example of a 'wicked problem'

ii. **Quicker transformational and transactional change is required** – system leaders need to collectively own the transformation required across their local health economy. Historically transformation and transaction processes have been lengthy and protracted, particularly the early stages of planning and gaining consensus across the local health economy. Simplifying these processes will both accelerate opportunities for improvements in patient care and reduce the costs of transactions. The 'rules' also need to be explained and understood further, as perception of competition and legislative issues can cause organisations to become overly risk averse.

iii. **Ambitious organisations with a proven track record should be encouraged to expand their reach and have greater impact** – transformational change requires strong and capable leadership. There are many successful NHS organisations and individual leaders with a track record of delivering consistently high quality healthcare to patients, but many have not thought beyond their current organisational boundaries. Leaders of successful organisations should become 'system architects', encouraged to use their entrepreneurial spirit to develop innovative organisational models and to codify and spread their success to other localities. Recognising these successful organisations, supporting them to develop enterprise strategies that expand their reach and developing new incentives will encourage more successful organisations to have a greater impact with less successful ones.

iv. **Overall sustainability for the provider sector is a priority** – there are currently 93 NHS Trusts. A proportion of these will become Foundation Trusts, but many will not reach the required standards in their current organisational form. Equally, there are some Foundation Trusts that would not meet the requisite standards for authorisation today and may be significantly challenged both clinically and financially. Long-term solutions need to be identified for these organisations, supported by appropriate governance models, to ensure that all patients can continue to access safe and reliable high quality care.

v. **A dedicated implementation programme is needed to make change happen** – In order to implement the ideas in this Report, two activities must occur in parallel: firstly, NHS leaders should be supported to develop awareness and knowledge of the available models and implementation approaches through a national programme of learning and sharing best practice; secondly, there should be a programme of demonstrator sites that can stimulate and accelerate change. This accelerated programme will support providers to test new organisational forms. Particular attention will be given to supporting successful organisations to develop entrepreneurial solutions to assure the delivery of reliable services in challenged health economies.

39. The evidence from the Review suggests that addressing these five key themes will accelerate the transformational change that is required to help overcome the challenges facing the NHS.

40. To ensure clarity of responsibility and accountability, each recommendation specifically identifies who should address its implementation.

Chapter One: Organisational Forms

One size does not fit all

A broader range of options is required

41. Organisational forms are different to legal entities.[21] The same legal entity can accommodate more than one organisational form and providers should consider being as innovative as possible to develop delivery models which support improvements in the delivery of care. The Review found examples of organisations that had a number of different organisational forms already operating within their trust.

42. The work of the Review has demonstrated that effective use of different organisational forms can help to support the reliable delivery of high quality care. The Review has determined that the following factors are key:

    i. no single organisational form is a panacea and there is no 'one size fits all';

    ii. there should be local determination of care models, which should in turn drive local decisions on organisational forms. Central, top-down solutions should be avoided;

    iii. multiple organisational forms can exist within a single legal entity;

    iv. research[22] has shown that different organisational models could help drive improvements in the quality of NHS services but emphasises the importance of execution in turning potential gains into real benefits; and,

    v. boards should think differently about their own organisation and use their social entrepreneurialism to develop new ways of delivering care. Ambitious trust boards should consider the development of an Enterprise Strategy[23] to drive change within and beyond their organisational boundaries.

43. This Review considered seven different organisational forms,[24] which are categorised as collaboration, contractual or consolidation and are depicted in Figure 1 and outlined in more detail in the table below:

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[21] A legal entity has a generic framework of functions, duties, requirements and powers as set out in statute

[22] The King's Fund and Foundation Trust Network (2014), Future organisational models for the NHS: Perspectives for the Dalton review

[23] An Enterprise strategy is a plan for growth and development that utilises innovative and novel approaches to ultimately deliver increased value in healthcare provision. This strategy involves seeking out and capitalising on opportunities to deliver increased value to staff, patients and the public and deliver high quality care in a sustainable manner. It goes further than identifying standard opportunities that present themselves in a market but embodies a raised level of awareness of the external environment that is expressed through innovative and novel practices. These changes are capitalised upon and viewed as opportunities for increased operational efficiency and effectiveness through continuous improvement in cost and operating base

[24] For the purposes of this review , organisational models are defined as – the structures of governance, accountability and management that are created to achieve specific aims and objectives in delivering services

Organisational Form	Definition
Collaborative	Collaborative forms bring together two or more organisations voluntarily to pool their resources to achieve better outcomes for patients or for financial benefit, while retaining their original legal entity. Federation and joint venture are examples.
Federation	Several organisations come together to collaborate to deliver one or more type of service or back office provision. Each organisation retains its sovereignty and there does not need to be a legal agreement. However, it is best practice for one trust or other body to be the nominated lead for governance, quality and finance, set out in a Memorandum of Understanding (MoU) or equivalent.
Joint Venture	Two or more organisations pool their sovereignty in either a corporate arrangement to create a new legal entity to manage a particular service line; or in a contractual arrangement to create a shared services agreement with another organisation. In contractual arrangements one trust takes the lead responsibility for governance, quality, performance and finance reporting.
Contractual	Contractual forms have more formalised agreements and there are often performance and quality standards agreed as part of the arrangement. Service level chains and management contracts are examples.
Service Level Chain	One provider provides services for other providers. There are several ways that this could be contracted, such as the host provider outsourcing services to the service level provider, a service level agreement where the host organisation holds the service level provider accountable for delivery, or paying a fee to use the policies and protocols of the first provider.
Management contract	Some or all management control of the operations of an organisation is awarded to another organisation to manage for an agreed duration.
Consolidation	Consolidation forms are when a change of ownership occurs and organisations come together to form a new organisation potentially delivering different services than previously. Mergers and acquisitions, integrated care organisations (which can also be contractual) and Foundation Group are examples.
Integrated Care Organisation	Brings together some or all of the acute, community, primary care, social care and mental health services in a variety of forms. The organisation manages patients from a particular population across defined care pathways supported by shared data, IT and information systems.[25]
Multi-site trust	Two or more organisations are brought together to become one organisation through merger; all the relevant organisations would dissolve and a new organisation would be formed. Alternatively, one organisation may acquire the other one, which dissolves and becomes part of the acquiring organisation.
Multi-service chain or Foundation-Group	This model is distinct to a large merged organisation as it has a separate 'group' Headquarters that sets the governance, standards, protocols and procedures, often with centralised procurement and back office functions. Each site is managed on behalf of the group by a management team that have delegated decision-making within the parameters set by the HQ board.

[25] Integrated care models can also be supported through contractual arrangements such as an overarching contract with a prime contractor or an alliance contract that binds together a number of separate organisations. A new organisational form is not the only route. Further details can be found in the supporting evidence pack

Other models

44. There are other models that providers of NHS care may wish to consider:

    i. **Buddying** – introduced into the NHS as a result of the Keogh Review and the subsequent Special Measures regime. The Review commissioned an evaluation of the experience of the 'buddying' model,[26] which concluded that the concept of buddying has been generally well received by organisations in 'special measures', albeit with some exceptions. It recommended that any provider, not just those in 'special measures', can benefit from the two-way learning and improvement such relationships can offer;

    ii. **Informal partnering** – providers should be encouraged to develop partnering arrangements to promote organisational learning and improvement. This report refers to this as informal partnering, which is considered to be an ongoing, voluntary process that organisations could enter into at any time.

    iii. **Clinical and strategic networks** – clinical networks have been used by clinicians as a mechanism to develop best practice for a significant time in the NHS. In November 2012, NHS England (then the NHS Commissioning Board) set out its vision for a single operating model for Strategic Clinical Networks that would sit alongside Clinical Senates and focus on further improving patient outcomes in the areas of cancer, heart disease and other significant areas such as maternity, paediatrics, mental health, dementia and neurological conditions.[27]

    iv. **Mutual or social enterprise** – during the course of the Review, the King's Fund report into staff engagement[28] and the benefit of the mutual[29] model was launched alongside a joint Cabinet Office and Department of Health programme of support;[30] Mutuals in Health: Pathfinder Programme research project into the benefits and barriers of mutual model in acute hospitals will be running in early 2015. This model was examined as part of this Review and was considered to be an ownership/governance model and as such could be applied to all of the different organisational forms described in this report.

Outline of each organisational form

45. More detail on each of the organisational forms considered by the Review is described below. The diagram outlines the different types of organisational form from collaboration through to consolidation and the relative benefits in terms of efficiency gains which they may offer.

46. The descriptions identify a set of circumstances for which each form may best be considered; associated benefits; potential pitfalls to avoid; and case studies outlining how they have been used by different providers to deliver high quality care for patients. Further detail on the organisational models can be found in the supporting evidence pack.

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[26] Foundation Trust Network (2014), Review of buddying arrangements, with a focus on trusts in special measures and their partnering organisations

[27] NHS Commissioning Board (2012), Strategic Clinical Networks: Single Operating Framework

[28] The King's Fund (2014), Improving NHS care by engaging staff and devolving decision-making – http://www.kingsfund.org.uk/publications/articles/improving-nhs-care-engaging-staff-and-devolving-decision-making

[29] Social enterprise, community interest company, employee-owned company, mutual are all terms used interchangeably. However, in this context 'mutual' is the formal term applied to the programme supported by the Cabinet Office and the Department of Health

[30] Mutuals in Health: Pathfinder Programme – https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/343507/Letter_to_Foundation_Trusts_and_NHS_Trusts.pdf

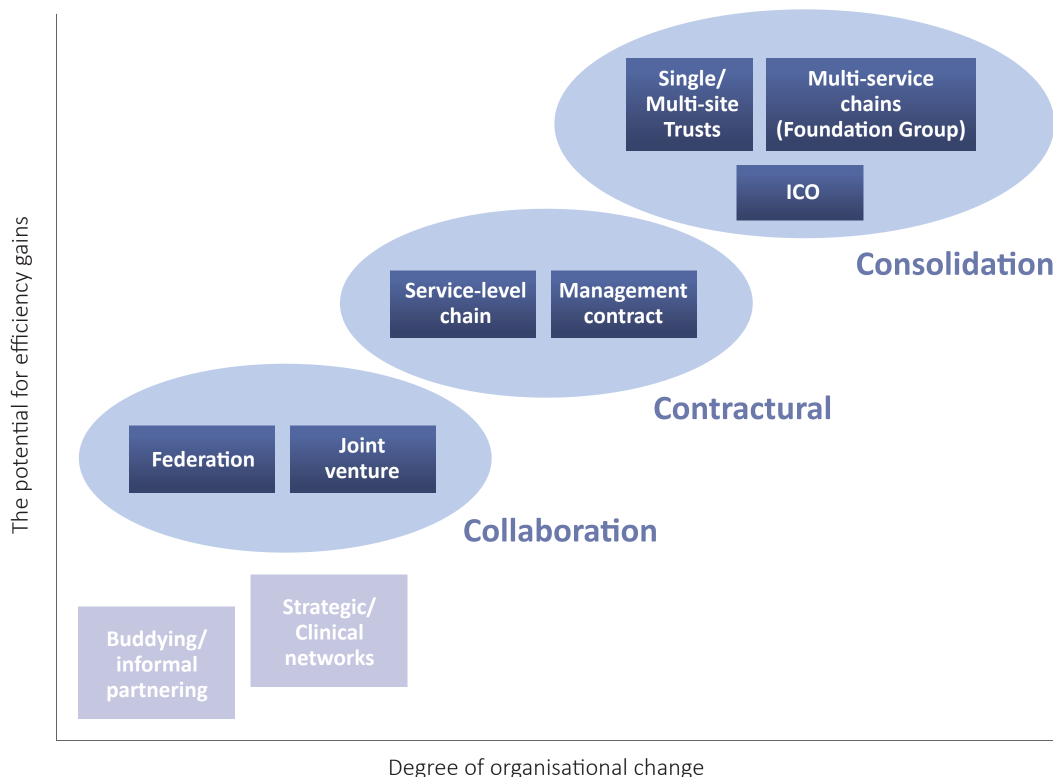
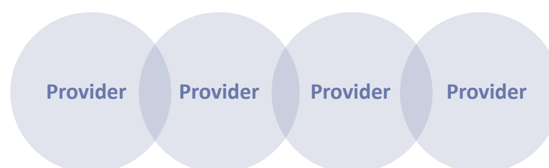


Figure 1: Different organisational forms and their potential ability to release efficiency gains[31]

Collaboration

Federation



47. A federation is when two or more providers agree to share resources for mutual benefit; they can be used to share support services, knowledge and expertise and even clinical resources between more than one provider. Each organisation retains its sovereignty and there does not need to be a legal agreement, but one trust or body would be the nominated lead for governance, quality and finance as reflected in a Memorandum of Understanding or equivalent.

48. A federation could be used to share best practice and quality improvement resources and to align patient pathways to improve patient outcomes and operational efficiency. An example of this is UCL Partners' work on the stroke pathway, as outlined in the case study below. Federation members in different parts of the country could share resources through technology, for example using a video-based clinical consultation platform to allow senior clinical staff to undertake outpatient and follow-up appointments across different sites without travelling. NHS providers in a federation may be able to access resources that are not available to all of them individually and to share the costs of existing resources.

[31] Adapted from: Pearson, Jonathan (2011), "Options for healthcare group working", GE Healthcare Finnamore, – http://www.gehealthcarefinnamore.com/insight/thought-leadership/10-thought-leadership/240-29-options-for-healthcare-group-working.html

49. Two of the most important questions that a prospective federation must answer are:

    i. What is the precise situation that the federation is looking to address?

    ii. Do all parties in the federation have complementary objectives and share a view of the nature and scope of its activities?

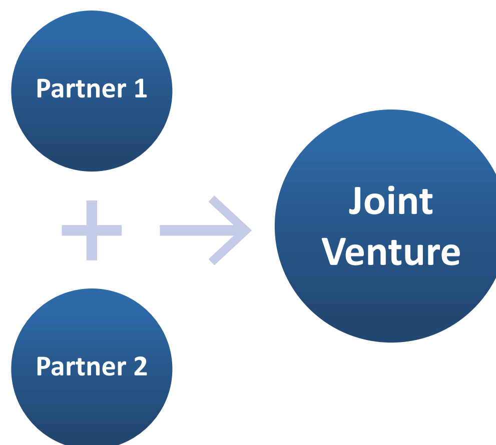
50. It is important to answer these and the further questions outlined in the supporting evidence packs, as without legal contracts enshrining the agreement, the success of a federation depends on the strength of the relationships between its provider members. These relationships must be able to endure the changes the federation is looking to execute.

Case study: UCL Partners

UCL Partners is an academic health science partnership containing over 40 higher education and NHS members, with a central team providing operational support and clinical academic leadership through a not-for-profit company. Together, its member organisations form one of the world's leading centres of medical discovery, healthcare innovation and education. By working together, UCLPartners' members are able to implement improvements in healthcare at a greater scale and pace to the benefit of their combined population of six million people.

UCL Partners have used their federated model to deliver commissioner's requirements to improve stroke care. This led to the consolidation of the treatment of all early-phase acute stroke patients in London into eight specialised centres. As a result of this consolidation, according to research funded by NHS London, over 400 lives have been saved since 2010.

Joint venture



51. A joint venture involves two or more providers of any sector creating a new legal entity to provide a particular service on their behalf. This can also be undertaken without forming a new legal entity if one provider takes responsibility for governance, quality, performance and finance reporting, which is known as a shared services agreement. Where a new legal entity is formed, the member organisations can agree a risk-share which allows each individual partner to gain from any surplus which could then be reinvested back into their core services. This is done via a special purpose vehicle.[32]

52. This is a more formal version of the federation model, which when used effectively can drive efficiencies through greater patient flows, efficient use of staff and standardisation of approaches to procurement and clinical protocols, thereby improving patient outcomes across a wider geographical footprint.

[32] A special purpose vehicle is a legal entity established to carry out narrow, specific or temporary objectives, which, in NHS terms typically pertains to a specialism or single task

53. Notably, joint ventures can offer a solution to organisations in geographic proximity that are unable in isolation to consistently meet the demanding service standards for emergency surgery and acute medicine across seven days. Creating a single shared service enables consolidation of workforce in designated specialities or services across organisations, allowing workforce planners to pool staff rotas across multiple sites.

54. One of the impediments to organisations pursuing service change, including consolidation of services, is that the leaders of organisations may consider that any consolidation results in the 'loss' of the service from their site and a corresponding 'gain' to another organisation who may receive that service on their site. The creation of a joint venture or single shared service means that affected organisations jointly own and govern the designated service(s) and are able to share in the benefits of economies of scale and scope of services, wherever they are provided. This can help overcome current objections, when trust boards are more or less enthusiastic about the need for change based on a judgement as to whether they will 'win' or 'lose' a service.

55. There are several joint ventures in place in the NHS. This organisational form has primarily been deployed where critical mass enables the more effective delivery of clinical standards or performance targets, such as in elective orthopaedics or as a result of the Carter pathology review[33] which recommended the development of larger pathology hubs. Despite demonstrated benefits, the model has not been adopted as widely as potentially it could, in part due to the lack of understanding competition rules, legislation and approval processes being perceived as barriers by organisations interested in forming joint ventures.

56. Questions that organisations that are considering joint venture more closely should consider are:

    i. Will Monitor need to approve? Dependent upon the size of the income and the associated risk and if the organisation is a Foundation Trust then Monitor may need to approve. The guide is that any transactions, including joint ventures, worth more than 10% of the trust's assets, revenue or capital[34] will need to be reported to Monitor.

    ii. What are the processes for sharing the surplus or managing the risk of deficit within the new entity across the partner organisations?

    iii. What impact will the joint venture have on staff? Who will employ and manage the staff and has TUPE[35] advice been sought?

Case study: South-West London Elective Orthopaedic Centre

Initially established in 2004 as an NHS treatment centre, The Elective Orthopaedic Centre (EOC) is a contractual joint venture between four NHS trusts in Southwest London to deliver strategic change in the delivery of planned orthopaedic care. The venture is hosted by Epsom & St. Helier University Hospitals NHS Trust, with its partners – St George's Healthcare NHS Trust, Kingston University Hospital NHS FT, and Croydon Healthcare NHS Trust – all in a contiguous geographical area.

Some of the outstanding features of the EOC have been enabled by its status as a joint venture, which, crucially, has separated the activity of the centre from that of its member trusts, allowing them to plan care strategically and without disruption from other services. Major benefits of this separation have been the ability to standardise patient care pathways, pool clinical excellence and make sizeable savings on procurement.

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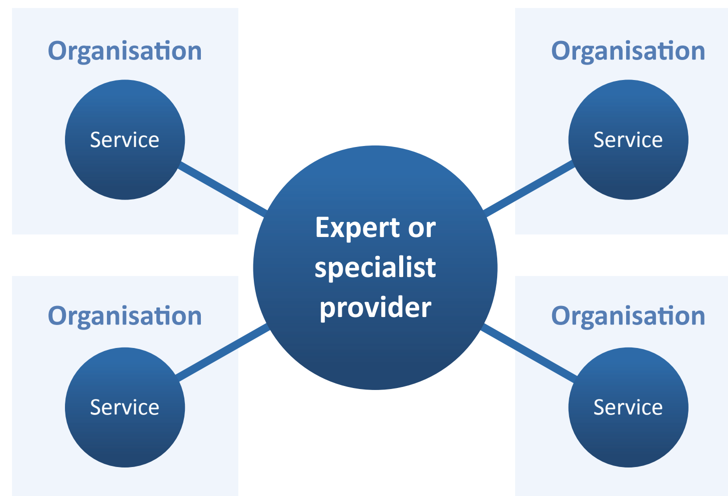
[33] Carter Review, 2008, http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Pathology/DH_075531

[34] Licence holders must report to Monitor any planned UK healthcare investments or other transactions worth more than 10% of their assets, revenue or capital. Monitor will then undertake a risk assessment proportionate to the impact on the continuity of services and the risk involved. Further information is contained in Monitors Risk Assessment Framework Guidance, August 2013, with particular reference within Appendix C as updated in April 2014. Also refer to the July 2014 CMA guidance on NHS mergers available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/339767/Healthcare_Long_Guidance.pdf

[35] Transfer of Undertaking of Protected Employment, applies when 75% of the new role is the same as the role the employee is currently undertaking

Contractual

Service-level chain



57. One provider delivers a service or specialty from premises owned by another provider. This has been previously termed the 'at' or @ model and could be considered as a host provider 'outsourcing' their activity.

58. There are three main ways that this model could be contracted:

    i. service delivery and accountability is wholly outsourced to the service level provider;

    ii. service delivery is provided by the service level chain, which is held accountable for performance by the host provider; or,

    iii. service delivery remains with the host provider using policies and protocols of the service level provider.

59. This organisational form is often deployed when trusts recognise that they are unable to provide the service to the required quality standards themselves. Outsourcing particular services to a service-level chain provides access to different expertise, new technology and helps resolve gaps in clinical workforce, accesses new technology. This allows the host provider to focus on delivering a smaller set of core services while providing greater patient benefit through the wider service offer for which it retains overall responsibility.

60. This is an important organisational form for developing the 'brand' of a provider organisation as well as expanding the scope and scale of the services to deliver greater economies of scale. It therefore requires the provider organisation to have the necessary capability and capacity to run services in distant sites that are not within its direct line of sight on a day-to-day basis.

61. This form has seen success, for example in ophthalmology services and cancer services, where organisations recognise that they are unable on their own to keep pace with the technological advancements in treatments. This organisational form drives a greater degree of standardisation as it is predicated on the provider organisation's ability to develop a replicable standardised operating model including protocols and pathways. Agreements need to be established between providers for arrangements when patients move across into other services, such as critical care, which require clear clinical governance and risk policies. This form therefore appears best suited to relatively self-contained specialities such as ophthalmology and cancer care, but has the potential to be widened to other specialties.

62. Questions that an organisation considering developing a service-level chain model should consider are:

    i. Who will be accountable for providing the services or speciality?

    ii. Have a set of replicable, standardised operating protocols and procedures been developed that can be easily transferred to another organisation?

    iii. What type of contractual arrangement will govern the service i.e. wholly outsourced, service-level agreement or provision of training on protocols and procedures?

63. It is important that the nature of the service arrangement is clear at the outset to ensure clinical governance, data gathering, performance reporting and quality inspections are undertaken correctly.

Case study: Moorfields Eye Hospital

Moorfields Eye Hospital is the largest provider of ophthalmology services in England, providing more than 33,000 episodes of inpatient treatment and more than 470,000 outpatient appointments each year. It operates a networked model of care across 23 locations in and around London. Apart from the hospital in central London, these locations are grouped into four distinct categories in discrete geographical clusters: District Hubs, such as Moorfields Eye Centre at Ealing, co-located with general hospital services; Local Surgical Centres; Community-based Outpatient Clinics, offering predominantly outpatient and diagnostic services; and Partnerships and Networks, where Moorfields offers medical and professional support to eye services managed by other organisations.

Approximately 50% of their total activity is delivered away from the central London hospital.

Management contracts

64. A management contract is the delegation of the management of whole or part of an organisation to a different organisation for a time-specified period. Management contracts can be let for single services, sites or whole organisations. These are particularly effective where there is poor clinical or financial performance which is not structural and can be transformed with a change of management and leadership. This is an asset-light way to allow alternative providers to deliver services to a population and provides access to expertise through the transfer of the operating model of the contractor.

65. Although the current example in the NHS is an independent sector provider, existing freedoms allow Foundation Trusts and NHS Trusts to enter into management contracts to manage operations or services on behalf of another NHS body.

66. NHS Trusts can be operated under management contract as at Hinchingbrooke Health Care NHS Trust, and it is possible for Foundation Trusts to be operated under management contract voluntarily, or if

required by Monitor where there are compliance issues. There are, however, some limits on the types of arrangements that can be put in place for Foundation Trusts given the different statutory framework and accountability structures in place; the extent of delegation and the responsibilities of all parties should be carefully considered in these instances.

67. Standardised practices could be brought across wholesale from the organisation that is managing the contract. This allows the sharing of back office functions to a greater degree including procurement practices and operational and clinical policies and procedures. The assimilation of the standard operating model of the organisation managing the NHS body is key to how quickly service standards may be improved or efficiencies can be derived.

68. There are several ways in which a management contract might be considered:

    i. in a situation where Monitor[36] or the NHS Trust Development Authority (TDA) deems that the leadership of the challenged organisation is the main issue, then it has powers to remove some or part of the trust board and contract out the management to another provider for a fixed period. This will support the TDA or Monitor to determine the future model that will ensure the clinical and financial sustainability of the organisation;

    ii. to widen the opportunity to gain management expertise with particular skill sets, such as turnaround or clinical service reconfiguration;

    iii. if there are particular issues such as asset management that require property management expertise, the separation of operations and property into an 'opco'/'propco' model could ensure the relevant skills are applied to the issues;

    iv as a first step towards a greater degree of consolidation, with reduced initial risk falling on the acquiring or lead Foundation Trust;

    v. to enable Foundation Trusts to test the Foundation Group model, without the risks associated with a full acquisition. This could help to build the skills and expertise required to run a Foundation Group model or chain; and,

    vi. these can take less time than a full acquisition and therefore could accelerate the turnaround of the organisation resulting in benefits to patients much more quickly.

69. Management contracts cannot be used to address underlying structural issues and should not be used as such.

70. Commissioners would performance manage the contract and would allow penalty clauses and break clauses to be added. This would give commissioners more confidence in supporting the service reconfiguration and change of management as there would be an exit strategy, which is far more difficult in a full acquisition.

71. NHS Trusts that enter into a management contract for a significant contract duration are still classed as NHS Trusts, and this poses a challenge under the current policy direction. There is provision in the legislation for these organisations to remain an NHS Trust at the end of the contract.[37] However, Monitor should give consideration to how it could authorise NHS Trusts as Foundation Trusts whilst under a management contract.

72. Questions that organisations interested in taking over the management control of an NHS body through a management contract route should consider are:

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[36] In the case of a Foundation Trust this has to be triggered by quality concerns raised by the CQC and/ or a breach or likelihood to breach a licence condition.

[37] Under s179(3) of the 2012 Act an NHS Trust may exist in this form when under management contract, and for three years following the contract end date, even after the repeal of the NHS trust legislation.

i. Is there a clearly articulated operating model which is codified and replicable in another organisation?

ii. Are all parties clear on the service and back office changes required and the level support for this both internal to and external to the organisation?

iii. Is sufficient management capacity available to take on the management of another organisation without risking a detrimental effect on your own organisation?

Case study: Ribera Salud Grupo

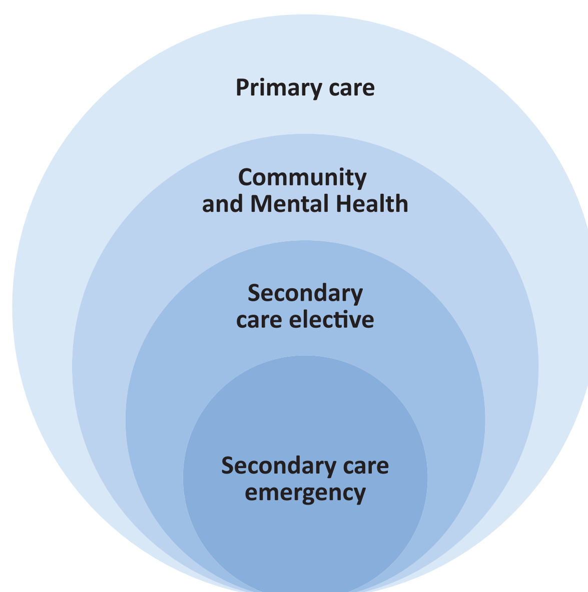
Ribera Salud Grupo was established in 1997 to design, build and operate a new hospital in La Ribera, Valencia Community, under a public-private partnership (PPP).

The Ribera hospital was the first privately run public hospital in Spain, and it expanded into primary health services shortly afterwards. The model has since expanded across Valencia and in other regions, with 4% of Spain's and 20% of Valencia's population now treated under these models. Ribera Salud operates the concession under contract with the government, which holds them to account, through a commissioner, for quality standards and outcomes. Ribera Salud assumes the risk for demand and outcomes over the duration of the contract.

They have a strong focus on decreasing clinical variability, with performance metrics intensively monitored and variation addressed. In addition, their capitated funding model and a 'money follows the patient' approach allows for defined public expenditure while encouraging quality and efficiency from the provider.

Consolidation

Integrated Care Organisation



73. Integrated care can be delivered through a formal or virtual vertically integrated model. The virtual model can be supported by alliance contracts across providers, or a prime contractor model whereby the commissioner enters into a contract with one organisation and that organisation sub-contracts with other providers to deliver care along the pathway. This organisational form is a type of the Primary and Acute Care System as set out in the NHS Five Year Forward View and offers providers the opportunity to 'dissolve

traditional boundaries'[38] and deliver innovative care models for their population. More information on the different contracting types can be found in the supporting evidence pack to this report.

74. The formal integrated care organisation[39] involves the vertical integration of one or more providers across a spectrum of care that could include primary, secondary (acute and mental health), community and social care. These are population based and deliver services to a defined cohort of patients with the aim of improving their outcomes, particularly for long-term conditions, by managing the coordination of their care. As set out in the NHS Five Year Forward View, this could include the new option of the Multispecialty Community Provider organisations which could take on the running of the main district general hospital, community hospital or have delegated budgetary responsibility for their registered patients.

75. This organisational form could potentially realise benefit for either whole local health economies or for a relatively large and well-defined group of high-intensity patients such as frail older people. There are a variety of organisations that could be included in an integrated care organisation and therefore this needs to be carefully developed based on the needs of the local population. Further information on the options for these models are set out in more detail in the supporting evidence pack including a cross reference to the NHS Five Year Forward View.

76. This organisational form can be either primary care or secondary care led. Where it is secondary care led it allows hospitals to operate in new areas of out of hospital care and to balance an investment in community-based services with a divestment in hospital-based care, without undue financial risk to the organisation. This is considered to provide an attractive model for secondary care providers, who might otherwise resist a transfer of resources from their organisation.

77. There are a variety of methods that commissioners can use to contract with integrated care organisations. Clarity on commissioner intentions over the medium term, particularly regarding the future tendering of community and mental health service contracts, is critical to the development of an effective integrated care organisation. Commissioners working with emergent or existing integrated provider models should make decisions to tender as appropriate to the care models they wish to deliver in their five year commissioning plans, in line with the Procurement, Patient Choice and Competition Regulations. This model may work best for providers whose commissioners are seeking to move towards a capitation or outcome-based commissioning model over longer contract duration.

78. Integration will usually require investment in integrated data systems to account for patient activity in each element of the integrated service, and the return on this investment may take several years. Integration should primarily be considered for improving outcomes and patient experience over the medium to long term; it does not provide a quick route to cost saving and may require significant technical detail to be worked through. This organisational form is a good example of where getting the clinical model right first should lead to organisational form later.

79. Questions that organisations considering collaborating to start to develop an integrated care organisations should consider are:

    i. Is there sufficient data available on your population? Is it possible to stratify their needs in order to determine the relevant care pathways and clinical models that need to be developed?

    ii. Is there a strategy or system for aligning IT and information systems?

    iii. What type of contracting arrangement will underpin the ICO?

[38] NHS Five Year Forward View, October 2014

[39] It is noted that this report uses the term integrated care organisation to represent the organisational form only. The payment mechanism such as capitated budget associated with Accountable Care Organisations is not considered as part of this report

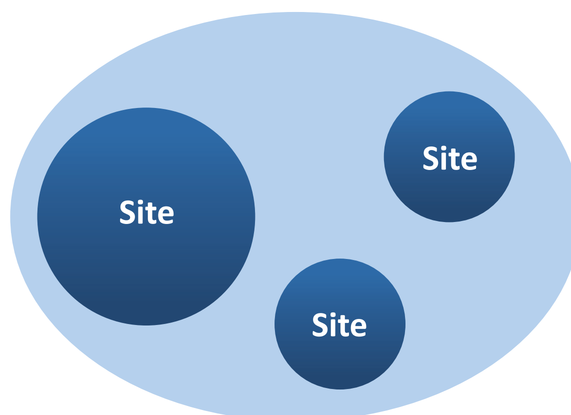
Case study: Integrated Care in Lambeth

The Lambeth Living Well Collective (LWC) brings together a number of mental health providers including the voluntary sector and South London and Maudsley (SLaM) NHS Foundation Trust, social care, public health, primary care as well as service users and commissioners.

Building on these existing strong relationships between providers and commissioners, the LWC decided to develop an integrated model through an alliance contract across a wide range of providers in the system, initially with a small group before expanding to bring in a wider spectrum of care. The alliance contract approach allows the providers and commissioners to build on the local collaborative approach, recognise all providers' contributions, reduce the risk of a dominant provider and to ensure that any changes are led by outcomes.

The CCG and local authority will co-commission the alliance contract, based around outcomes developed by the LWC. As well as delivering better outcomes and experience for patients, the contracting approach is expected to deliver shared savings across the system.

Multi-site Trust



80. A multi-site trust is the most common organisational form for larger organisations in the NHS. This is where, through a series of transactions, mostly contiguous, one provider owns and operates a number of hospital facilities in close geographical proximity.

81. There are infrastructure, clinical, and corporate synergies that can be realised through the merger or acquisition of neighbouring or nearby organisations. Due to this being most widely used within close geographical boundaries, competition regulations will need to be considered as part of any transaction. The patient benefit case that underpins a transaction of this type will need to be carefully considered and thought through. Monitor and the Competition and Markets Authority (CMA) have recently issued new guidance to support organisations interested in undertaking a transaction.[40]

82. As this model involves full change of management control to the acquiring organisation or the newly formed trust board of the merged organisation, there are considerable opportunities to standardise practices. Evidence from the European models was that a focus in the first instance on back office functions such as IT, transactional HR, finance, payroll etc. produces efficiencies that can then be applied to future acquisitions with greater benefit.

[40] Monitor and Competition and Markets Authority (2014), Supporting NHS providers considering transactions and mergers, https://www.gov.uk/government/publications/supporting-nhs-providers-considering-transactions-and-mergers

83. Questions that organisations interested in merger or acquisition should consider are:

    i. Does this acquisition or merger align with strategic aims?

    ii. Is there a suitable governance and accountability structure to incorporate a new site?

    iii. Is there a clear transition plan to integrate the organisation quickly, post-transaction, paying particular attention to cultural aspects?

    iv. Are staff going to be affected? Has TUPE advice been sought?

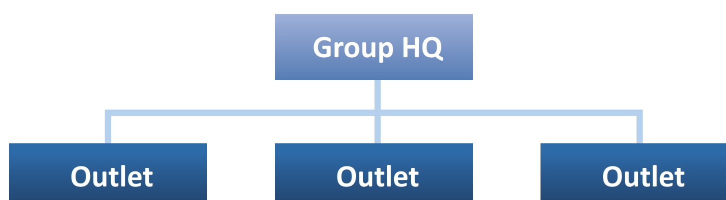
    v. Has the patient benefit case been clearly articulated?

Case study: Royal Free London NHS FT's acquisition of Barnet and Chase Farm Hospitals

In July 2014, Royal Free London NHS FT acquired Barnet and Chase Farm Hospitals, moving from a single site trust to a multi-site trust with three separate sites. Barnet and Chase Farm Hospitals was struggling financially and judged to be unable to achieve Foundation Trust status on its own. Several hospitals in the vicinity were considered as merger partners in a process of options appraisal, with Royal Free London NHS FT identified as the most suitable partner.

It is too soon to judge the success of the merger, but there are clear realisable benefits for both organisations resulting from the organisational change. All three sites will be able to achieve efficiency savings and realise greater economies of scope, as well as exchange clinical expertise so as to most appropriately configure provision and optimise services for the benefit of patients.

Multi-service chain (Foundation Group)



84. A multi-service chain or Foundation Group is a model in which one provider owns and operates a number of separate subsidiaries across a large, dispersed geographical area. Chains have separate group headquarters (HQ), which set standards, protocols and procedures with centralised management and procurement functions. All sites in the chain are managed on behalf of the group by a management team that have delegated decision-making responsibilities within the parameters set by the HQ board. Organisations in a Group structure often have a Growth and Development strategy[41] that underpins their approach to the development of the Group.

85. There are several ways that a Foundation Group structure could be formed:

    i. acquisition by the organisation of another single organisation;

    ii. simultaneous multiple acquisitions by the provider of more than one organisation; or,

    iii. the merger of two or more organisations to create a new large group organisation (this would require all legal entities to be dissolved and a new single organisation, with a new name, to be created).

[41] A growth and development strategy sets out the strategic aims of the organisation and how it intends to derive greater value for the organisation as a whole through increasing in size either through commercial success through the winning of more business or to increase in size through acquisitions either particular service lines or specialities or at the scale of whole organisation. This Report also refers to this as an Enterprise Strategy.

If at least one NHS FT is merging with any number of other FTs or NHS Trusts to create a group, authorisation by Monitor is required.

86. It is possible for Foundation Trusts to adopt a Group structure (Foundation Group) within the current legislative framework. The key requirement is to ensure that the local populations served by all of the different subsidiaries (or individual sites) are represented on the trust headquarters' Council of Governors. Accordingly, Foundation Trusts considering adopting a group structure should consider whether their governance structures are fit for purpose, and make any necessary adjustments to ensure appropriate representation and accountability in all their sites including changes to their constitution. NHS Trusts could merge to form a Group structure but this would need to be able to demonstrate the requisite clinical and financial standards to be authorised as a Foundation Trust Group in order for this to be supported by the TDA and Monitor.

87. As with the multi-site trust, this structure gives the greatest opportunity for organisations to improve service standards and derive efficiencies through standardisation. The evidence of this Review found that European models have successfully created benefits through efficiencies from procurement, back office and clinical pathways – and that this has been through both contiguous and non-contiguous organisations being acquired by the Group and brought into its standard operating model.

88. The Review commissioned research by the Nuffield Trust[42] to understand the difference between a group structure and a large merged organisation. This highlighted that the skill set of the leadership of a chain or group structure is very different to that of a large, merged single organisation. It requires a separation of strategic management (at HQ level) from operational management (at each managed entity) and the creation of a standardised operating model, with standard policies and protocols. The trust board at the HQ level would need to be detached from being the trust board of the primary organisation so that the latter would become one of the operating entities and so that the HQ trust board could give equal consideration to all of the subsidiaries.

89. Foundation Group structures can contain a blend of acute, mental health and community services. As long as the patient benefit case and the business cases are comprehensive there should be no barrier to a mental health trust acquiring an acute trust (or vice versa) in this way. The patient benefit and efficiencies to be gained may require greater consideration if there are not clinical synergies to be derived.

90. Lessons from the Academy schools model suggest that some academy chains grew too big, too quickly, stretching managerial capacity and exposing the whole chain to risk. Schools are much smaller entities than hospitals, as organisations should consider this carefully when considering their Growth and Development (Enterprise) Strategy.

91. Questions that organisations that are considering developing the Foundation Group should answer are:

    i. Does the acquisition of this organisation support the realisation of strategic aims? Does this meet the aims set out in the Growth and Development Strategy?

    ii. Is there a clearly articulated and codified standard operating model that can be transferred to the new entity?

    iii. Is there sufficient management capacity to undertake the necessary transition and transformation of the acquired organisation?

[42] Nuffield Trust (2014), Provider chains: lessons from other sectors. A report for the Dalton Review into new options for providers of NHS care

Case study: AMEOS German Hospital Group

AMEOS is one of the major hospital groups in the German speaking world with 68 facilities across Germany and Austria. Although the organisation is for-profit it undertakes a significant proportion of publically funded health provision on the same terms as the public healthcare.

AMEOS's management structure is a key enabling factor in being able to operate very successfully over such a large geographical area. Their headquarters is in Zurich with four regional offices all of which mirror the structure of the central office – providing support hubs for the facilities in each region.

The group's business model is to identify and acquire failing hospitals and invest in their facilities and services to provide long-term value. Conducting procurement exercises centrally in Zurich enables the organisation to save up to 20% on procurement when new sites are taken over. This, combined with the implementation of group methodologies, means they are able to assimilate and turn-around failing sites, effecting collective processes and standards to realise efficiencies.

Considerations

92. The evidence gathering, research and advice from the Review have demonstrated that all of these organisational forms are possible within the current legislative and regulatory framework.

93. During the Review, five countries were visited and case studies from nine different hospital groups examined. Learning from these international visits has consistently demonstrated that the benefits driven through the group structure are based on the ability to drive standardisation and include:

    i. standardisation of back office processes;

    ii. collective procurement strategies which enable large savings to be made through reduction in the number of product lines and greater guaranteed volumes, particularly when adding new sites to the group;

    iii. consolidation of clinical support services;

    iv. standardised clinical protocols and clinical pathways agreed across the network of clinicians in the group, enabling reliable delivery of service standards and improved outcomes;

    v. standardised approach to improvement methodology;

    vi. standardised approach to the adoption and spread of innovation, particularly for new technologies and devices; and,

    vii. group culture and values reinforced and supported across all of the subsidiaries.

94. Trust boards should consider the relevant benefits of standardisation that each of the organisational forms can deliver. This will require trust boards to consider acting outside their existing boundaries in either of the three types of organisational form *collaborative, contractual* or *consolidation.*

95. For trusts that are seeking to ensure they are able to continue to meet quality standards reliably over seven days and make best use of their clinical workforce, particular attention should be paid to the collaborative models.

96. Boards of NHS Trusts considering their sustainability plans should consider whether the existing scale and scope of their service portfolio enable them to meet required quality and financial standards; and if not, whether alternative organisation forms could better support the clinical models required.

97. When working with other providers to develop innovative solutions, trust boards should be clear that the changes are for the benefit of patients. When such arrangements would significantly harm choice and competition, such that there might otherwise be an adverse impact on patients, trust boards should be clear that the expected benefits outweigh these potential adverse effects. Working in this way will help ensure solutions work well for patients and therefore comply with the competition rules.

98. Exploratory work is currently underway through the Mutuals in Health: Pathfinder Programme to determine how trusts could adopt alternative governance forms such as social enterprises or community interest companies. These forms can be licensed and regulated by Monitor under their current powers. This flexibility opens up opportunity for existing NHS Trusts to think differently about their future. Monitor should identify how they would license those NHS Trusts that may become a new legal form, ensuring that requisite standards for Foundation Trust status are applied.

99. Organisations should consider developing an Enterprise Strategy that responds to the commissioning intentions and other external factors to identify novel and innovative approaches for transformational change. Leaders of successful organisations should consider how to grow and develop their organisations, using an appropriate organisational form as the vehicle to enable this.

Recommendation to trust boards

As part of the 2015/16 business planning process, trust boards should consider their response to the NHS Five Year Forward View and determine the scale and scope of their service portfolios. They should consider whether a new organisational form may be most suited to support the delivery of safe, reliable, high quality and economically viable services for their populations.

Recommendation to trust boards

Trust boards of successful and ambitious organisations should develop an enterprise strategy and should consider developing a standard operating model that could be transferred to another organisation or wider system.

Chapter Two: Making change easier and quicker

Quicker transformational and transactional change is required

100. The previous section of the report set out the various options open to providers of NHS care in considering how they might do things differently. This section focuses on providers they might be enabled to adopt these models, particularly for those delivered through transactions, addressing key areas such as gaining agreement, speeding up the process and supporting organisations to deliver transformation.

Speeding up the transformation of local health economies

101. It is very difficult to create the right organisational form to deliver sustainable services if there is uncertainty over the future care or service model. Commissioners – along with the wider system and with political support – will need to work with providers and engage with patients to determine sustainable service models, supporting providers to develop the organisational forms which can deliver those models. It is imperative that local commissioners and other local health partners commit to the models of care they co-design to best meet local need.

102. The NHS Five Year Forward View outlined a range of care models and approaches that commissioners and providers should seriously consider as part of their five-year strategic planning. Commissioners will need to work closely with providers to understand how these care models could be delivered across their respective health economies and, along with NHS England, consider how best to collectively meet the costs of transformative change which may include providers adopting an alternative organisational form. All parties should act on the commitment in the NHS Five Year Forward View that "we will therefore now work with local communities and leaders to identify what changes are needed in how national and local organisations best work together".[43]

103. Where commissioners agree plans for service transformation, they are responsible for ensuring that there is sufficient funding to achieve these plans. In limited cases where entrenched challenges mean that a solution within the current resource is not possible, consideration might be given by the Department of Health as to whether central investment can be justified based on the future returns for the health economy. This will be on a case by case basis.

104. Monitor and NHS England should play a role in helping commissioners to understand how they can work within the Procurement, Patient Choice and Competition Regulations to bring about transformational change. This support could include, for instance, helping commissioners understand how to consider and incorporate the views and needs of providers and the public while meeting the goals of good procurement.

[43] NHS Five Year Forward View, October 2014

Recommendation to NHS England and Clinical Commissioning Groups

NHS England should require Clinical Commissioning Groups (CCGs) to set out in their five year strategic commissioning plans:

a. the future care/service models they wish to support; and,

b. how they will use their allocated funds for service transformation to support providers to deliver the agreed transformational and organisational change.

Where multiple CCGs and providers are taking forward service transformation across a shared geographical area, NHS England should help broker agreement as to how costs are met between all parties.

Speeding up the transaction negotiation

105. Mapping of the transactions carried out over the past two years was undertaken for the Review. This demonstrated that the transactions assessment undertaken by Monitor and the approvals and negotiations with the Department of Health, TDA, NHS England and HM Treasury were usually the most straightforward part of the process. The most time consuming element of the process was – rightly – gaining local consensus regarding the appropriate service model; this highlights the importance of ensuring that all parties are committed to the transformational change required.

106. Too often, the NHS has entered a transaction intended to drive change without a full understanding of the transformational change required. Not only have these transactions taken a long time, often they have not realised the anticipated benefits. Providers and commissioners must be clear that not all transformational change requires a transaction, but where change of ownership or management control has been decided upon, this should happen quickly.

107. In the case of distressed organisations, the speed of the transaction is vital to ensuring the on-going sustainability of the services delivered to the population. Long and protracted negotiations can lead to a deterioration of the position of the organisation to be acquired. In order for these options to remain affordable, it is very important to complete transactions as quickly as possible whilst ensuring the right checks and balances have taken place. It was evident from the mapping exercise that it is not always clear which organisation should be funding which elements of transactions, when and who needs to be involved at each stage of the process and what their expectations are. This should be clearly laid out in a more transparent process.

108. The average cost of undertaking a transaction is £5m per organisation,[44] which includes due diligence fees, legal fees, interim staffing, project management and other costs. These fees are often incurred by both the acquiring organisation and the vendor. This is money that could be better spent on patient care; reducing the costs whilst maintaining the integrity of the process would achieve better value for money and deliver better care for patients.

109. The work of the Review examined the factors that could both reduce the costs of undertaking transactions and speed up the time taken. In any transaction, the following factors need to be taken into account:

    i. an assessment that a transaction is the best option to resolve long standing clinical and financial viability issues and that a transaction would be in the interests of patients and most likely to result in the long term clinical and financial sustainability of the local heath economy;

    ii. cost of undertaking the transaction (advice and due diligence); and,

    iii. implementation costs for service transformation.

[44] Department of Health; NHS Group Financial Management estimate

110. In order to reduce the cost and time taken for these transaction processes, three areas have been identified which, if brought together, would bring greater transparency to potential bidders. These are:

    i. An **independent due diligence –** this would be both financial and clinical due diligence and would be commissioned by national bodies covering a sector wide remit. This would establish:

        a. the 'day one running costs' of the organisation, including the size of the operational deficit and any structural deficits;

        b. the known risks or legacy issues within the organisation including performance issues such as CQC enforcement notices; and,

        c. the unknowns going forward i.e. potential issues that are not able to be quantified but could arise.

    This would form the basis for negotiations and would be agreed as reliable by both the Department of Health and the bidding organisations. The contract could be extended by the potential acquiring organisation to examine particular aspects and assure its own due diligence requirements. The negotiation would then be based on a mutually agreed approach to any future risk that may emerge following the transaction.

    ii. The parameters of any **financial package** would be based on the results of the independent due diligence. This would include:

        a. maximum level of revenue support available and the number of years over which the deficit would need to be reduced;

        b. level of support of any structural deficit (case-by-case based on due diligence);

        c. maximum capital financing available;

        d. any 'pass through' costs that the Department of Health would be willing to fund such as the impact of nationally agreed pay increases (case by case based on due diligence); and,

        e. level of indemnity against unknown risks.

    iii. Commissioning intentions should be made as clear as possible as part of this prospectus to allow potential bidders to develop their patient benefit case and service reconfiguration model as accurately as possible.

111. Pre-packaging this information together into a **tender prospectus** would provide much greater transparency for potential bidders on the parameters and therefore the potential risk that would be contained within the deal. This would enable negotiations to focus on whether the proposed solution, change of ownership and organisational model are right for patients rather than on the detail of the support available.

Streamlining the transaction process and understanding the rules

112. Transactions should take no longer than a year to complete after the decision is reached that the transaction is the route to sustainability.[45] This will help ensure that the quality of care delivered to patients does not deteriorate excessively throughout this period.

113. Once an organisation has decided it wants to enter into a transaction, there are often requirements to submit multiple documents requiring similar information for the approval of different external organisations, both locally and nationally. Each document may have different judging criteria, resulting in

[45] Once agreed by the Monitor or TDA board

inconsistent decision-making processes and subsequent requirements for clarification. Completing these documents can result in substantial losses of managerial time and can be off-putting for organisations, particularly smaller ones that may not have previous experience of transactions.

114. The introduction of standardised documentation with clear judging criteria and a unified process with clear guidance would make transactions much easier for bidders and reduce the overall time taken. This process should be open and fair so that all types of providers and potential bidders can develop their cases accordingly.

115. Competition law is not and should not be seen as a barrier to developing innovative solutions that work well for patients, but it is still often perceived to be. The Competition and Markets Authority (CMA) and Monitor have sought to explain the roles in the review of NHS transactions that meet the relevant thresholds. For example, the CMA and Monitor published a helpful short guide for NHS Managers explaining their review of NHS transactions in July 2014.[46] Monitor also published revised guidance on how it assesses and provides advice to the CMA on the benefits of NHS transactions.[47] In addition, Monitor supports organisations in the early stages of their planning to better understand the nature of any potential competition issues, so solutions that work well for patients can be taken forward. The CMA may also offer advice on transactions which are reviewable under merger control provisions. It is the responsibility of trusts and commissioners to engage with Monitor or the CMA, and familiarise themselves with the process they should undertake.

116. Those organisations that are not considering a large transaction but may be considering a joint venture, development of a service-level chain or federation should also be aware of the need to consider any potential competition issues that may arise. Monitor has recently published guidance on arrangements which could give rise to violations of competition law.[48] Monitor and the CMA should continue widely engaging and assisting the sector. The supporting evidence pack to this report has a high level guide to competition issues.

117. Choice and competition can bring about benefits for patients, meaning that some arrangements can harm these benefits. Even where this is the case, such arrangements can lead to improvements in services – the key consideration for the CMA, with advice from Monitor, is whether these lead to overall patient benefits. Where changes to organisational form are being considered to support better models of care, patients should not receive a poorer quality service due to perceptions about barriers from competition requirements. In October 2013 Monitor, the OFT and Competition Commission issued a joint statement outlining the latest steps in ensuring an effective process for the competition review of transactions that acts in patients' interest.[49] Monitor should continue engaging early and support the trusts to ensure that the patient benefit case is well developed and articulated.

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[46] The CMA also published detailed guidance on the review of NHS transactions that qualify for review. Competition Markets Authority (2014), CMA Guidance on the review of NHS Mergers, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/339767/Healthcare_Long_Guidance.pdf

[47] Monitor and Competition and Markets Authority (2014), Supporting NHS providers considering transactions and mergers, https://www.gov.uk/government/publications/supporting-nhs-providers-considering-transactions-and-mergers

[48] Monitor (2014), NHS healthcare providers: working with choice and competition, https://www.gov.uk/government/publications/nhs-healthcare-providers-working-with-choice-and-competition

[49] Office of Fair Trading, the Competition Commission and Monitor (2013), Ensuring the patients' interests are at the heart of assessing public hospital mergers, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283809/131017_oft_cc_monitor_merger_statement_final.pdf

Recommendation to the Department of Health

A single, unified process with standardised documentation outlining clear criteria should be developed to support future transactions. This should include guidance for all parties including Foundation Trust Governors.

Recommendation to Department of Health, Monitor and the TDA

A Tender Prospectus approach that has the parameters of the transaction clearly laid out should be made available to all potential bidders in the interests of speed and transparency.

Recommendation to the Secretary of State

The Secretary of State should set a requirement to the national bodies that, except in exceptional circumstances, all transactions are completed within one year or less from the time the decision is taken by the Board of the TDA or Monitor that a transaction is the route to sustainability for an organisation.

Ambitious organisations with a proven track record should be encouraged to expand their reach and have greater impact

A new 'kitemark' of success should be developed for ambitious organisations to aspire to

118. With 242 separate organisations, the NHS appears relatively unconsolidated compared to its European and US counterparts. If quicker solutions are to be found for the most challenged organisations in the health sector, it is right to look to successful organisations with a strong track record of success to provide the leadership to deliver reliable, high standards of care more widely across the system. This may be through informal support, but in some situations will mean those successful organisations taking extended management responsibilities over other organisations.

119. Foundation Trust status was introduced in 2004 and recognised excellence in quality, governance, leadership and financial management. Achieving FT status brought with it the rewards of independence from Whitehall and new freedoms which were designed to lead to innovation and entrepreneurial spirit in the NHS. This spirit existed in the first few waves of FT authorisations, but has not been as widespread as hoped; the Review heard that for some organisations FT status has become an 'end in itself'. Creating a new status to which the most successful organisations can aspire would not only recognise high performance, but has the potential to reignite an entrepreneurial spirit that could spread best practice across the country.

120. A new credentialing system should be developed that would 'kitemark' the most successful organisations. This credential would build upon the current oversight and assessment frameworks of the CQC and Monitor and would additionally measure the ability of an organisation not only to define its standard operating model, culture and approach but also to transfer and encourage assimilation of its practices into another organisation, thereby improving that organisation's performance. CQC assessment remains the most important measure of quality, but for organisations interested in expanding their offer it is right that their ability to do this is also tested. Credentialing would be open to all providers of NHS care, irrespective of speciality or sector.

121. As part of the Review, the Kings Fund examined the factors which a credentialing approach could measure.[50] This concluded that the Monitor and CQC processes include most of the elements required; however, to drive up standards more widely it is also necessary to assess the collection of systems and processes used by organisations to deliver success. Examples that could be measured include having an explicit improvement methodology or a replicable approach to leadership development or staff engagement.

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[50] Credentialing providers to take on additional responsibilities – an analysis of the evidence and stakeholder views; The Kings Fund, September 2014

122. The Kings Fund report also considered the supplementary evidence which could also be assessed for the purposes of credentialing, one example of which was the characteristics associated with the High Reliability Organisation (HRO) as defined by the Agency of Healthcare, Research and Quality (AHRQ).[51]

The qualities of a highly reliable organisation are recognised within five key characteristics:

i. **Sensitivity to operations –** a constant awareness by leaders and staff of the state of systems and processes that affect patient care, including high visibility of leaders engaging with staff.

ii. **Reluctance to simplify –** simple processes are good, but simplistic explanations of why things work or fail are risky. Avoiding overly simple explanations of failure (unqualified staff, inadequate training, communication failure etc) is essential to understand the real reason that patients are placed at risk.

iii. **Preoccupation with failure –** when near-misses occur, these are used as evidence of systems that should be improved to reduce potential harm to patients. Rather than viewing near-misses as proof that the system has adequate safeguards, they are viewed as symptomatic of areas in need of more attention.

iv. **Deference to expertise –** leaders should listen and respond to the insights of staff who know how processes really work and the risks patients really face. Leaders must recognise that the ideas for improvement are found deep inside their organisations.

v. **Resilience –** leaders and staff need to be trained and prepared to know how to respond when system failures do occur.

123. The credentialing system would identify those organisations capable of disssseminating best practice and excellence more systematically throughout the NHS. Monitor is well placed to lead on further determining the assessment criteria that would underpin a credentialing framework and should take on this additional responsibility, working with other national bodies. A good or outstanding CQC well led assessment should be a prerequisite for any credentialing process.

124. Recognising such excellence where it exists would encourage high performing providers to assess their operating model and consider their strategic capability to extend their systems and culture into other areas. Credentialing should also go further than just providing public recognition for a provider's high standards; additionally an organisation should benefit from its track record of high achievement. A procurement framework should be developed with categories for management contract and acquisition which organisations could opt into as appropriate.

125. The effect of a framework would be that organisations successful in meeting the requisite credentialing standards could be considered to automatically pass the pre-qualification questionnaire (PQQ) stage of any tendering processes.[52] This framework would then be used to arrange support for challenged organisations, providing faster solutions than are currently possible.

126. Local commissioners and providers would be able to approach credentialed organisations – knowing they have both high performance and strategic capability – when seeking new service delivery or partner organisations. In addition, regulators and national bodies could have confidence that, where credentialed organisations are supporting locally determined transformational change, there will be lower risk attached to these changes so that the maximum patient benefit can be delivered in the shortest time.

[51] Hines et al (2008), Becoming a High Reliability Organization: Operational advice for hospital leaders: Prepared by the Lewin Group for the Agency for Healthcare Research and Quality

[52] It is noted that the Invitation to Tender (ITT) stage would be open to all organisations on the framework

127. Acquisitions and letting of management contracts to support challenged organisations should not be held up during the establishment of the credentialing process and procurement framework. The assessment criteria should be developed and tested through the next few transactions, clearly identifying through the tender process the key characteristics and capabilities that an organisation will need to demonstrate in order to be credentialed.

128. Given that most organisations will not yet have developed an enterprise strategy for growth and development, it is expected that few organisations will have the requisite experience to be credentialed in the first instance. The breadth and depth of the framework will take some time to develop. Over time, however, it is anticipated that as more organisations codify their standard operating model and develop the required skill set, there will be an increase in the number of credentialed organisations and therefore a strong pool from which to draw through the framework.

129. The TDA and Monitor should be able to go outside the framework if the credentialed organisations do not match the specification or if a stronger patient benefit case can be derived through a local solution. However, once fully established, such deviation from the framework should be exceptional.

Recommendation to Monitor and the Care Quality Commission (CQC)

A new credentialing process, to recognise successful organisations capable of spreading their systems and processes to other organisations, should be developed by July 2015. This should build on CQC and Monitor ratings, with a good or outstanding rating a prerequisite.

Once agreed, Monitor should be responsible for the process and the first wave of credentialing should be completed by October 2015.

Recommendation to Monitor and the Care Quality Commission (CQC)

A list of all credentialed organisations should be published on both Monitor and the CQC websites and made available to every Clinical Commissioning Group.

Recommendation to CCGs and trusts

CCGs and trusts should use this list of credentialed organisations to identify new partner organisations most likely to deliver transformational improvement

Recommendation to Monitor and the TDA

A procurement framework should be developed which allows interested credentialed organisations the ability to register for management contract and acquisition opportunities. This framework should be live from or before April 2016.

Inclusion on this register would mean that an organisation automatically passes the pre-qualification questionnaire (PQQ) stage of any tendering processes. The framework should then be used by the TDA and Monitor to procure support for challenged organisations.

Leadership capacity and capability is crucial to the delivery of transformational change

130. In order to deliver the transformational change outlined throughout this report, the NHS will require a substantial cadre of strong, capable leaders with a range of skills.

131. Sir Stuart Rose will be publishing his review of NHS Leadership later in 2014/15, addressing the challenges and solutions for the future of leadership in the NHS. Separately to this, this Review considers that there are insufficient leaders in the NHS with the required skill set to meet the upcoming challenges of delivering new models of care. This needs to be addressed.

132. There are many highly accomplished, capable leaders in senior leadership roles on trust boards, many with a strong operational background. However, the very best operational managers do not necessarily make the best strategic Chief Executives. There is a difference between the skill set required to drive strong operational performance within an organisation and the skills to set strategic direction and develop an organisation to its fullest potential. That is not to say that one set of skills is better than the other, but rather that they are different.

133. If entrepreneurial organisations are interested in pursuing options such as Foundation Group or management contracts, this will require trusts boards to think and act very differently. Clearer governance and decision-making parameters will need to be created and the trust board will need strong strategic and enterprise leadership capability. This need was identified in the recent Framing the Future[53] work undertaken by the London Leadership Academy.

134. Operational roles are hugely important, particularly those who are supporting clinical leaders or are clinical leaders themselves. But these roles are often underrated. The development of the Foundation Group structure or the management contract approach offers the opportunity for a 'dual track' career path for leaders. New governance structures that require a separate headquarters running multiple subsidiaries, all with a separate Hospital Management Team, will require the development of a new Operational Managing Director role to be accountable for all operational management on each site. This role could enable those with excellent operational skills to focus on the single site or subsidiary management of the chain. These should be highly valued roles and remunerated accordingly.

135. Leaders of trust boards in successful organisations who are willing and credentialed to take over the management control of a struggling organisation, either through management contract or acquisition, should have the benefit they are bringing to the wider NHS adequately recognised through their remuneration and reward, in line with their organisation's remuneration policies.

There should be a greater degree of headroom created for leaders to turnaround struggling organisations

136. One of the biggest disincentives for successful organisations considering whether to acquire a struggling provider is the potential for their overall performance and financial position to be negatively affected. This can be mitigated by allowing a grace period for financial and operational performance to be agreed with the relevant national bodies in advance. Monitor's current practice of requiring organisations to recover performance according to a trajectory, rather than an absolute standard, should be adopted and understood more widely. This would allow the Board of the acquiring organisation the time and headroom to make the necessary changes within the acquired organisation. As part of this, trust board members and Chief Executives should be confident that their performance will not be unfairly assessed and that acting in the interests of the wider health system will not negatively affect their future careers.

137. As the Care Quality Commission's new inspection regime continues to operate more widely, it is increasingly likely that quality issues will be identified in some trusts which may lead, or may already have led, to an enforcement notice. As with Monitor's oversight, a trajectory should be agreed with the relevant national bodies and in particular the CQC as to the amount of time needed to address these challenges. Acquiring organisations should not be penalised for legacy issues if they are otherwise on an agreed improvement trajectory.

[53] Work undertaken (not yet published) by the London Leadership Academy to determine what the challenges of London will be in 2034 and therefore what the future leaders will require

138. A considerable amount of risk is inherent in transactions, which can affect the liquidity ratio or Continuity of Services Rating (CSR)[54] for an organisation to an extent trust boards may deem unacceptable. In some cases boards seek external financing to rebalance this ratio; this does not always make long term financial sense. Organisations can apply to have investment adjustments applied by Monitor, by which they assess the underlying risk in the transaction and adjust the reported rating to take this into account. This has not been widely used, but could offer an opportunity to improve value for money for some transactions.

139. If an NHS Trust has been deemed in need of a transaction, once a preferred acquirer or contractor has been identified and Heads of Terms have been agreed, work should be undertaken quickly to create integrated operational structures and prevent further deterioration in performance caused by ongoing uncertainty. Where possible, shadow running of governance and management structures should be established, for example through a management contract, without prejudice to the final decision by the Secretary of State on the transaction, to ensure patient safety is paramount.

Recommendation to Trust Boards

Trust boards should consider the new operational and strategic leadership roles required in order to support the new organisational model, and put developmental plans in place accordingly.

Recommendation to the Leadership Academy

The Leadership Academy should support the development of the requisite skills and experience for the new operational and leadership roles and build these into the career paths and leadership and development training of current and future NHS leaders.

Recommendation to Department of Health, Monitor and CQC

The Department of Health, Monitor and the CQC should agree a ‘grace period’ for acquiring organisation with an agreed trajectory of finance, performance and quality standards improvement for the acquired or contractually managed organisation, separate from the overall performance of the combined organisations.

This ‘grace period’ should take into account historical quality issues and the impact of any agreed financial investment adjustments.

Recommendation to Monitor and the TDA

Monitor and the TDA should ensure that – where appropriate – an acquiring or contractually managed organisation can start to create integrated operational structures, once the Heads of Terms have been agreed, so that these may be run in shadow form prior to the final decision on the transaction being taken.

[54] This replaces the previous Financial Risk Rating (FRR)

Overall sustainability for the provider sector is a priority

Monitor and the NHS Trust Development Authority need more options to prevent further deterioration in quality of care

140. This section outlines tools which, when combined, have the ability to drive considerable transformational change throughout the health sector at pace and scale. In addition, these could be used to great effect by Monitor and the TDA to address the deeply ingrained challenges faced by a small number of organisations.

141. As Monitor, the TDA and the Department of Health identify solutions for challenged organisations, they must also not neglect the potential benefits offered from the expansion of successful providers. Time is of the essence and therefore a wider range of options will be required in order for change to happen quickly.

142. The TDA is currently working through all NHS Trusts' five year strategic plans to identify their likelihood of achieving a sustainable organisational form and categorise them accordingly. As part of this work, the TDA is working with NHS England to ensure that commissioner and provider plans are consistent. Those NHS Trusts that are deemed unsustainable in their current form will be clearly identified as part of this process and an accelerated solution will need to be found. This segmentation is planned to have been completed later in 2014/15.

The TDA have segmented the NHS Trust sector into the following categories:[53]

i. Organisations with a clear and credible plan for reaching Foundation Trust status and a timeline of less than two years for doing so (Category A1)

ii. Organisations with a clear and credible plan for reaching Foundation Trust status and a timeline of less than four years for doing so (Category A2)

iii. Organisations with the potential to reach Foundation Trust status but which currently lack a clear and credible plan and timeline for doing so. The intention is that this would be a small, time-limited group which can be targeted for intensive development support (Category A3)

iv. Organisations that cannot reach Foundation Trust status in their current form and where acquisition by another organisation is likely to be the best route to sustainability (Category B1)

v. Organisations that cannot reach Foundation Trust status in their current form and where a franchise, management contract or other innovative organisational form is likely to be the best route to sustainability (Category B2)

vi. Organisations where further work is needed to determine the best route to sustainability. This would be a small, time-limited group with any further work to be undertaken by April 2015 (Category C)

143. The TDA should publish, at the earliest opportunity, the categorisation for each NHS Trust and its associated plans for achieving FT status or an alternative organisational form. The Department of Health should then use its regular accountability arrangements to hold the TDA to account to ensure the plans remain on track.

144. Challenged organisations (categories B1 and B2) should be supported to adopt an alternative organisational form through the implementation of a management contract or via an acquisition. This implementation could happen in one of two ways, sequentially or in parallel.

[55] NHS Trust Development Authority (2014), Board Paper B: TDA Board meeting. 18 September 2014

145. The *sequential* route would see the TDA determining the individual plans for each organisation and running one process at a time. This could take several years to complete, which would not ensure a timely reduction in clinical variation to patients. Additionally, these organisations would most likely continue to be in receipt of interim revenue deficit funding from the Department of Health throughout this period which will not deliver best value for the taxpayer.

146. In contrast, the more radical parallel approach would be for the TDA to examine its segmentation of NHS Trusts and to further categorise similar organisations based on geography or other categories, in order to undertake transactions in 'batches'. This could deliver a more accelerated solution, capable of restoring reliable, high quality services. This approach could also encourage ambitious providers, with enterprise or growth strategies, to respond with innovative solutions. For example, Foundation Trusts may form joint ventures with other Foundation Trusts or the independent, voluntary, or social care sectors, in order to run management contracts.

147. For those organisations that face short term difficulties or who are judged by Monitor or the TDA to be making satisfactory progress on an improvement trajectory (eg, TDA categories A1 and A2), formal improvement support provided by another organisation should be considered. Since the introduction of special measures and 'buddying' in 2013, it has become more apparent that expanding the reach of successful organisations into challenged ones can yield benefits for the NHS. This has opened up new options for the TDA and Monitor. If support does not result in improvement, an escalated intervention will be required.

148. As part of the Review, research was commissioned from the Foundation Trust Network to evaluate the success of the 'buddying' model. This research found that a precondition for success was a 'good fit', particularly compatability across the two organisations' culture and values compatibility across the two organisations in culture and values.[56] The buddying trust provides advice, guidance and experiential and technical know-how without delegated decision-making authority, so this approach cannot drive significant change. The Report advises that an expanded and formalised buddying approach from successful and stable organisations could provide significant support to challenged organisations which have improvement potential in their current form.

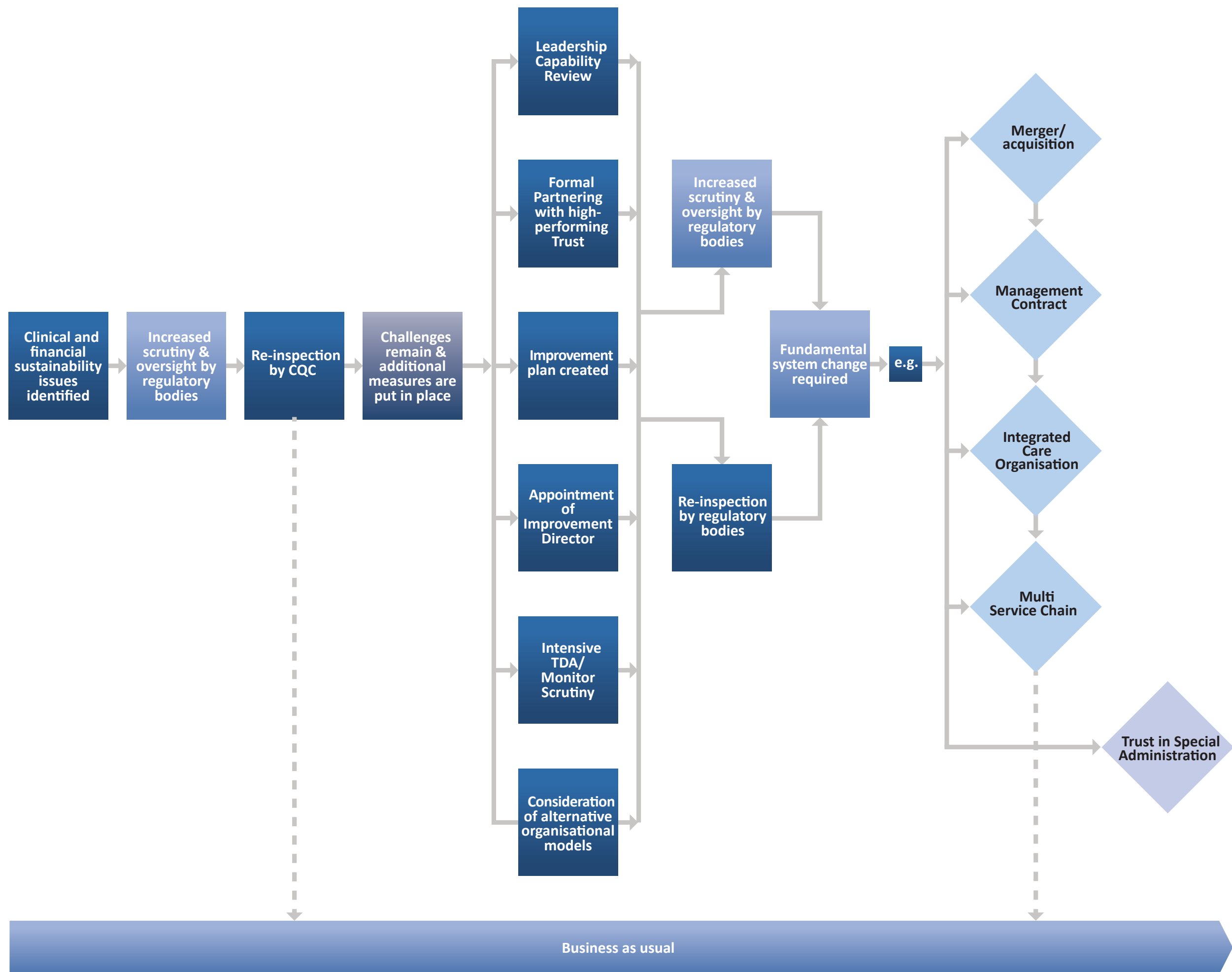
149. Monitor and the TDA should identify organisations interested in offering buddying support, with minimum qualifying criteria including a CQC assessment of 'good' overall. Fair and appropriate fees should be paid to organisations providing support, with consideration given to using target driven incentives within the fee structure.

150. As part of its ongoing work Monitor should ensure that any Foundation Trust which it identifies as being in 'persistent difficulty' produces a five year strategic plan that determines the appropriate organisational form, matched to innovative models of care. The plan must have clear implementation timescales for achievement.

151. Where Monitor judges that a Foundation Trust is unable to turn around its performance and quality issues within the agreed timescales, it should continue to intervene quickly using its formal powers. This includes attaching licence conditions, such as suspending board members, to ensure that solutions are implemented quickly. This intervention should also include an assessment of the merits of the FT in persistent difficulty pursing a transaction with a 'credentialed' organisation, once this process has been developed, to ensure the interests of patients are always above preservation of traditional organisational boundaries. Figure 2 below sets out a suggested route for regulatory intervention, including where consideration of an alternative organisational form might take place.

[56] Foundation Trust Network (2014), Review of buddying arrangements, with a focus on trusts in special measures and their partnering organisations

Figure 2: Suggested stages of regulatory oversight and intervention, including where consideration of alternative organisational form should take place.



Recommendation to the TDA

The TDA should publish the categorisation of and plans for each of the 93 NHS Trusts in the Foundation Trust pipeline, along with the trajectory and milestones for when and how each organisation will achieve Foundation Trust status or other sustainable organisational form.

Recommendation to the Department Of Health

The Department of Health should hold the TDA to account for meeting the trajectory and milestones for each of the 93 organisations.

Recommendation to the TDA

The TDA should consider accelerating the solutions for patients and communities currently served by organisations in persistent difficulty, by running batched procurements for category B1 and B2 NHS Trusts.

Recommendation to Monitor and the TDA

The buddying system should be expanded, beyond the special measures trusts, into a partnering system to allow organisations with the potential to improve early access to support and guidance from credentialed organisations.

Arrangements should be developed to identify and remunerate trusts capable of providing support.

Should buddying not result in the required improvement within a defined time period, a re-categorisation of the NHS body should be considered so that further action can be enacted quickly.

Recommendation to Monitor

Monitor should consider using their existing categorisation process to drive more rapid interventions.

Where Monitor determines that a FT is in ‘persistent difficulty’, it should require that FT to produce a plan with clear improvement timescales. If the FT is subsequently unable to demonstrate improvement against this plan, Monitor should compel that FT to present a new sustainability plan. This may include adopting a new organisational form or pursuing a transaction with a ‘credentialed’ organisation.

Chapter Three: Making change happen

A dedicated implementation programme is needed to make change happen

Implementation of the different organisational forms at scale

152. The extent of variation across the country in the delivery of high standards of care must be addressed as soon as possible. Whilst many organisations are considering new and innovative solutions to address quality and financial challenges, the recommendations of this Review need to be implemented quickly and widely in order to have the greatest impact for patients.

153. It is highly likely that new **collaborative arrangements** can enable improvements in care by shifting the mindset of trust boards towards one of joint ownership and governance with other organisations. Commissioning and regulatory bodies should engage with leaders of provider organisations to rethink 'business as usual', encouraging them to think outside their organisational boundaries and consider partnerships and new collaborations across their health and social care economy. This could lead to the implementation of new organisational forms, without the need for organisations to feel like 'winners' or 'losers'. These collaborative approaches will be crucial to the development of new models of care cited in the NHS Five Year Forward View.

154. A wide programme, delivered through health sector membership organisations, should be made available to support leaders to consider the options presented here in more detail as part of the 2015/16 planning round. An additional web-based resource would ensure all materials are easily accessible as well as providing a forum for organisations to share best practice and debate. Webinars, action learning sets and newsletters would support wider information sharing.

155. Practical checklists should be developed in order to assist organisations in planning. These should ask a series of questions that organisations considering any of the different organisational forms will need to ask themselves, in addition to practical tips on where to go for information, when to seek professional advice and pitfalls to avoid. These would be distributed through the national programme of learning and sharing best practice.

Further development of the ideas in this Review

156. Although the Review has undertaken a large amount of research, evidence gathering and testing of legislation and other technical challenges, it has not had the opportunity to test these in 'real life scenarios'. Some of the issues that organisations will face will require additional support to help the management team to navigate the issues.

157. In order to do this effectively, it is recommended that a number of organisations are supported to become a **demonstrator site**. These would be organisations that already have relatively well thought out plans that include implementing one of the organisational forms outlined in the report. The demonstrator sites would commit to sharing their experience and to being evaluated, such that the learning can facilitate wider and faster adoption over time.

158. Supporting the implementation of the models and disseminating the learning from a number of demonstrator sites will drive locally appropriate, sector led – rather than top down – approaches to addressing the challenges faced by all providers.

159. Those organisations interested in becoming demonstrator sites should consider the recommendations

of this Report – in conjunction with their response to the NHS Five Year Forward View – as part of the 2015/16 planning round and develop business cases accordingly.

160. The programme of demonstrator sites would support interested organisations in implementing new organisational forms in practice. The demonstrators should receive financial support for implementation costs and be formally evaluated as part of the process. Learning from the process of adoption and impact of the organisational forms would be shared with the wider sector to facilitate subsequent development of new organisational forms in non-demonstrator sites.

161. Although the demonstrator programme would provide additional funding to support transactions, there should be clear criteria that any transaction must also stand up to scrutiny on its own merits; the demonstrator programme should not subsidise inappropriate transactions or business plans. However, intervening earlier in appropriate cases to support preventative transformational change would have clear benefits for patients and the taxpayer.

162. The Department of Health, NHS England, Monitor, the TDA and CQC should consider quickly taking forward the recommendations made in chapter two of this report to develop a new approach so that, in the future, options such as management contracts and transactions are far easier and quicker to enact.

Recommendation to the Department of Health

The evidence and findings from the Review should be communicated across the health sector, alongside the business planning round, through a national programme of learning and sharing best practice.

Recommendation to Department of Health, Monitor and TDA

The national bodies should support a number of demonstrator sites where organisations implement a change to their organisational form. This should be evaluated and the learning shared with the wider sector.

Appendix 1: Sir David Dalton appointment letter

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

Sir David Dalton
Chief Executive
Salford Royal NHS Foundation Trust

14 February 2014

Dear Sir David

I am writing to confirm your appointment to lead a review into how we enable the best leaders and organisations in the NHS to expand their reach and deliver more for patients. I am grateful for your agreement to undertake this important work, drawing on your experience at high-performing Salford Royal and from buddying Buckinghamshire NHS Trust while it is in special measures.

It is already clear that the CQC's new inspection regime has revealed some fantastic care in our NHS. But it has also unveiled some stark variation – some poor care, weak leadership and patients not being looked after as they deserve to be. The hospitals placed in special measures by Monitor and the Trust Development Authority (TDA) are a decisive response to this.

The findings from the inspection regime have also indicated that hospital leadership has a profound effect on the quality of care and treatment that is provided. Frontline staff are the bedrock on which all our fantastic NHS care is delivered, but it is also clear that inspiring, innovative and brave leadership teams are behind the very best that the NHS has to offer. And yet their influence is limited in a UK hospital sector which is, by international comparisons, relatively unusual in having a structure of large, stand-alone hospitals.

Leading hospitals want to expand and work in new and innovative ways to provide better care, more efficiently, and not leave struggling providers isolated. You have seen first-hand how the buddying system introduced as part of the special measures process has offered external advice and leadership from the best in our NHS to the places where problems are most acute.

I believe that the best organisations, stewarded by the best leaders, should be able to provide more outstanding care to more patients. Other sectors and international healthcare systems have embraced models including networks of hospitals and clinical services, non-geographical chains, management contracts and other joint ventures. Some examples of similar enterprise exist in parts of the NHS but I would value your help in understanding how we can learn from and extend this work.

As we discussed, I would like the review to cover:

- The extension of the buddying and mentoring schemes in the special measures hospitals programme;
- Management contracts so that outstanding leadership teams can take on a more formal relationship;
- Improving incentives for our best NHS hospital trusts to take on turnaround projects and extended management responsibilities;
- A new framework for NHS providers who are certified as outstanding and the go-to people for turnaround projects and extended management responsibilities; and
- The arrangements which could enable local and non-geographical networks of hospitals or services under one leadership team.

I would like this review to give prominence and drive to consideration of these issues, on which my officials have done some preliminary work. You will be the figurehead, leading the review, providing direction and a focal point for engagement with other Chief Executives and interested stakeholders more widely. You will need to work closely with Monitor and the TDA in undertaking this review. A small team of my officials will support you in this work, and in the preparation of a report by June 2014. At least as important as this report, though, will be the conversation with the sector and the momentum you generate.

Thank you once again for agreeing to lead this review, and I look forward to working closely with you in the coming months.

Yours sincerely

JEREMY HUNT

Appendix 2: List of Review Panel Members

The review was chaired by Sir David Dalton, CEO of Salford Royal NHS Trust. Sir David was supported by an expert panel comprising the following individuals:

Name	Title	Organisation
Sir Andrew Cash	Chief Executive	Sheffield Teaching Hospitals NHS Foundation Trust
David Behan – deputised by Paul Bate	Chief Executive	Care Quality Commission
Miranda Carter	Executive Director, Provider Appraisal	Monitor
Chris Hopson	Chief Executive	Foundation Trust Network
Jim Mackey	Chief Executive	Northumbria Healthcare NHS Foundation Trust
Steve Melton	Chief Executive	Circle Healthcare
Stephen Dalton	Chief Executive	Mental Health Network NHS Confederation
Rob Webster	Chief Executive	NHS Confederation
Dame Julie Moore	Chief Executive	University Hospitals Birmingham NHS Foundation Trust
Jim Easton	Chief Executive	Care UK Healthcare Division
Ian Dodge	National Director, Commissioning Strategy	NHS England
Anna Dugdale	Chief Executive	Norfolk and Norwich University Hospitals NHS Foundation Trust
Mark Newbold	Chief Executive	Heart of England NHS Foundation Trust
David Flory- deputised by Ralph Coulbeck	Chief Executive	Trust Development Authority

Sir David Dalton and the Review Team led the writing of the report with expert guidance and advice from the Expert Panel members. The Panel members met six times to discuss the findings and recommendations. They advised in a personal capacity rather than as representatives of their organisations. The governance of the review panel meetings can be found at www.srft.nhs.uk/dalton-review/.

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HEALTH AND WELLBEING BOARD

3 August 2015

Report of: Chief Executive

Subject: LOCAL HEALTH AND SOCIAL CARE PLAN

1. ITEM FOR INFORMATION

At the Council meeting held on 25th June 2015, an update was received on the development of a plan for submission to NHS England to see the delivery of integrated health and social care services from the hospital site. In taking forward the wishes of Council, it was proposed that a Hartlepool Local Health and Social Care Plan Working Group be established; the draft terms of reference for the working group is attached

HARTLEPOOL LOCAL HEALTH AND SOCIAL CARE PLAN WORKING GROUP

Council at its meeting on the 12 March 2015 (Minute 157) resolved that 'the Council work with the NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (HaST CCG) to develop a plan for submission to NHS England to see the delivery of integrated health and social care services from the hospital site and that the Council take responsibility for the associated consultation so it is meaningful and services are shaped according to the wished of Hartlepool residents.'

In taking forward the wishes of Council, it is proposed that a Hartlepool Local Health and Social Care Plan Working Group be established. The remit of the Working Group to identify health and social care planning priorities which can be considered by appropriate decision making bodies, including the Hartlepool Health and Wellbeing Board, in the development of the local plan for the delivery of integrated health and social care services across Hartlepool, including the University of Hartlepool Hospital site.

A draft Terms of Reference for the Working Group is attached at **Appendix A** for Members consideration and further views sought as to the identification of an appropriate Independent Chair, as also requested by Council. In considering candidates for the position, attention is drawn to the potential role for a representative from the Northern Clinical Senate. Clinical Senates were established in 2013 as an independent source of strategic/clinical advice and leadership to Clinical Commissioning Groups (CCGs) and stakeholders to assist in making the best decisions about healthcare for the populations they represent. There are 12 Clinical Senates across the country, the membership of which includes health professions and representatives from patients, volunteers and other groups and further information in relation to the role and remit of the Senate's is attached at **Appendix B**.

It is suggested that an approach be made to the Northern Clinical Senate to nominate an appropriate individual to become the independent Chair of the Working Group.

Subject to the approval of Council, and the availability of the Independent Chair, it is proposed that the Key stages for the conduct of the Working Group's activities be as follows:-

Member Briefing – Introduction to Independent Chair and powers / role and remit of the Working Group.

Meeting One – Analysis of need in Hartlepool and identification of gaps and potential opportunities in service provision.

Meeting Two – Consideration of draft health and social care planning priorities.

Meeting Three – Consideration of recommended draft health and social care planning priorities prior to consultation.

Meeting Four – Consultation feedback and finalisation / approval of health and social care planning priorities for consideration by appropriate decision making bodies, including the Hartlepool Health and Wellbeing Board, in the development of the Plan.

Recommended

i) That the Terms of Reference attached at Appendix A be approved.

ii) That the proposed key stages and timescales for development and approval of the health and social care planning priorities be approved.

iii) That the Northern Clinical Senate be asked to nomination an appropriate individual to take up the position of Independent Chair on the Hartlepool Local Health and Social Care Working Group.

iv) That Members note that the Terms of Reference will be considered by the HaST CCG Governing Body at its next meeting to be held on 28 July 2015.

Terms of Reference

Hartlepool Local Health and Social Care Plan Working Group

1 Introduction

1.1 Hartlepool Borough Council on 12th March 2015 resolved that a Working Group be established with NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (HaST CCG) to identify health and social care planning priorities to inform the development of the 'Hartlepool Local Health and Social Care Plan' for the delivery of integrated health and social care services across Hartlepool, including the University of Hartlepool Hospital site.

1.2 The Working Group is to be known as the Hartlepool Local Health and Social Care Plan Working Group and referred to as the 'Working Group' for the purposes of this document. The plan for the delivery of integrated health and social care services across Hartlepool, including the University of Hartlepool Hospital site, is to be known as the Hartlepool Local Health and Social Care Plan and referred to as the 'Plan' for the purposes of this document.

1.3 This protocol provides a framework for the scope, composition and conduct of the Working Group's activities in the formulation of the Plan.

2 Power and Functions of the Working Group

2.1 Section 116(A) of the Local Government and Public Involvement in Health Act 2007 requires the local authority and its partner clinical commissioning group to have a view on how arrangements for the provision of health-related services could be more closely integrated with arrangements for the provision of health services and social care services in the area. The Health and Social Care Act 2012 also places a duty on the Health and Wellbeing Board to encourage integrated working (Section 195), prepare / implement Health and Wellbeing Strategies and Plans and places responsibility for the commissioning of health services that improve the physical and mental health service, including prevention, diagnosis and treatment, with the HaST CCG (Section 14(139)).

2.2 The Health and Social Care Act 2012, placed health scrutiny functions with the local authority allowing retention of the functions within Full Council with Section 199 of the Act allowing the local authority to provide the Health and Wellbeing Board with information to enable / assist in the performance of its functions. In fulfilling its responsibility to review and scrutinise matters relating to the planning provision and operation of health services, Full Council established the Working Group to take forward the development of a plan for the delivery of integrated health and social care services across Hartlepool, including the University of Hartlepool Hospital site.

3 Terms of Reference / Remit of the Working Group

3.1 To work in partnership with the HaST CCG in the identification of local strategic priorities to inform the development of the Plan for the delivery of integrated health and social care services across Hartlepool, including the University of Hartlepool Hospital site.

3.2 To progress the identification of local strategic priorities the Working Group will:-

i) Consider issues arising from the Hartlepool Joint Strategic Needs Assessment (JSNA) alongside the implementation of the Five year Forward View; and

ii) Receive, and consider, evidence, from professional / expert witnesses and 'other interested parties', as detailed in Sections 4.2 and 4.3 respectively.

4 Membership of the Working Group

4.1 The Working Group will consist of:

- All 33 Hartlepool Borough Councillors; and
- Co-opted representatives from the HaST CCG.

4.2 Evidence and views to be provided by professional / expert witnesses to inform the identification of local strategic priorities for consideration in the development of the Plan. Sources of this professional / expert advice to be (not exclusively):

- Officers from Hartlepool Borough Council and HaST CCG;
- Representatives from the North Tees and Hartlepool Foundation Trust;
- Representatives from Tees, Esk and Wear Valleys NHS Foundation Trust;
- Representatives from the HaST CCG;
- Representatives from the North Durham Clinical Commissioning Group;
- Representatives from the North East Ambulance Service; and
- Any other individuals with suitable clinical / medical expertise.

4.3 Views to be sought from 'other interested parties' to inform the identification of local strategic priorities for consideration in the development of the Plan. Other interested parties to include:

- Residents from Hartlepool, Stockton-on-tees and East Durham;
- Hartlepool Healthwatch;
- Councillor / Officer representation from Durham County Council and Stockton Borough Council; and
- Members of Parliament for Hartlepool, Easington and Sedgfield.

5 Status of Plan

5.1 The Working Group will identify, and agree, strategic health and social care planning priorities for consideration by the Hartlepool Health and Wellbeing Board and HaST CCG Governing Body in the development of a strategic health and social care plan.

5.2 Key stages for the conduct of the Working Group's activities will be as follows:-

Member Briefing – Introduction to Independent Chair and powers / role and remit of the Working Group.

Meeting One – Analysis of need in Hartlepool and identification of gaps and potential opportunities in service provision.

Meeting Two – Consideration of draft health and social care planning priorities.

Meeting Three – Consideration of recommended draft health and social care planning priorities prior to consultation.

Meeting Four – Consultation feedback and finalisation / approval of health and social care planning priorities for consideration by appropriate decision making bodies, including the Hartlepool Health and Wellbeing Board, in the development of the Plan.

6 Appointment of Chair and Vice Chair

6.1 The Chair of Working Group will be independent from the Council, the HaST CCG and any other participating parties.

6.2 In the conduct of their role, the Chair is to have an understanding of:

- The challenges facing the provision of health services in the region;
- The role and remit of the HaST CCG, health providers and the Health and Wellbeing Board; and
- Health Commissioning aims and objectives.

6.3 Given the importance of the role of the independent Chair in facilitating / managing the conduct of the meetings, bringing knowledge and expertise to the decision making process, meetings of the Working Group will only proceed if the Independent Chair is present.

6.4 On this basis, a Vice-Chair will not be appointed.

7 Role of the Chair

7.1 It will be the role of independent Chair to:

i) Ensure that:

- All members of the Working Group, expert witnesses and representatives from all other interested parties show due respect for process; and
- All views are fully heard and considered.

ii) Ensure the Working Group members have the knowledge and skills as required to properly and efficiently discharge the functions of the Working Group.

iii) Provide strategic clinical advice, guidance and direction to the Working Group.

iv) To uphold and promote the purpose of the Working Group and to interpret its Terms of Reference when necessary.

v) Liaise with Officer from Hartlepool Borough Council Officers and HaST CCG on the requirements of the Working Group, including:

- The setting of agendas and the dates, times and location of meetings.
- Advanced notice of officers / witnesses to attend, bringing together groups of health professionals in the provision of evidence.
- Approval of notes for each meeting of the Working Group.
- Formulation of the Plan for consideration by Council, the Health and Wellbeing Board and the HaST CCG Governing Body.

8 Final Report and Recommendations

8.1 The Working Group will agree proposed local strategic priorities for consideration by appropriate decision making bodies, including the Hartlepool Health and Wellbeing Board, in the development of the Plan for the provision of integrated health and social care services across Hartlepool, including the University of Hartlepool Hospital site.

8.2 Meeting will operate on a participatory basis with the primary aim /objective of reaching a consensus across all parties.

9 Administration

9.1 Meetings of the Working Group will be open to the public, other than where confidential or otherwise sensitive information is considered, in these instances the public should not be permitted access to that part of the meeting and for the duration of the consideration of that item or material.

9.2 The quorum for meetings of the Working Group shall be one quarter of the whole number of Hartlepool Borough Council members (9) with at least three representatives from the HaST CCG.

9.3 The date, time and location of meetings will be set by the Chair in consultation with Chief Executive of Hartlepool Borough Council and Chief Officer, HaST CCG.

9.4 Notice of meetings of the Working Group will be sent to each member of the Group at least 3 clear working days before the date of the meeting. Notices of meetings will include the agenda, papers / reports and notes for the previous meeting for confirmation. ‘To Follow’ reports will only be allowed in exceptional circumstances with the approval of the Chair.

9.5 Communication with the media in connection with the Working Group’s activities will be handled in conjunction with the HaST CCG’s press office.

10 Declarations of Interests and Code of Conduct

10.1 Declarations of interest will be in line with the requirements of Hartlepool Borough Council’s Constitution (Part 5 - Members Code of Conduct).

10.2 All members of the Working Group will be required to comply with the principles included in the Authority’s Code of Conduct for Members and to act in compliance with the seven Nolan Principles for Standards in Public Life, as outlined in Section 28 of the Localism Act 2011. The seven Principles being:-

- Selflessness;
- Integrity;
- Objectivity;
- Accountability;
- Openness;
- Honesty; and
- Leadership.

What is a Clinical Senate

Clinical leadership is at the heart of the new NHS commissioning system and is vital to fulfil the ambition for continuous improvement in the quality of services and outcomes for patients. Clinicians from across different professions, working together with patients and others to provide leadership and advice at both a local and wider geographical area, will be necessary if commissioners are going to be supported to make decisions which will transform health care.

Whilst Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board (NHS CB) are able to seek clinical advice from a range of sources, Clinical Senates have been developed in such a way that their members are able to take a broader, strategic view on the totality of healthcare within a particular geographical area. This ensures that future clinical configuration of services is based on the considered views of local clinicians and in the best interests of patients.

The type of strategic advice and leadership Clinical Senates are able to provide includes:-

i) Engaging with statutory commissioners, such as CCGs and the NHS CB to identify aspects of health care where there is potential to improve outcomes and value;
ii) Providing advice about the areas for inquiry or collaboration, and the areas for further analysis of current evidence and practice;
iii) Promoting and supporting the sharing of innovation and good ideas;
iv) Mediating for their population about the implementation of best practice, what is acceptable variation and the potential for improvement with AHSNs for a specific part of the country. Based on evidence and clinical expertise, they will be able to assist in providing the public profile on service changes;
v) Providing clinical leadership and credibility. Understanding the reasons why clinical services are achieving current clinical outcomes and advising when there is potential for improvement through significant reconfiguration of services;
vi) Taking a proactive role in promoting and overseeing major service change, for example advising on the complex and challenging issues that may arise from service reconfiguration within their areas;
vii) Linking clinical expertise with local knowledge such as advising on clinical pathways when there is lack of consensus in the local health system; and
viii) Engaging with clinical networks within a geographical area.

Clinical Senates span professions and include representatives of patients, volunteers and other groups. They work with Strategic Clinical Networks, Academic Health Science Networks, Local Education and Training Boards and research networks to develop an alignment of these organisations to support improvements in quality.

There are a number of important features that distinguish Clinical Senates from other bodies in the new health system:-

i) They cover a larger geographical area than many other bodies;
ii) They will not focus on a specific condition and will take a broader, more strategic view on the totality of healthcare than clinical networks (of all types); and
iii) They have a more clinical focus than Health and Wellbeing Boards or Health Overview and Scrutiny Committees.

HEALTH & WELLBEING BOARD

3 August 2015

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

Subject: LEARNING DISABILITY UPDATE - TEES INTEGRATED COMMISSIONING GROUP (TIC)

1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required; for information.

2. PURPOSE OF REPORT

2.1 To provide the Health & Wellbeing Board with an update on progress in relation to the Tees Integrated Commissioning Group action plan for adults with learning disabilities and a number of key areas affecting this agenda.

3. BACKGROUND

3.1 The Tees Integrated Commissioning Group (TIC) consists of the four Local Authorities (Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton) and the North of England Commissioning Support Unit (NECS), representing both Hartlepool & Stockton on Tees Clinical Commissioning Group and South Tees Clinical Commissioning Group (CCG)

3.2 The group was established in 2006 to ensure consistency of approach across Tees in respect of commissioning arrangements for adults with a learning disability. Over time the remit of the group has expanded to include autism, and more recently mental health.

3.3 The group is well established and has been instrumental in supporting and developing a number of Tees Framework agreements, including:

- Tees Advocacy Hub
- Tees Forensic Workstream
- Tees Autism Framework and Strategy

4. TEES INTEGRATED COMMISSIONING GROUP – ACTION PLAN

4.1 The terms of reference for the group were reviewed and revised in 2014 and will be reviewed again to include reference to mental health.

4.2 The proposed TIC action plan for 2015/16 is attached as **Appendix 1**.

5. PROGRESS ON PREVIOUS ACTIONS

5.1 The driving force influencing the TIC action plan has been the national Transforming Care agenda, previously referred to as the Winterbourne View Concordat. The resulting focus was in establishing an agreed joint plan across health and social care to ensure people with a learning disability were appropriately placed in accommodation that met their needs. Subsequently this work expanded to include people who were receiving assessment or treatment within a 'NHS specialised commissioned forensic service'.

5.2 Following the publication of the Winterbourne View Concordat (December 2012) which identified the poor standards of care and support experienced by adults with a learning disability, the chair of the Joint Improvement Board (NHS England & Local Government Association) asked for assurance of collaboration between health and local authorities.

5.3 The report found widespread poor service design, failure of commissioning, failure to transform services in line with established good practice and failure to develop local services and expertise to provide a person centred and multidisciplinary approach to care and support.

5.4 The main actions identified for TIC commissioners through the review and concordat were to:-

- Complete and maintain a register
- Identify people placed in inpatient services
- Ensure people receive an appropriate review of their care
- Identify those who are placed 'inappropriately'
- Agree a plan to move on with all parties
- Develop commissioning plans

5.5 A joint report was presented to Hartlepool Adult Services Committee in July 2013 to providing a stock-take of the position and advise that a joint plan was being developed which included a review of existing inpatient assessment and treatment bed requirements for the future.

5.6 It is important to note that this work will be on-going as there remains a flow of people that will make the transition through to adult services with the same level of complexity and associated specialist requirements, whose needs will require careful planning and commissioning.

5.7 In 2013/14 a review of bed occupancy was completed by NECS and significant reinvestment, in line with a reduction in inpatient beds, was recommended.

5.8 The review has resulted in an increased response from specialist community teams to support local learning disability services with an intensive community support response (8am-8pm) and on-call arrangements.

6. RISK

6.1 The 'Transforming Care' timescales identified nationally posed a significant challenge given the complexity of the people identified, and the risk of re-admission throughout the programme remained high. The timescales required a 50% reduction in the number of people in hospital provision by June 2014 – most regions were not able to achieve this target.

6.2 The market within Teesside required a significant shift in development with regard to workforce training and culture. A range of re-developed community provision was required to meet the needs of this vulnerable and challenging group of people.

6.3 As at June 2015, there are two people in inpatient care currently that have Hartlepool Borough Council identified as their responsible Local Authority.

- 1 person, admitted in 2013 into a specialist package of care, has received a full Care and Treatment Review and is being considered for discharge within the next 6-8 months.
- 1 person, admitted in the last 3 months is currently undergoing assessment and treatment and is not considered to be ready for discharge at this stage.

6.4 Three Hartlepool patients identified from the initial Winterbourne Assessment Process have been successfully resettled into bespoke packages of care in the community and there are increased positive signs of improvement in terms of quality of life indicators for all three people.

6.5 An enhanced community support provision has been implemented to further support local infrastructure with the aim of preventing unnecessary admission and support effective planned discharges. The service is a pilot model that will be evaluated at key milestones to ensure that it is meeting the required objectives and outcomes. This has been achieved through the reduction of some inpatient assessment and treatment beds and the shift in investment and expertise to the community.

6.6 Further work is ongoing with Tees Local Authority and CCG partners to establish the requirements of those patients who are currently within the secure service provision of NHS England, but who may be stepping down to local non secure services. The forecasting of the commissioning requirements for these people is a significant challenge as their needs can be more complex and challenging to existing service provision.

7. TEES INTEGRATED COMMISSIONING GROUP – ACTION PLAN

7.1 In response to the Transforming Care agenda, the current action plan will be further developed to include any outcomes linked to the recent NHS England regarding 'Fast Track' arrangements.

8. FAST TRACK ARRANGEMENTS

8.1 On 3 June 2015 NHS England issued a clarion call to health care leaders to redesign the care of patients across the NHS so that it is sustainable for the future and better able to meet the needs of patients.

8.2 Five 'fast track' sites will receive extra support to transform services for people with learning disability and/or autism and challenging behavior or a mental health condition.

- Greater Manchester and Lancashire;
- Cumbria and the North East;
- Arden, Herefordshire and Worcestershire;
- Nottinghamshire;
- Hertfordshire.

8.3 The transformation will be about improving lives by closing inpatient beds and strengthening services in the community. The five areas will receive extra technical support from NHS England to draw up transformation plans over the summer, and will be able to access a £10 million non-recurring transformation fund to kick-start implementation from autumn 2015.

8.4 A regional Transformation Board has been established to support the process and is chaired jointly by CCG Forum and ADASS leads.

9. NEXT STEPS

9.1 The Tees Integrated Commissioning Group will:-

- Continue to progress actions within TIC meetings
- Await the outcome of the Learning Disability Self Assessment
- Link recommendations from the reconfiguration task force and North East standards to the TIC action plan
- Work collaboratively to develop local bids to support the Fast Track implementation

10. PUBLIC ENGAGEMENT

10.1 The action plan, and progress against actions, will be shared with the Hartlepool Learning Disability Partnership Board and sub groups.

10.2 Evidence of actions achieved is reported using the Annual Self Assessment process and this includes independent validation. The outcomes are captured and form the basis of a National Learning Disability Overview report.

11. RECOMMENDATIONS

11.1 It is recommended that members of the Health & Wellbeing Board note progress on actions to date, note updates on recent developments and receive further reports

12. REASONS FOR RECOMMENDATIONS

12.1 The Tees Integrated Commissioning Group action plan provides evidence of local involvement, engagement and consultation in developing and shaping future service provision.

12.2 The action plan sets out a shared commitment to learning disability services with a process that allows progress to be monitored.

13. BACKGROUND PAPERS

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

https://www.improvinghealthandlives.org.uk/

https://www.improvinghealthandlives.org.uk/projects/jhscsaf2014

14. CONTACT OFFICER

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Transforming Care

What needs to happen	How will it happen	Lead	By when	Update	Linked to draft Care Standards
Explore opportunities to develop a Teeswide AMHP service along with considering how this can work with Forensic Service below	Discuss with AMHP Tees leads to obtain view on possibilities.	Neil, Colin, Pat, Karen	Take a report to Tees CG by 19 June 2015	Will explore possibility of forming a Tees AMHP Service. May have to examine issues such as pay etc. Took forward the proposal to Tees CCC group, spoken to Ian Hall who agreed to link in with some regioanl AMHP work through ADASS.	8
Report on Forensic review	Review currently taking place and paper to be shared once completed(end of June 15)	Colin	15th May 2015	Fully costed options paper to be developed by end of June 2015 and to be shared with TIC members	10
Compile community / inpatient bed data to be gathered	Data from business intelligence to be gathered including information from TEWV	Donna	15th May 2015	Inpatient data collected. TEWV data currently be gathered. Will be shared at Complex Inpatient and Community Group (remodeled forensic workstream group)	9
Complex care and support contract to be completed and shared with TIC members for agrement.	Heather Weir to provide	Colin	30th May 2015	Contract details shared - awaiting feedback	1 - 3 - 5 - 6 - 8 - 10
Tender process to be arranged	Heather Weir to arrange process	Colin	31st May 2015	Feedback on pocess	1 - 3 - 5 - 6 - 8 - 10
Framework implemented			31st September	work completed	
Terms of Reference from the network and work plan to be obtaine.	Request to be made for Judith Thompson to provide terms of reference and work plan. To be shared with TIC group	Kellie	27th March 2015	Terms of reference of regional network changed and will be embedded in new Tees Commissioning arrangemnts	
TIC to make considerations of the above	Review at meeting in June 15		30th June 2015		

Review the standards Donna is doing for the community services with TEWV	Circulate to TCG members for comments.	Donna	23rd March 2015	Measures and outcomes for community model shared with TICG and awaiting sign off with TEWV	10
Information on inpatients who need to move on.	Need to understand individual information in relation to Inpatient CCG's / NHSE Commissioning	Donna	30th April 2015	inpatient data collected for CCG commisisoned cases to be shared at next Complex Inpatient and Community Group. Awaiting the NHSE data.	4 - 5 - 6 - 8 - 9 - 10
Understand who we have in our area.	Contact Lynn Bradford and re-request list with information broken down across Tees.	Donna	30th April 2015	Response sent to NHSE to ask for Mts to be Tees focsued at TICG- request for current cases and estimated steps down timeframe to be shared	4 - 6 - 8 -9 -10
Review Forensic LD to transforming care & review people	combine the Tees workstreams, Forensic & Transforming care	Donna	30th Sept 2015	Group has new terms of reference new approach pending the outcome of any bids for additional resources to NHS England	
Complete the review of respite and day care	Task and finish group in place to revise demands and review current model to see if fit for purpose.	Neil	31st August 2015	Information recirculated to the group and agreement for this to be addressed at future TIC meeting	2
Individual Service Designs to be undertaken for each identified Transforming Care case	Positive Support in Tees to undertake ISD's have issued a business case	TIC	Ongoing in line with Transforming Care agenda	Potential to develop local capacity to support he songoing Care and treatment reveiew recomendations unsing individual service design model	2 - 3 - 4 - 5- 6 - 7 - 8 - 9

Mental Health					
What needs to happen	How will it happen	Lead	By when	Update	
Complete CAMHS list	List to be compiled and report completed and shared	Derek	17th April 2015	Ongoing	8
Gather information from CAB for each LA area	Ask CAB about figures which link to MHA assessment from TEWV (Julie & Vanessa)	Derek	30th April 2015	Work progressing	8 10

Understand who are our providers in mental health.	Use CQC as basis to establish current MH provision	Neil	20th April 2015	Neil to pull information from CQC Website - completed	3
Identify gaps to develop a framework	Identify gaps in provision across Tees	Neil	21st April 2015	Neil will present information at next TIC	6
Include mental health within this group	Agreed to establish Mental Health Workstream	Donna	23rd March 2015	Picked up- Donna will feed in iro MH	3 6
Need reps from all four LA's to crisis concordat group.	Make sure people have information before they attend	Neil to send invite	20th March 2015	Next meeting 24th April South Tees CCG Boardroom, North Ormesby Health Villiage- ongoing - new Tees Crisis Action plan	
LA's to look at individual strategies and bring them back to TIC	Review individually	TIC Leads	17th Oct 2015	Agenda for future TIC meeting	

Transitions					
What needs to happen	How will it happen	Lead	By when	Update	
Share the transition referral checklist	TIC	Colin	27th March 2015	Referral shared	
Invite Head of service of children's services to TIC	Discussion to take place	Colin	30th Oct 2015		
Discuss agenda and include everything needed around "vision"	Discussion at April meeting	Colin	17th April 2015	Completed	1 - 2 - 3 - 4 - 5 - 6 - 7 - 8- 9 - 10

Autism					
What needs to happen	How will it happen	Lead	By when	Update	
Information on what we need to do along with increasing membership of Tees ASDG	What we need to do – Why you need to attend	Derek	30th April 2015	Linda has sent letter to current members. Agreed AutismProviders to be invited to future meetings.	

Annual Review of the Autism Framework and review Quality Framework	Share outcomes of the quality review	Neil	21st Aug 2015	All Framework providers to be invited to next ASDG meeting, list of providers sent to Linda for circulation	1 - 3 - 5 -6 - 8 - 10
Complex Health Care Respite Review – include Autism in this	Neil to discuss at meeting – what needs to be included and to involve Autism	Neil	27th mar 2015	Agreed to tag onto TIC meeting	2
Childrens Strategy – all Commissioners to comment on document	Derek to circulate	Derek	2 weeks	Comments return	
Review and update Adult Strategy and to include Workforce Development / Autism Friendly Communities	ASDG	Derek	30th April 2015	To meet with Chris Stonehouse and ensure Children's and Adults Strategy are aligned.	
Review performance indicators with TEWV	Donna to address in Contract meeting	Donna	27th March 2015	Completed and shared with TIC. TEWV to sign off.	

HARTLEPOOL & DISTRICT HOSPICE
BREATHLESSNESS SUPPORT PROGRAMME
REPORT FOR HEALTH & WELLBEING BOARD (Prepared 16 July 2015)

1.0 INTRODUCTION

1.1 This report prepared has been prepared for the Health & Wellbeing Board. Previous interim progress reports have been submitted to the Health & Wellbeing Work Stream on 2 September 2014, 28 October 2014, 30 January 2015, 1 March 2015 and 16 April 2015.

1.2 The Breathlessness Support Programme Pilot has comprised of 9 x 6 week programmes, with the final programme ending on 23 March 2015. It is with confidence that we present the progress and benefits that the service has brought both to the patients and the health economy.

1.3 The initial concept of the programme was to support the relief of pressures in the accident and emergency departments through reducing anxiety related breathlessness admissions. Data received from NECS provides a broad view of the patient attendance information pre, during and post course up to Programme 7; however the data provided is combined for Hartlepool and Stockton and this prevents us from providing conclusive evaluations of the Hartlepool service which is quite different from the Stockton service. Differences in the service delivered from Hartlepool include:

- Transport in a specially adapted vehicle with oxygen facilities.
- Access to Nurse Practitioners.
- Evening Comfort Calls to provide patients with support and access to other healthcare support should this be required.
- Up to 6 Complementary Therapy treatments.
- Therapeutic Support Package including 3 individual and 3 group counselling sessions, which data demonstrates a significant improvement in wellbeing.

Therefore comparisons cannot be drawn of the key interventions that make a difference to patient attendance through A&E. Data has subsequently been submitted for all 9 programmes together with a request for an analysis of pre, during and post programme medical interventions and the Hartlepool and Stockton programmes separated out in order to provide an effective analysis of which programme has proved the most effective.

1.4 Evaluation of the Core Aims of the Programme

Core Aim	Activity	Patient Feedback	Carer Feedback	Recommendations	Strategy for Delivering Recommendations
To support the philosophy of the Expert Patient in enabling patients to self-manage the associated complexities of their disease, particularly in relation to psychological wellbeing.	Clinical advice. Smoking cessation advice. Nutrition advice. Physio rehabilitation. Therapeutic writing. Counselling sessions. Complementary Therapy.	Following Complementary Therapy sessions legs have 60% less pain. Sleeping has improved 60%. It is a very good course for people like me with COPD Emphysema, it does help when you are scared, anxious and panicky. I would definitely recommend it.	At a carer session the attendees thought it would be a good idea if their loved ones could continue to access day services and even to the point of paying for complementary therapies or talking therapies as their loved ones had gained such a lot from coming.	Counselling and Complementary Therapy sessions have proved very popular promoting relaxation, relieving tension, reducing stress and facilitating easier breathing. One patient has successfully weaned off oxygen altogether due to their reduction in anxiety and others have used the techniques during breathlessness attacks to gain control over their breathing. Complementary therapies have increased mobility in some service users and have facilitated better sleep with others. One patient reported 60% reduction in pain due to the complementary treatments.	Continue with the core elements of the service.
To reduce the reliance of patients on using Accident & Emergency to manage their illness.	Comfort calls. Specialist Day Service one day per week (Monday).	I have learned to manage my illness better. I have never met such an understanding, caring, willing to listen team of staff.	She really enjoyed the telephone calls, just having someone to listen to her. This comment was followed up by a request that the phone calls could continue for a little while longer rather than just stopping them completely straight away.	The data provided by NECS clearly demonstrates a reduction in A&E attendances throughout the duration of the course. There is however an increase in attendances after the course but it is still significantly less than pre course attendance. Therefore one could extrapolate from the data that a continued support mechanism be put in place.	

Core Aim	Activity	Patient Feedback	Carer Feedback	Recommendations	Strategy for Delivering Recommendations
To support the Care Closer to Home Agenda and reduce unnecessary admissions.	42 patients have participated in the course through programmes 1-7	I am just starting to feel like I am getting somewhere, I would have liked a bit longer to work on things. This course has gone by in the blink of an eye. I will miss the group and the comfort calls.	I am interested in the possibility of xxx accessing day trips out in the future to enable her to increase confidence levels and gain her life back.	Potentially admit more patients per course bearing in mind the number of Counsellors required.	
To support the Joint Strategic Needs Assessment challenges for long term conditions.	The course aligns the strategic intent of the Better Care Agenda through improving the health of people with long term conditions, enabling them to stay at home longer and reducing A&E attendances and acute admissions.	I have really enjoyed my time at the Hospice course, I have learned a few things, it also made me feel safe and comfortable and I met lovely nursing staff and made some new friends.	Keep doing what you are doing as the course gave xxx a new lease of life and she is very happy. I hope you can continue these sessions with others so they can benefit from them like xxx has.	Whilst there is clearly a financial saving to Commissioners through reduced A&E attendances and hospital admissions and to the Acute Trust through the availability of bed capacity; the wider benefits must be acknowledged that will provide savings and efficiencies elsewhere in the system, i.e. GP appoint-ments, District Nurse visits etc. What is more important however is the improved quality of life for both patient and carer, both physically and psychologically.	Continue with the service but increase awareness and publicise the benefits to health professionals and referrers. A full year effect evaluation will demonstrate even greater savings as the data provided is only for 8 months, 2/3 of the pilot period.

Core Aim	Activity	Patient Feedback	Carer Feedback	Recommendations	Strategy for Delivering Recommendations
To provide an integrated support service working in collaboration with primary and secondary care.	The following professionals have referred patients into this service: • Respiratory Nurse (D Wood) • Respiratory Nurse (L Johnson) • Respiratory Nurse (B Siddle) • Community Matron (A Turner) • Community Matron (A Hume) • Hart Medical Practice (Dr Lasa, GP) • Nurse Practitioner (E Awad)			Ensuring all GP's are aware how to refer into the programme.	If re-commissioned, to present the programme at the Health and Wellbeing Board, Healthwatch meeting and to other health professionals.

Core Aim	Activity	Patient Feedback	Carer Feedback	Recommendations	Strategy for Delivering Recommendations
To provide patients with self-management tools.	Relaxation DVD. Breathing exercises. Psychological therapy. A Therapeutic Support Package which consists of a combination of therapeutic group and individual sessions. Each patient can attend 3 individual and 3 group counselling sessions.	Breathing techniques have helped. Talks on controlling anxiety and relaxation helped. Social Services arranged 24 hour panic monitor to be fitted. Sleeplessness explained to me was a good help. Relaxes me. Had a panic attack through the night and practiced breathing techniques for 20 minutes which controlled my breathing, didn't require admission to hospital. Coming to the programme has calmed me down and taught me how to breathe when I am at home or outside. Facing problems, being more positive. Breathing is easier, feel it has motivated me to walk about more. I found the group very helpful and it has given me the confidence that I have not had for a long time. It is a lot of help, builds confidence and helps to cope with your condition much better.	I feel supported as a carer as my husband has found the sessions useful. He has had reassurance and it has helped him to cope with his depression and feelings, which in turn have helped me to feel better as I am not worrying about him as much. I attended the sessions and learned a great deal about breathlessness. My wife has benefited from the fitness section with exercise and medication advice. Keep doing what you are doing as the course gave her a new lease of life and she is very happy. I hope you continue these therapy sessions with others so that they too can benefit from them like she has.	Service users have reported that being able to explore and discuss topics such as anxiety, managing difficult emotions, relaxation, sleep difficulties, transition in family life, spirituality and sexuality have helped reduce feelings of anxiety and worthlessness and have enabled them to use the tools provided throughout the programme to manage their symptoms.	Continuation of course.

Core Aim	Activity	Patient Feedback	Carer Feedback	Recommendations	Strategy for Delivering Recommendations
To ensure a responsive service that prevents hospital admission for psychological and minor psychological crisis.	Specialist Nurse support including a Nurse Practitioner. Evening Comfort Calls to provide patients with support and access to other healthcare support should this be required. Access to a 24 hour advice helpline manned by specialist nurses, with access to 24 hour medical cover. Self-help techniques.	Straight talking has taught me to take a step back from situations. Massage improved mobility quite a lot. Careful and more aware when using gas – don't panic as much. The one-to-one talks really help to get things off my chest and has benefited me no end.	The course was very helpful in my partner coming to terms with breathlessness and would recommend the course to everyone. I just think for my husband it has been a positive time. He is a lot more positive in his attitude, as before he was in danger of becoming depressed as he felt useless, but thank you he is a lot better now. The sessions have given my dad reassurance.	Promote the service to A&E professionals as a referral source.	

Core Aim	Activity	Patient Feedback	Carer Feedback	Recommendations	Strategy for Delivering Recommendations
To increase social inclusion and peer support.	Day care activities. Peer support. Transport which is provided by a specially adapted patient transport vehicle, with oxygen facilities.	Companionship – someone to talk to. Learning to relax more with information given. Friendly, informative, well respected. Enjoyed massage – feel more light hearted, contented and happy. Staff help me and it was nice to have other people with the same problem. Everything I needed was well covered and more, I really need the contact with others.	My husband attending the course gave him something to focus on and a chance to meet other people, as well as a break for myself. Great to know that she has been getting out, meeting people and getting advice and support. He has really enjoyed the group meetings. It has given him a reason to get ready and mix with others and also helped with his breathing. Carer Group sessions with staff and other relatives to learn about the programme and to meet people in similar situations. Carers are also able to access one free Complementary Therapy session. She is becoming house reliant and coming to the Hospice is getting her out of the house.	The overwhelming common theme from participants is that they would like the programme to be longer and/or to have some follow-up support system in place, as social isolation has been one of the greatest morbidity factors in their lives. They feel on completion of the course they are returning to that isolation and this has resulted in a loss of confidence, increased anxiousness and depression. Specific feedback is that coming to this group even one day a week makes their world "bigger". Many of the service users have requested to come back onto the programme, which suggests a need for more social integration following the development of the building blocks of self-management. Providing additional social care opportunities post programme to maintain social inclusion and peer support; this will also support carers to have more free time.	Provide follow-up opportunities by holding regular social meetings i.e. a half-day a fortnight on weekends or evening support group sessions. Completion of the course has left some participants worried about how they will be supported but we need to be mindful of not creating co-dependency situations whilst still offering further support to carers and professionals.

Core Aim	Activity	Patient Feedback	Carer Feedback	Recommendations	Strategy for Delivering Recommendations
To deliver an innovative high quality service.	Feedback scores high in the quality aspects of the programme. Complementary Therapy treatments, with each patient able to access up to 6 individual sessions.	Relaxing, listening to music, using breathing techniques, massage feels nice and relaxing and I get immediate relief. Makes me feel relaxed for a couple of days. I wish and hope that all the groups involved will ask if there could be funding to carry on these groups. I hope everyone feels the way I do as I have come on great. I am joining in discussion more, meeting new people and the staff are exceptionally helpful in whatever your require-ments are. Thank you for having me and I hope that I can come back. The programme is great, you are treated like a person and not a number. I have benefitted so much from the group, our group has involved all kinds of staff and I have benefitted from it all.	You have supported me a lot and thank you very much for helping my husband and me. Now the sessions have finished I have felt that when he was at the session I had some time to relax and switch off. Makes myself feel better knowing he is getting solid advice. Enjoyed the Complementary Therapy, it was very relaxing. I would have liked the programme to be longer than six weeks as I feel this would have benefitted (patient) more. One carer has become a volunteer for the Hospice.	One of the main outcomes was to provide support for carers and opportunities to facilitate this have been offered. Uptake of this facility have been poor, with the main reason being cited as the opportunity to have a day of freedom from responsibilities of caring and to be able to catch-up with friends or perform tasks which get delayed. It could be that support for carers would be better facilitated through additional time out and increased attendance of their family member in this supported environment. These evaluations include data for 7 completed programmes. Each programme has been evaluated individually and lessons learned have been applied to the subsequent programmes. Increasing the length of the programme.	Continuous evaluation and reflection post each programme has enabled a process of continuous change and improvement and this should be continued with if the course is commissioned. Presentation of the service at conferences and in peer journals as an innovative collaboration between commissioners and the voluntary sector, demonstrating real integration.

Core Aim	Activity	Patient Feedback	Carer Feedback	Recommendations	Strategy for Delivering Recommendations
To deliver an innovative high quality service (Cont/d…)		This course was excellent. I was amazed at something as good as this. Excellent advice, care and friendship. No matter what you ask your questions are always answered. This course is very important and helpful to people with our condition and it must be top of the list for re-funding. Because company and treatment is excellent and reassuring. It's nice to know that the staff understand how you feel and very helpful. Disappointed not to be coming back. The staff are a godsend to anyone with COPD problems. Having someone to talk to and who listened sympathetically and the comfort of being looked after.			

Core Aim	Activity	Patient Feedback	Carer Feedback	Recommendations	Strategy for Delivering Recommendations
To deliver an innovative high quality service (Cont/d…)		Would like the opportunity to return to the course, maybe at three month intervals. I find reflexology uplifts mood and helps digestive system. This has been a revelation for myself, I was unaware these places existed and would love to continue to attend.			
To signpost to other appropriate services.	Social Services benefits and personal budgets referrals. Pulmonary Rehab Programme. Day care referrals. Smoking Cessation, Benefits Advice, Nutrition and Physio Rehabilitation provided by invited speakers with onward referral.		It has been an eye opener for my mum with regard to benefits and medication advice, as well as the opportunity to try different things that could help.	It should be noted that a significant proportion of service users did not have any benefits support in place and despite receiving a talk and referral in week three of the programme, delays in assessment by Social Services have resulted in many weeks of delay before they could access support after completion of the programme. This compounds feelings of isolation and anxiety. In terms of providing wider support, 30% of service users have been referred to a Social Worker for assessment for a personal budget and 80% of patients who received benefits advice have been referred for other benefits. Ensuring benefits assessments are undertaken and processed quickly for personal budgets and personal health budgets to facilitate choice.	Commitment by the CCG and Local Authority to support patients with individual personal budgets and health budgets to enable patients to access a full range of services.

1.4 The programme pathway is shown below, where patients are able to access the following support:

2.0 QUANTITATIVE DATA

2.1 Data relating to referrals and attendance levels for programmes 1-9 are detailed in the table below:

Referrals/Patients	Prog 1	Prog 2	Prog 3	Prog 4	Prog 5	Prog 6	Prog 7	Prog 8	Prog 9	Total	Comments
Total number of referrals received in month	5	8	7	11	10	8	9	7	4	69	
Total number of eligible referrals received in month (meet referral criteria)	5	7	6	9	10	8	9	4	4	62	
% of patients commencing programme within 6 weeks of referral	100.0%	100.0%	67.0%	67.0%	100.0%	28.6%	14.3%	75.0%	50%	80.4%	• 1 client unable to attend first week due to holiday, requested deferment to next programme. • 4 clients unable to attend first week, deferred until next programme. • 3 clients too short notice for programme (less than 1 week), deferred until next programme. • 3 clients not enough information on referral, deferred until next programme.
Referral Sources											• Respiratory Nurse (D Wood) • Respiratory Nurse (L Johnson) • Respiratory Nurse (B Siddle) • Community Matron (A Turner) • Community Matron (A Hume) • Community Matron (B Peckett) • Dr Lasa, Hart Medical Practice • GP Nurse Practitioner (E Awad)
Primary Respiratory Condition											• COPD • Bronchiectasis • Pleural Thickening (Asbestosis) • Emphysema • Lung Disease • Heart Failure Stage 1
Number of patients commencing programme	5	5	6	6	6	7	7	4	4	50	• 2 clients referred to Stockton. • 6 clients did not want to attend. • 4 clients too busy to attend on a Monday.

Referrals/Patients	Prog 1	Prog 2	Prog 3	Prog 4	Prog 5	Prog 6	Prog 7	Prog 8	Prog 9	Total	Comments
Breakdown of patients attending individual elements/all elements of programme:											
Attended week 1	5	5	6	6	5	7	7	3	3	47	
Attended week 2	4	4	6	5	6	7	7	4	4	47	
Attended week 3	5	4	6	4	6	7	7	4	4	47	
Attended week 4	5	3	5	4	6	6	7	4	3	43	
Attended week 5	4	4	6	4	6	7	7	3	4	45	
Attended week 6	4	3	6	3	6	7	6	2	3	39	
% of patients that complete all stages of the 6 week programme	90.0%	76.7%	97.2%	72.2%	97.2%	97.6%	97.6%	83.3%	87.5%	89.5%	Main reasons for non-attendance: • Prior medical appointments. • Unwell at home with non-respiratory illness. • Unwell at home with breathing problems, chest infection, cold. • Too ill to attend. • Family engagements. • Holiday • 2 clients admitted to hospital with infection (non-respiratory). • 2 clients admitted to hospital with COPD. • 1 client deceased.
Comfort Calls											All clients declined comfort calls on Prog 9.
Number of comfort calls week 1	7	10	6	6	8	9	6	6	0	58	
Number of comfort calls week 2	9	9	6	4	8	8	0	8	0	52	
Number of comfort calls week 3	9	7	9	5	8	8	10	8	0	64	
Number of comfort calls week 4	9	7	8	5	8	8	9	8	0	62	
Number of comfort calls week 5	9	7	9	6	8	8	2	8	0	57	
Number of comfort calls week 6	4	3	9	3	8	4	0	8	0	39	
Total number of comfort calls	47	43	47	29	48	45	27	46	0	332	
Total length of time spent on comfort calls	249 mins	136 mins	90 mins	56 mins	49 mins	52 mins	41 mins	189 mins	0 mins	757 mins	
Average length of time spent on each comfort call	5.3 mins	3.2 mins	1.9 mins	1.9 mins	1.0 mins	1.2 mins	1.5 mins	4.1 mins	0 mins	2.3 mins	

Referrals/Patients	Prog 1	Prog 2	Prog 3	Prog 4	Prog 5	Prog 6	Prog 7	Prog 8	Prog 9	Total	Comments
Number of calls at Escalation Level 1	47	43	47	29	48	45	27	46	0	332	
Number of calls at Escalation Level 2	0	0	0	0	0	0	0	0	0	0	
Number of calls at Escalation Level 3	0	0	0	0	0	0	0	0	0	0	
Number of patients referred to smoking cessation services	0	0	0	0	0	1	0	1	0	2	The majority of patients who smoke have previously been referred to smoking cessation service, therefore poor uptake.
Does patient currently smoke	0	1	4	3	2	5	2	1	0	18	
Did patient receive talk and information on benefits advice	4	4	6	5	6	7	7	3	3	45	
Number of patients referred for benefits advice	2	2	6	5	3	7	0	2	0	27	
Number of patients referred to a Social Worker	0	2	1	4	2	1	0	3	1	14	
Number of complementary therapy sessions attended	23	17	25	15	15	21	23	16	11	166	
Number of individual therapeutic counselling sessions attended	13	10	16	14	18	20	24	10	12	137	
Number of group therapeutic counselling sessions attended	14	13	17	10	17	21	18	10	10	130	
Transport patient numbers week 1	2	3	6	3	2	6	5	2	2	31	
Transport patient numbers week 2	1	3	6	3	4	6	5	3	3	34	
Transport patient numbers week 3	0	3	6	2	4	6	5	3	3	32	
Transport patient numbers week 4	0	2	5	2	3	5	5	3	2	27	
Transport patient numbers week 5	0	3	6	3	3	6	5	2	3	31	
Transport patient numbers week 6	0	2	6	2	3	6	4	2	2	27	
Carers	**Prog 1**	**Prog 2**	**Prog 3**	**Prog 4**	**Prog 5**	**Prog 6**	**Prog 7**	**Prog 8**	**Prog 9**	**Total**	**Comments**
Number of carers offered inclusion on the programme	4	5	6	4	6	7	7	4	4	47	• Prog 1 - client 1 did not want carer inviting. • Prog 4 - clients 3&5 are each other's carers.
Number of carers attending carers element of the programme	0	2	2	0	0	4	2	1	2	13	• Main reason carers do not attend is that they use the time to attend appointments (i.e. medical, hair/beauty), catch-up on jobs, (i.e. shopping), visit friends, enjoy some free time.
Number of carers who took the offer of a complementary therapy	1	2	2	0	0	1	3	0	0	9	

Patient & Carers Evaluation	Prog 1	Prog 2	Prog 3	Prog 4	Prog 5	Prog 6	Prog 7	Prog 8	Prog 9	Total	Comments
Number of patients sent copy of evaluation form	5	5	6	5	6	7	7	4	4	49	• Prog 4 - client 6 deceased.
Number of patients who returned the evaluation form	4	3	6	4	6	7	7	2	4	43	
Number of carers sent copy of evaluation form	4	5	6	3	6	7	7	4	4	46	• Prog 1 - client 1 did not want carer involving. • Prog 4 - clients 3 & 5 are each other's carers, client 6 deceased.
Number of carers who returned the evaluation form	2	1	2	0	4	4	2	4	1	20	
Medical Interventions	**Prog 1**	**Prog 2**	**Prog 3**	**Prog 4**	**Prog 5**	**Prog 6**	**Prog 7**	**Prog 8**	**Prog 9**	**Total**	**Comments**
A&E admissions since last visit	0	2	0	0	0	0	1	0	0	3	• 1 client with 2 admissions to hospital with non-respiratory infection. • 1 client admitted with COPD.
GP visit re breathlessness/anxiety since last visit	0	0	0	0	0	0	0	0	0	0	
Out-of-hours service accessed since last visit	0	0	0	0	0	1	0	0	0	1	• 1 client diagnosed with pleurisy.

2.2 Data relating to psychological and therapy feedback is show below. MYCAW (Measure Yourself Concerns and Wellbeing) has been used, which is a tool for measuring improvements in psychological wellbeing.

MYCAW **Therapeutic Counselling Session**	**Score Unchanged**	**Score Improved**
Concerns: • Anxiety • Panic attacks • Breathlessness/breathing • Frustration and limitations due to shortage of breath • Lack of breath when/after walking • Dizzy spells after bending down • Breathing when sitting for long periods • Controlling breathlessness when chatting • Not sleeping well at night/sleep loss/night time anxiety • Stairs and full buses • Bathing and showering • Dressing • Housework • Off balance • General fitness • Being alone/loneliness • Emotional – feel like crying • Depression • Stress • Maintaining independence • Medication, how and when	19 25.7%	55 74.3%

MYCAW **Complementary Therapies**	**Score Unchanged**	**Score Improved**
Concerns: • Breathing when bathing, tiring makes me breathless • Getting ready in the morning • Communication – unable to breathe correctly • Fatigue due to breathlessness • Exercise • Not expecting family to look after me/family issues • Not been able to go shopping or on holiday abroad re oxygen • Anxieties • Coping • How to manage when partner in hospital • Keeping house tidy • Accepting way of life at present • Social aspect – isolated, loneliness • Unable to work • Frustration – not being able to do things.	22 28.9%	54 71.1%

2.3 Each programme has also included talks/information/education from the following:

- Team Introduction
- Welcome Pack
- Smoking Cessation (invited speaker)
- How to Access Benefits (invited speaker)
- Nutrition (invited speaker)
- Safe Use of Oxygen at Home (invited speaker)
- Physio Rehabilitation (invited speaker)
- Therapeutic Writing Session (invited speaker)

3.0 **Conclusion**

Throughout this report, evidence is presented from both a quantitative and qualitative aspect. Quantitative date is presented in the form of numbers of patients and their carers accessing the different elements offered through the programme and additionally demonstrates activity in relation to hospital and primary care services during the programme. Updated NHS data is not available to us at the point of compiling the report therefore we cannot assess a full year effect of hospital attendances. What is demonstrable however is that for all patients through the duration of the programme, none of them attended their GP surgery. With GP surgeries across the country struggling to meet the demand for appointments, this shows real benefits to the health economy and frees up appointments for other patients. It also demonstrated patients are managing their illnesses better which is meeting the "expert patient" philosophy of the programme.

Qualitative data is captured and demonstrated through the patient and carer responses included in the tables. Patient and carer feedback is quite startling in some of the language used which shows how profound this programme has been in giving people their "lives back". Patients have benefitted both physically and psychologically enabling them to feel more confident not only in managing their symptoms but also in being part of the community rather than house bound "ill people".

The overwhelming common theme from participants is that they would like the programme to be longer and/or to have some follow-up support system in place, as social isolation has been one of the greatest morbidity factors in their lives. They feel on completion of the course they are returning to that isolation and this has resulted in a loss of confidence, increased anxiousness and depression.

With carer support being high on the agenda for the JSNA, this programme gives carers time for catching up on their lives but also equalises some of the lost balance in the carer/patient relationship as the patient is more able to look after themselves. One couple resumed normal marital relationships following the programme as the man (disclosed to a carer) had

felt too sexually debilitated previously and frightened to have a normal relationship with his wife.

The patients demonstrated through their MYCAW (Measure Yourself Concerns & Wellbeing) scores an overall 74.3% improvement after the Therapeutic Counselling sessions and a 71.1% improvement after the Complementary Therapy sessions.

This programme offers excellent value for money and could be looked at further in terms of supporting the COPD and respiratory pressures in Hartlepool.

4.0 **Presentation**

4.1 A presentation on the Breathlessness Support Programme will be made to the Health & Wellbeing Board on 3 August 2015, where the following data (copy attached) will also be presented:

- NECS data (January & June 2015) for A&E, Outpatient and Inpatient activity and costs before/during the Breathlessness Support Programme.
- NECS data (January & June 2015) for A&E, Outpatient and Inpatient activity and costs after the Breathlessness Support Programme.
- Overall analysis (January & June 2015) for A&E, Outpatient and Inpatient activity and costs before/during and after the Breathlessness Support Programme.

Butterwick and Hartlepool Hospices Combined Breathlessness Support Group Patient List and their Related Activities

Prepared by Chief Executive & Deputy Chief Executive 14 July 2015

Patient No	Before/During Butterwick & Hartlepool Hospices (up to 6 months before service start) JANUARY 2015 NECS DATA							Before/During Butterwick & Hartlepool Hospices (up to 6 months before service start) JUNE 2015 NECS DATA						
	AE Activity	AE Cost (£)	OP Activity	OP Cost (£)	IP Activity	IP Cost (£)	Max number of months before/during service start	AE Activity	AE Cost (£)	OP Activity	OP Cost (£)	IP Activity	IP Cost (£)	Max number of months before/during service start
1	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
2	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
3	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	1	£3,813	1
4	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
5	1	£113	0	£0	2	£1,160	1	1	£113	0	£0	2	£1,160	1
6	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
7	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
8	0	£0	1	£824	1	£2,268	No activity	0	£0	0	£0	0	£0	No activity
9	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
10	0	£0	0	£0	2	£1,086	4	0	£0	0	£0	2	£1,086	4
11	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
12	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
13	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
14	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
15	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
16	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
17	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
18	0	£0	0	£0	3	£6,923	4	0	£0	0	£0	3	£6,923	4
19	1	£113	0	£0	3	£5,500	No activity	0	£0	0	£0	0	£0	No activity
20	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
21	0	£0	1	£288	0	£0	1	0	£0	1	£288	0	£0	1
22	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
23	0	£0	0	£0	1	£2,234	2	0	£0	0	£0	1	£2,234	2
24	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
25	0	£0	0	£0	1	£3,294	5	0	£0	0	£0	1	£3,294	5
26	0	£0	0	£0	1	£523	No activity	0	£0	0	£0	0	£0	No activity
27	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
28	1	£113	1	£824	2	£3,188	5	0	£0	0	£0	1	£5,255	5
29	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
30	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
31	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
32	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
33	1	£112	1	£375	0	£0	5	1	£112	1	£375	0	£0	5
34	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
35	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
36	0	£0	0	£0	2	£2,198	5	0	£0	0	£0	1	£514	5
37	1	£121	1	£288	3	£1,543	5	2	£242	1	£288	5	£3,716	5
38	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
39	1	£141	1	£288	4	£1,814	5	1	£141	1	£288	5	£2,129	5
40	0	£0	1	£293	1	£514	5	0	£0	0	£0	1	£514	5
41	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
42	1	£112	0	£0	3	£4,148	2	1	£112	0	£0	2	£3,520	2
43	2	£225	1	£293	7	£12,826	5	1	£113	1	£293	4	£6,742	5
44	2	£244	0	£0	5	£4,363	3	0	£0	0	£0	1	£523	3

Butterwick and Hartlepool Hospices Combined Breathlessness Support Group Patient List and their Related Activities

Prepared by Chief Executive & Deputy Chief Executive 14 July 2015

Patient No	Before/During Butterwick & Hartlepool Hospices (up to 6 months before service start) NECS DATA JANUARY 2015							Before/During Butterwick & Hartlepool Hospices (up to 6 months before service start) NECS DATA JUNE 2015						
	AE Activity	AE Cost (£)	OP Activity	OP Cost (£)	IP Activity	IP Cost (£)	Max number of months before/during service start	AE Activity	AE Cost (£)	OP Activity	OP Cost (£)	IP Activity	IP Cost (£)	Max number of months before/during service start
45	1	£122	0	£0	3	£3,305	2	1	£122	0	£0	2	£1,037	2
46	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
47	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
48	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
49	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
50	0	£0	0	£0	5	£7,782	3	0	£0	0	£0	3	£5,576	3
51	1	£113	0	£0	1	£2,268	No activity	0	£0	0	£0	0	£0	No activity
52	1	£122	0	£0	2	£3,411	5	1	£122	0	£0	1	£523	5
53	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
54	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
55	0	£0	0	£0	1	£2,268	4	0	£0	0	£0	1	£2,268	4
56	0	£0	0	£0	2	£2,790	4	0	£0	0	£0	1	£523	4
57	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
58	1	£143	0	£0	1	£1,691	4	1	£143	0	£0	1	£1,691	4
59	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
60	1	£121	0	£0	2	£3,952	4	1	£121	0	£0	0	£0	4
61	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
62	1	£113	2	£1,113	5	£10,767	5	0	£0	1	£288	3	£6,009	5
63	0	£0	0	£0	1	£2,288	No activity	0	£0	0	£0	0	£0	No activity
64	0	£0	0	£0	4	£7,250	3	0	£0	1	£288	3	£4,982	3
65	1	£113	0	£0	1	£2,889	No activity	0	£0	0	£0	0	£0	No activity
66	0	£0	0	£0	1	£591	0	0	£0	0	£0	1	£591	0
67	1	£121	0	£0	2	£2,854	1	1	£121	0	£0	2	£2,854	1
	19	£2,260	10	£4,587	72	£107,689		12	£1,461	7	£2,110	48	£67,478	

Butterwick and Hartlepool Hospices Combined Breathlessness Support Group Patient List and their Related Activities

Prepared by Chief Executive & Deputy Chief Executive 14 July 2015

Patient No	After Butterwick & Hartlepool hospices (up to 6 months after service end) JANUARY 2015 NECS DATA							After Butterwick & Hartlepool hospices (up to 6 months after service end) JUNE 2015 NECS DATA						
	AE Activity	AE Cost (£)	OP Activity	OP Cost (£)	IP Activity	IP Cost (£)	Max number of months after service end	AE Activity	AE Cost (£)	OP Activity	OP Cost (£)	IP Activity	IP Cost (£)	Max number of months after service end
1	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
2	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
3	0	£0	0	£0	0	£0	2	0	£0	0	£0	1	£398	2
4	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
5	0	£0	0	£0	1	£628	No activity	0	£0	0	£0	0	£0	No activity
6	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
7	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
8	1	£132	0	£0	1	£2,846	5	1	£132	0	£0	1	£2,846	5
9	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
10	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
11	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
12	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
13	1	£112	0	£0	2	£6,250	1	1	£112	0	£0	2	£6,250	1
14	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
15	0	£0	0	£0	1	£3,259	4	0	£0	0	£0	1	£3,259	4
16	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
17	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
18	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
19	0	£0	0	£0	0	£0	3	0	£0	0	£0	1	£2,234	3
20	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
21	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
22	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
23	1	£121	0	£0	1	£3,244	1	1	£121	0	£0	1	£3,244	1
24	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
25	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
26	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
27	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
28	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
29	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
30	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
31	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
32	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
33	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
34	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
35	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
36	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
37	0	£0	0	£0	0	£0	0	1	£112	0	£0	0	£0	0
38	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
39	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
40	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
41	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
42	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
43	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
44	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity

Butterwick and Hartlepool Hospices Combined Breathlessness Support Group Patient List and their Related Activities

Prepared by Chief Executive & Deputy Chief Executive 14 July 2015

Patient No	After Butterwick & Hartlepool hospices (up to 6 months after service end) JANUARY 2015 NECS DATA							After Butterwick & Hartlepool hospices (up to 6 months after service end) JUNE 2015 NECS DATA						
	AE Activity	AE Cost (£)	OP Activity	OP Cost (£)	IP Activity	IP Cost (£)	Max number of months after service end	AE Activity	AE Cost (£)	OP Activity	OP Cost (£)	IP Activity	IP Cost (£)	Max number of months after service end
45	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
46	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
47	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
48	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
49	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
50	2	£253	0	£0	2	£3,316	2	2	£253	0	£0	2	£3,316	2
51	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
52	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
53	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
54	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
55	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
56	0	£0	0	£0	1	£3,244	1	0	£0	0	£0	1	£3,244	1
57	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
58	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
59	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
60	0	£0	0	£0	1	£514	0	0	£0	0	£0	1	£514	0
61	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
62	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
63	1	£121	0	£0	1	£3,006	0	1	£121	0	£0	1	£3,006	0
64	0	£0	0	£0	0	£0	2	1	£132	0	£0	1	£514	2
65	0	£0	0	£0	1	£981	0	0	£0	0	£0	1	£981	0
66	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
67	0	£0	0	£0	0	£0	No activity	0	£0	0	£0	0	£0	No activity
	6	**£739**	**0**	**£0**	**12**	**£27,289**		**8**	**£983**	**0**	**£0**	**14**	**£29,807**	

Butterwick and Hartlepool & District Hospices Combined Breathlessness Support Group Data

Prepared by Chief Executive & Deputy Chief Executive, Hartlepool & District Hospice, 14 July 2015

Patient No	Difference Before/During Activity January 2015	Difference After Activity January 2015	Overall Activity January 2015	Difference Before/During Cost (£) January 2015	Difference After Cost (£) January 2015	Overall Cost (£) January 2015	Difference Before/During Activity June 2015	Difference After Activity June 2015	Overall Activity June 2015	Difference Before/During Cost (£) June 2015	Difference After Cost (£) June 2015	Overall Cost (£) June 2015
1	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
2	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
3	0	0	0	£0	£0	£0	1	1	0	£3,813	£398	-£3,415
4	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
5	3	1	-2	£1,273	£628	-£645	3	0	-3	£1,273	£0	-£1,273
6	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
7	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
8	2	2	0	£3,092	£2,978	-£114	0	2	2	£0	£2,978	£2,978
9	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
10	2	0	-2	£1,086	£0	-£1,086	2	0	-2	£1,086	£0	-£1,086
11	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
12	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
13	0	3	3	£0	£6,362	£6,362	0	3	3	£0	£6,362	£6,362
14	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
15	0	1	1	£0	£3,259	£3,259	0	1	1	£0	£3,259	£3,259
16	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
17	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
18	3	0	-3	£6,923	£0	-£6,923	3	0	-3	£6,923	£0	-£6,923
19	4	0	-4	£5,613	£0	-£5,613	0	1	1	£0	£2,234	£2,234
20	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
21	1	0	-1	£288	£0	-£288	1	0	-1	£288	£0	-£288
22	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
23	1	2	1	£2,234	£3,365	£1,131	1	2	1	£2,234	£3,365	£1,131
24	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
25	1	0	-1	£3,294	£0	-£3,294	1	0	-1	£3,294	£0	-£3,294
26	1	0	-1	£523	£0	-£523	0	0	0	£0	£0	£0
27	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
28	4	0	-4	£4,125	£0	-£4,125	1	0	-1	£5,255	£0	-£5,255
29	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
30	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
31	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
32	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
33	2	0	-2	£487	£0	-£487	2	0	-2	£487	£0	-£487
34	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
35	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
36	2	0	-2	£2,198	£0	-£2,198	1	0	-1	£514	£0	-£514
37	5	0	-5	£1,953	£0	-£1,953	8	1	-7	£4,246	£112	-£4,134
38	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
39	6	0	-6	£2,243	£0	-£2,243	7	0	-7	£2,559	£0	-£2,559
40	2	0	-2	£807	£0	-£807	1	0	-1	£514	£0	-£514
41	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
42	4	0	-4	£4,260	£0	-£4,260	3	0	-3	£3,632	£0	-£3,632
43	10	0	-10	£13,344	£0	-£13,344	6	0	-6	£7,147	£0	-£7,147
44	7	0	-7	£4,607	£0	-£4,607	1	0	-1	£523	£0	-£523
45	4	0	-4	£3,427	£0	-£3,427	3	0	-3	£1,159	£0	-£1,159
46	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
47	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
48	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
49	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
50	5	4	-1	£7,782	£3,569	-£4,213	3	4	1	£5,576	£3,569	-£2,006
51	2	0	-2	£2,381	£0	-£2,381	0	0	0	£0	£0	£0
52	3	0	-3	£3,533	£0	-£3,533	2	0	-2	£645	£0	-£645
53	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
54	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
55	1	0	-1	£2,268	£0	-£2,268	1	0	-1	£2,268	£0	-£2,268
56	2	1	-1	£2,790	£3,244	£454	1	1	0	£523	£3,244	£2,722
57	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
58	2	0	-2	£1,834	£0	-£1,834	2	0	-2	£1,834	£0	-£1,834
59	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
60	3	1	-2	£4,072	£514	-£3,558	1	1	0	£121	£514	£394
61	0	0	0	£0	£0	£0	0	0	0	£0	£0	£0
62	8	0	-8	£11,992	£0	-£11,992	4	0	-4	£6,298	£0	-£6,298
63	1	2	1	£2,288	£3,127	£838	0	2	2	£0	£3,127	£3,127
64	4	0	-4	£7,250	£0	-£7,250	4	2	-2	£5,271	£647	-£4,624
65	2	1	-1	£3,002	£981	-£2,021	0	1	1	£0	£981	£981
66	1	0	-1	£591	£0	-£591	1	0	-1	£591	£0	-£591
67	3	0	-3	£2,975	£0	-£2,975	3	0	-3	£2,975	£0	-£2,975
Total	**101**	**18**	**-83**	**£114,536**	**£28,028**	**-£86,508**	**67**	**22**	**-45**	**£71,048**	**£30,790**	**-£40,259**

HEALTH & WELLBEING BOARD

3 August 2015

Report of: Director of Public Health

Subject: DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2014/15

1. TYPE OF DECISION/APPLICABLE CATEGORY

Non key decision.

2. PURPOSE OF REPORT

2.1 The purpose of this report is to present for information to the Board the Director of Public Health Annual Report for 2014/15. This report will be presented to full Council in August 2015.

3. BACKGROUND

3.1 The requirement for the Director of Public Health to write an Annual Report on the health status of the town and the Local Authority duty to publish it is specified in the Health and Social Care Act 2012.

3.2 Director of Public Health Annual Reports are not a new requirement, as prior to 2012, Directors of Public Health in the National Health Service (NHS) were expected to produce annual reports.

3.3 Historically, the equivalent of the Director of Public Health Annual Report was produced by the Local Authority Chief Medical Officer.

4. Director of Public Health Annual Report

4.1 The Director of Public Health Annual report 2014/15 focuses on the issues relating to health and work. The report explores the following:

1. Relationship between employment and good health and poor health.
2. Historical overview of employment in Hartlepool
3. Health and employment.

4. Role of employers and employees in improving and protecting health.
5. Regulation.
6. Equal opportunities.
7. Success stories.
8. Vision and the future creation of employment.

4.2 The report concludes that there is a positive relationship between health and work and reflects the work of Professor Sir Michael Marmot, who concludes in The Marmot Report 2010, that we should seek to 'create fair employment and good work for all'.

5. RECOMMENDATIONS

5.1 Members receive this report for information.

6. REASONS FOR RECOMMENDATIONS

6.1 Ensures compliance with the statutory duties under the Health and Social Care Act 2012 for the Director of Public Health to produce a report and the Local Authority to publish it.

7. CONTACT OFFICER

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Director of Public Health Report

Public Health, Wealth & Employment - 2014/2015

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Foreword

I am delighted to introduce my second Director of Public Health Annual Report since Hartlepool Borough Council assumed responsibility for public health on 1st April 2013. The 2014/15 annual report, Health, Wealth & Employment focuses on health and work.

Employment is good for our health. Work provides us with income to enable us to sustain ourselves and meet our basic human needs to have shelter, warmth and food to eat. Work often provides us with so much more than this; it gives us a sense of self-esteem, achievement, social interaction and a positive contribution to society.

Studies have shown a clear relationship between socioeconomic status and health. People in professional or managerial positions often have greater life expectancy than those in unskilled or manual professions [1]. It is well documented that people in more deprived circumstances generally have worse health than those in more affluent ones and employment status is part of that complex picture. The health of people who are unemployed tends to be worse than those who are employed [2].

Employers have a role to play to maintain and even improve the health of their employees. Hartlepool Borough Council is leading the way nationally on this through workplace health initiatives. The work that has been done to improve the health of employees, not only within the Council but also in other businesses, was recognised during 2014 when Hartlepool Council won the first ever Public Health Minister's Award for our approach to improving Workplace Health.

The importance of health and work is not a new concept. Over the past century, efforts have been made to improve working conditions of employees and legislation and enforcement have been critical to this purpose. Health and safety legislation aimed at protecting employees from unnecessary risks to their health is vital for the workplace. Such legislation has gone a long way to protect the physical health of workers in more recent times. For others, the burden of disease they suffer today might be from historical exposure to risks in the workplace such as those who suffer from mesothelioma.

This report explores some of the issues regarding health and work described above. It reflects on what has been achieved and what more can be done, to improve and protect the health of the people of Hartlepool.

Louise Wallace
Director of Public Health
Hartlepool Borough Council

Health and Work

Workplace interventions to improve health and wellbeing [1]

In September 2014, Public Health England published the report 'Workplace interventions to improve health and wellbeing'. This report reviewed the links between working conditions and health inequalities. The report illustrates social gradients in employment status and working conditions in England and that people from the most deprived areas are at high risk of unemployment. Some people in employment are at risk of operating in poor working conditions. This results in a greater risk of poor physical and mental health.

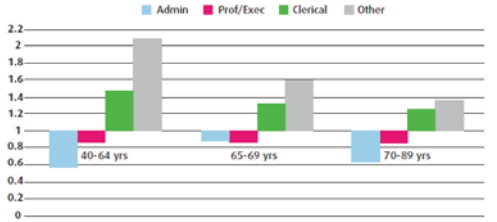
A number of key actions were provided to demonstrate how psychosocial working conditions can be improved through:

- Greater employee control over their work;
- Greater employee participation in decision-making;
- Line management training;
- Effective leadership and good relationships between leaders and their employees;
- Engaging employees, ensuring employees are committed to the organisation's goals and motivated to contribute to its success;
- Providing employees with the in-work training and development they need to develop job satisfaction;
- Providing greater flexibility within a role to increase an employee's sense of control and allow them to improve their work-life balance;
- Reducing stress and improving mental health at work as these are leading causes of sickness absence; and
- Addressing the effort-reward imbalance.

The report identifies different methods that should be considered to improve health in the workplace, such as:

- How control and autonomy over work, and life outside of work, contributes to good health;
- An increase in staff participation and involvement in workplace interventions has a positive impact;
- Flexible working can increase a sense of control an individual feels and assist management of their work-life balance;
- Effective line management can improve employees' health & wellbeing and performance;
- There is a strong link between employee engagement and better mental and physical health;
- The importance of training and development opportunities;
- Rewarding employees for their efforts contributes to a good psychosocial working environment;
- The significance of reducing stress and improving mental health to reduce the number of work-related sickness absences;
- Feedback from employees can ensure actions are effective; and
- It is important that the interventions are available to everyone (particularly temporary/fixed-term and semi-skilled/unskilled workers).

Sir Michael Marmot, author of Fair Society, Healthy Lives - the strategic review of Health Inequalities in England post - 2010



The graph right shows the death rate in each grade relative to the average for the whole civil service population (set at 1). The Administrators (highest grade) have about half the average mortality at age 40-64 yrs, while the office support staff who make up the 'other' grade have about twice the average. Hence there is a four-fold difference between the bottom and top grade. [2]

Hartlepool Steelworks' Bridge and the derelict offices in Greatham Street taken in the mid 1980's

Health and Work

The Whitehall studies

The so-called 'Whitehall Studies' are long-term studies of men and women examining the influences on health of circumstances at work, at home and in the wider community. They have revealed important information about the relationship between work and health and also about gradients in health between different social groups (determined by job grade). The name derives from the study of the health of British civil servants who worked in London.

The first Whitehall study began in 1967 and included 18,000 men. It showed that men in the lowest employment grades were much more likely to die prematurely than men in the highest grades. [3]

The second Whitehall study from 1985 onwards was set up to determine what underlies the social gradient in death and disease and to include women [4]. Sir Michael Marmot – who has done so much to investigate and explain the causes of social inequalities in health – is the current director of the second study.

The results of these studies are now feeding in to national policy discussions. They are highly relevant to the longstanding concern with social inequalities in health. The research has been in the lead in showing that health and its determinants should be viewed much more broadly. The circumstances, in which people live and work, are not just crucial for perceived well-being but they are major influences on health.

The twelve causes of productivity drain [5]

Cambridge University and Rand Europe carried out a study on 21,000 employees across the UK. They found that there are 12 factors that contribute to loss of productivity through absenteeism and presenteeism. These factors range from personal and health concerns (such as weight and mental health) to workplace stressors (including bullying).

The twelve areas correlated with diminished productivity are:

- Having financial concerns;
- Sleeping less than seven hours per night;
- Being underweight;
- Being overweight;
- Physical inactivity;
- Adding unhealthy fats to meals, such as butter or mayonnaise;
- Showing symptoms of depression;
- Being subject to bullying in the workplace;
- Having strained relationships with colleagues;
- Being subject to unrealistic demands in the workplace;
- Having high blood pressure; and
- Having at least one musculoskeletal condition.

According to the report, the results were dependent on each worker's overall satisfaction with their job.

Historical Overview

Employment history of Hartlepool

1833 - In the 1830s, a railway was built to connect Hartlepool to the collieries of the South Durham Coalfield, and work began on modern docks to handle the increased traffic which was anticipated. This led to the port of Hartlepool thriving, with the export of coal and import of timber.

1875 - To the southwest of the old town, an Act of Parliament had allowed the building of the 'West Hartlepool Dock Company' which opened in 1847. This provided employment opportunities which led to West Hartlepool growing at speed and overshadowing the old town.

1897 - The vast Hartlepool docks became one of the largest shipbuilding complexes in the country, with the town prospering with high employment and population growth. The shipbuilding industry was supplied by the town's marine engine works and steelworks.

1956 - In the 1950s, the industrial landscape changed and oil refineries began to open at the mouth of the River Tees. Together with the reduction in the use of coal and the coming closure of some rail lines, this had a great impact on Hartlepool.

1972 - As the economy moved away from heavy manufacturing industry such as steelworks and engineering, unemployment in the town increased. This led to decaying buildings and old redundant works, with substantial industrial change required within the area.

1974 - The Hartlepool Nuclear Power Plant was approved in a move to reduce dependence on coal-fired plants and adopt alternative means of electricity generation. This led to thousands of construction jobs being created and hundreds of higher skills employment opportunities in the operation of the facility.

1990 - The 1990s saw the closure of the last coal mine in the region which ended an era of at least 800 years. Plans were developed for major regeneration programmes to rejuvenate the area and its economy.

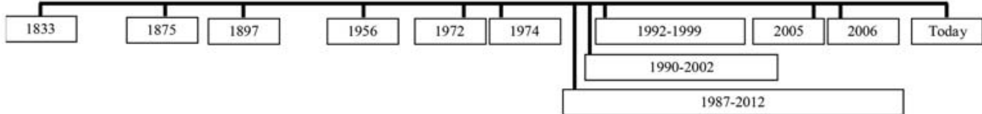
1992 - The town was transformed with the Hartlepool Marina being re-developed into a retail, housing and leisure destination providing a range of employment opportunities. The Summerhill Conservation Area was created and tourism destinations such as Hartlepool Museum and Hartlepool Art Gallery were opened.

1999 - Despite the employment landscape changing within Hartlepool over the last century, the town still has an industrial heritage and Hartlepool Steel Fabrications constructed the Angel of the North sculpture in Gateshead.

2006 - Hartlepool's economy has historically been linked with the maritime industry, something which is still at the heart of local business. Hartlepool Dock is owned and run by PD Ports with major employers operating in the town such as Heerema Fabrications, Tata Steel, Huntsman Tioxide and Able UK.

Today - The launch of the Hartlepool Vision and Masterplan will deliver a major regeneration programme for Hartlepool focusing on the eight key areas of Church Street, Waterfront, Port Estate, Queen's Meadow, Headland, Town Centre, Seaton Carew and Headland.

Page 13 overleaf shows a timeline of workplace legislation since 1833.



Date	Legislation	Description
1833	Factory Act	Established Factory Inspectorate with powers to prosecute employers providing unsafe working conditions.
1875	Factories and Workshop Act	Centralised Inspectorate; Chief Inspector appointed.
1897	Workmen's Compensation Act	Introduced the concept of employer's liability and benefits regardless of who was to blame for accidents.
1956	Agriculture Act	Extended legislation to agricultural sector.
1972	EMAS	Employment Medical Advisory Service created to give advice and medical monitoring.
1974	Health and Safety at Work etc Act	Placed a legal duty on employers to train, inform, instruct and supervise employees to protect their health and safety. Established the Health and Safety Commission (HSC) and the Health and Safety Executive (HSE) which incorporated EMAS.
1987-2012	Control of Asbestos at Work regulations	Places a duty not to carry out work which exposes or is likely to expose employees to asbestos. Notification of works on asbestos. 2004 Duty to manage asbestos in buildings.

Date	Legislation	Description
1990-2002	Control of Substances Hazardous to Health (COSHH)	Placed duties on employers to protect employees from the substances they have to work with. Included 6 key steps: • Assessment of risk; • Prevention or control of exposure; • Use of control measures; • Maintenance, examination and testing of control measures; • Health surveillance; and • Information, instruction and training.
1992-1999	Health & Safety at Work six regulations introduced.	Six regulations on health & safety at work introduced covering: • Health and safety management; • Work equipment safety; • Manual handling of loads; • Workplace conditions; • Personal protective equipment; and • Display screen equipment.
2005	Control of Noise at Work Regulations	Requires employers to take action to protect employees from hearing damage.
2006	Health Act	Implemented in England July 2007, Smoke-free premises, places and vehicles. No smoking signs, offences relating to smoking in smoke-free premises, fixed penalties and age for sale of tobacco.

Health and Employment Status

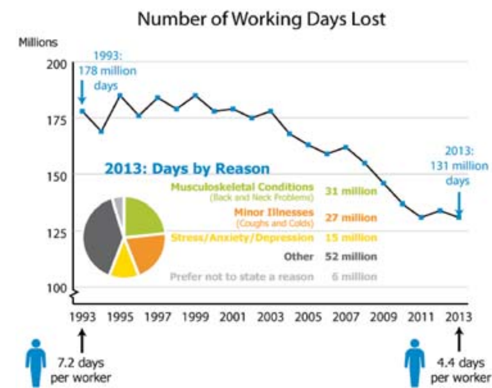


Table 1 - Source: Labour Force survey - Office for national Statistics - ref [8]

"A shift in attitudes is necessary to ensure that employers and employees recognise not only the importance of preventing ill-health, but also the key role the workplace can play in promoting health and well-being."

Dame Carol Black, Advisor on Work and Health, Dept of Health

Among individuals in work, the prevalence of mental health problems is about 14 per cent
(Adult Psychiatric Morbidity Survey, 2007)

Almost one-quarter (23%) of Jobseeker's Allowance claimants have a mental health problem (McManus et al 2012). More than 40 per cent of incapacity benefits claimants have mental health problems
(Psychological Wellbeing at Work, Van Stolk et al, 2014)

131 million days were lost due to sickness absences in the UK in 2013, down from 178 million days in 1993
(Sickness absence in the labour market, ONS (2014)

Table 2: Percentage of working hours lost through sickness by occupation in 2013

Source: Labour Force survey - Office for national Statistics - ref(8)

Health and Employment Status

Health and employment

Employment rates in Britain are high compared to most other countries. The employment rate of those with a health condition is increasing but, at any given time, about 7% are still on incapacity (Employment and Support Allowance, or ESA) benefits and an additional 3% are off work sick.

The annual economic costs of sickness absence and worklessness associated with working age ill-health are estimated to be over £100 billion. This is greater than the current annual budget for the NHS and equivalent to the entire GDP of Portugal [1].

There is, therefore, a need to develop plans to improve the health and well-being of the working age population – to help ensure a healthy retirement, to promote social and financial inclusion and to deliver prosperity to individuals and employers in Hartlepool and the country as a whole.

It is widely regarded that 'good work is good for you', and being unemployed or on long-term sickness leads to an increased risk of chronic conditions, poor mental health and a lower life expectancy. It can provide structure and routine and a sense of self-worth which is essential for our wellbeing.

There is also evidence that happy and satisfied workers are more productive at work. In terms of national well-being, an ageing population means that having more people in work is increasingly important for our communities and the economy [2].

"After being out of work for 2 years or more, you are more likely to retire or die than move back into employment" [3].

Job satisfaction is also considered a strong predictor of overall individual well-being [4]. Many factors can contribute to people's feelings of satisfaction about their job such as the nature of the work, their pay and their hours of work. In the financial year ending 2013, nearly 8 in 10 (77.6%) adults aged 16 and over in the UK reported that they were somewhat, mostly or completely satisfied with their job [5].

Worklessness is associated with poorer physical and mental health and well-being [6]. For example, in 2012 research by the Department for Work and Pensions (DWP) and NatCen Social Research found that Jobseeker's Allowance claimants had lower personal well-being than other people of employment age [7]. DWP are now researching support packages for the very long-term unemployed with the aim of reducing anxiety associated with work placements.

Employment type and industry can also have a significant effect on health and wellbeing. For example, in 2013 more than twice as many working hours were lost in the leisure and caring sector as opposed to managers and senior officials. (see table 2 - Percentage of working hours lost through sickness by occupation in 2013)

Health and Wellbeing at Work

It is vitally important that employers in Hartlepool are aware of the role they can play in improving the health of their workforce and in turn the wider community. A workforce supported by a proactive employer with a robust health and wellbeing strategy has both organisational and individual employee benefits:

For the organisation	For the employee
A well-managed health and safety programme	A safe and healthy work environment
A positive and caring image	Enhanced self-esteem
Improved staff morale	Reduced stress
Reduced staff turnover	Improved morale
Reduced absenteeism	Increased job satisfaction
Increased productivity	Increased skills for health protection
Reduced health care/insurance costs	Improved health
Reduced risk of fines and litigation	Improved sense of wellbeing

Source: www.who.int [1]

In Hartlepool and the North East of England, employers can access free support for health at work via the North East Better Health at Work Award **www.betterhealthatworkne.org.**

In 2014, the potential employee reach within approximately 200 North East employers signed up to the award scheme was over 160,000. In Hartlepool alone, over 8000 employees from 20+ workplaces have achieved at least one stage of the regional award.

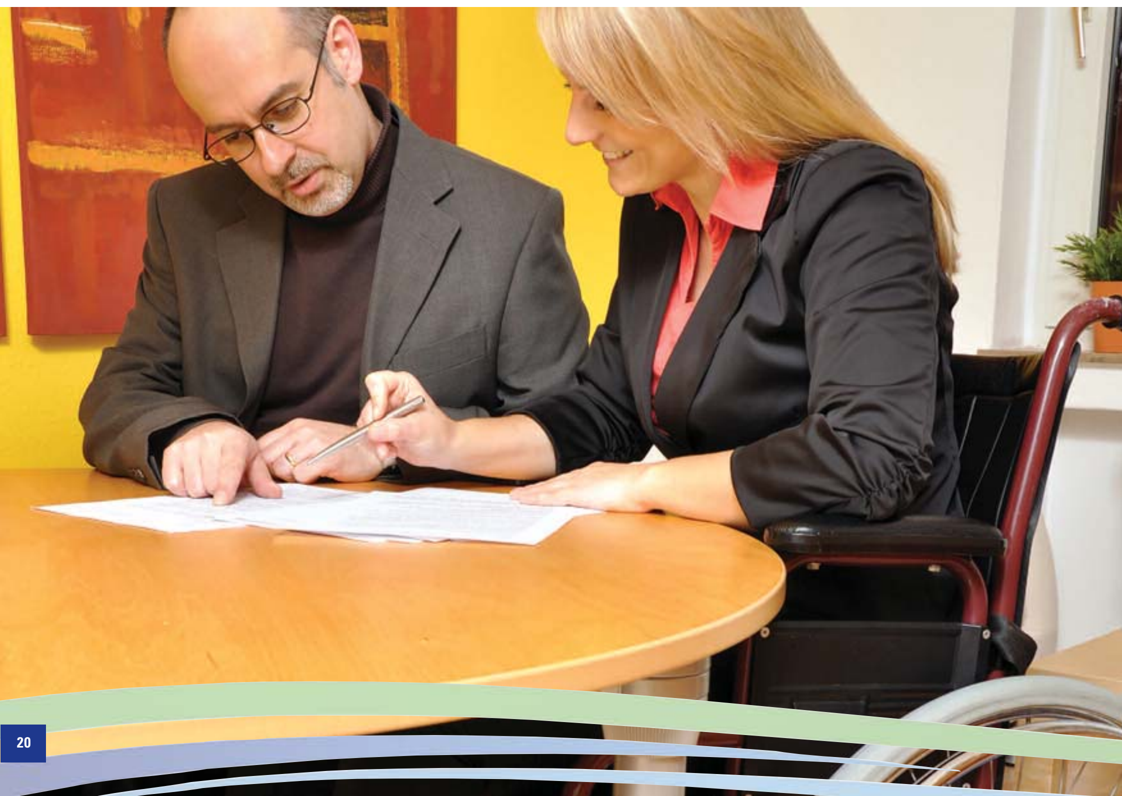
The Public Health Team in Hartlepool Borough Council provides local support and coordination for workplace health in the town, having achieved the Bronze, Silver, Gold and Continuing Excellence stages of the North East Better Health at Work Award each year since 2010.

In October 2014, Hartlepool Borough Council was recognised by Public Health Minister Jane Ellison in her first award scheme, for its efforts to improve the health of the Hartlepool workforce [2].

The Public Health Minister's Award, which was launched in June 2014, was developed by the Department of Health and Royal Society for Public Health to celebrate excellence in public health. In its first year, the award recognised excellence and innovation in workplace health and wellbeing initiatives.

Hartlepool Borough Council Director of Public Health, Louise Wallace receives the award from Public Health Minister, Jane Ellison.

"Since 2008/9, sickness absence within the Authority has reduced from 9.9 days per wk (working time equivalent), to 7.9 in 2013/14, and continues to decline."



Roles and Responsibilities

Chapter 5

The following chapter (5) show the roles and responsibilities of employers and employees, regulation changes and how the council are creating equal opportunities for all in respect of employment and workplace health.

The chapter summarises the different topics being discussed; what the council has done to improve these issues; what the council is going to do to further improve; and how the outcomes of any actions can be measured.

The topics within this chapter are:

Roles of employers and employees:

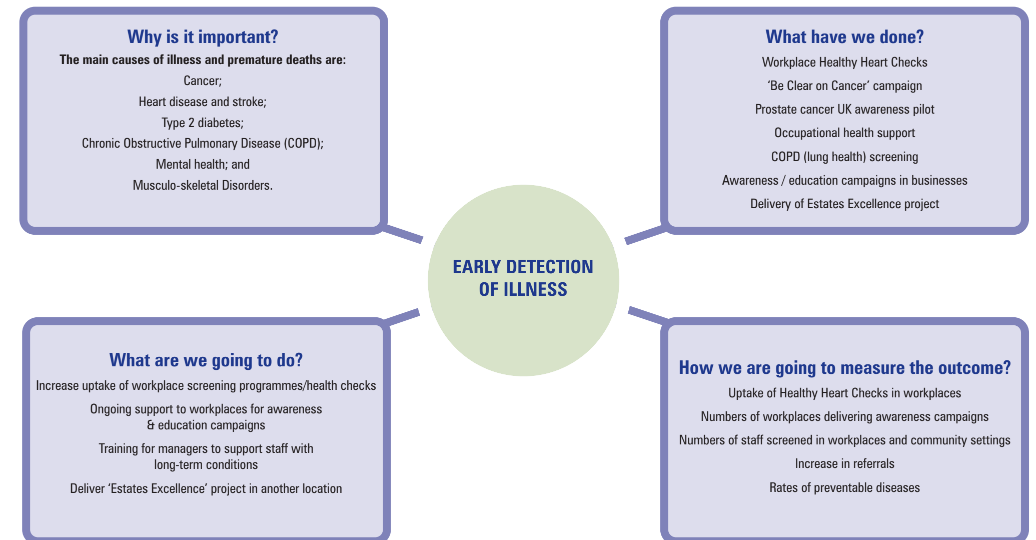
- Early detection of illness.
- Mental illness.
- Back, neck, joint and muscle disorders.
- Lifestyle advice to reduce illness.

Regulation:

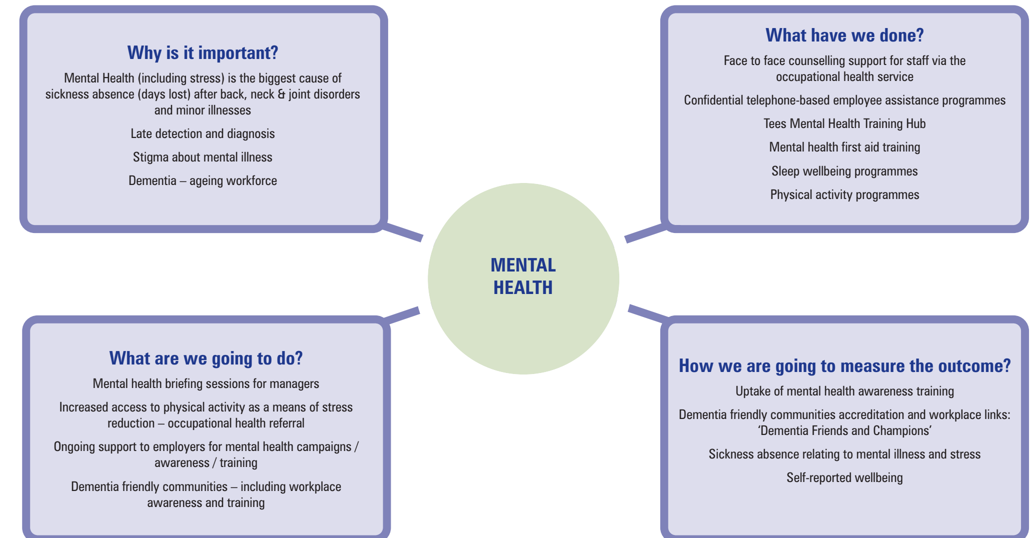
- Enforcement of health and safety and work.

Equal opportunities:

- People who have a learning disability and /or autism.
- People who have a mental illness.
- People who have a physical disability and/or a sensory loss/impairment.
- Employment for adults who have a learning disability or difficulty.
- Employment opportunities for all.


EARLY DETECTION OF ILLNESS
Why is it important?
The main causes of illness and premature deaths are:
Cancer;
Heart disease and stroke;
Type 2 diabetes;
Chronic Obstructive Pulmonary Disease (COPD);
Mental health; and
Musculo-skeletal Disorders.
What have we done?
Workplace Healthy Heart Checks
'Be Clear on Cancer' campaign
Prostate cancer UK awareness pilot
Occupational health support
COPD (lung health) screening
Awareness / education campaigns in businesses
Delivery of Estates Excellence project
What are we going to do?
Increase uptake of workplace screening programmes/health checks
Ongoing support to workplaces for awareness & education campaigns
Training for managers to support staff with long-term conditions
Deliver 'Estates Excellence' project in another location
How we are going to measure the outcome?
Uptake of Healthy Heart Checks in workplaces
Numbers of workplaces delivering awareness campaigns
Numbers of staff screened in workplaces and community settings
Increase in referrals
Rates of preventable diseases

Roles and Responsibilities



Roles and Responsibilities

Why is it important?

Second main cause of sickness absence - 31m days (24%)

Short and long-term injuries caused by manual handling or prolonged sitting

Display screen equipment and effects of sitting too long

Manual and repetitive labour

What have we done?

Physiotherapy / occupational health support.

Health and safety training

Amended working duties to support return to work

Workplace risk assessment

Workplace health monitoring

Workstation support – ergonomic design

Musculo-skeletal disorder training for managers

BACK, NECK, JOINT AND MUSCLE DISORDER

What are we going to do?

Physical activity programmes - prevention and rehabilitation

Improved workstations

Preventative physiotherapy exercises

Desk-based pilates / yoga exercises

Improved working practices and equipment to prevent musculo-skeletal disorders

How we are going to measure the outcome?

Reduction in musculo-skeletal disorders

Occupational health reports

Quicker return to work after sickness absence

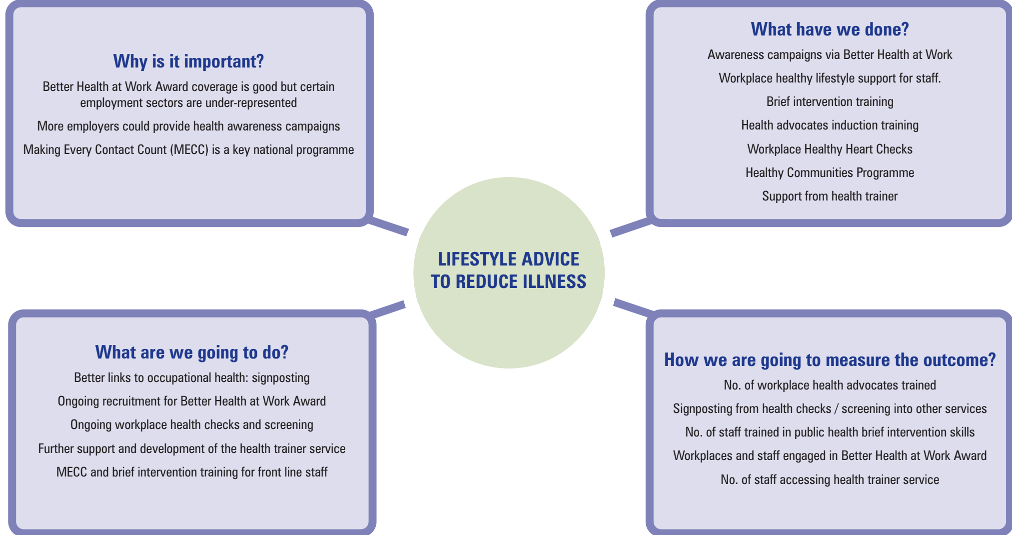
More preventative support

Earlier identification of risks

Improved monitoring of workplace conditions

Hartlepool Borough Council's Health Trainer Service

Roles and Responsibilities



Why is it important?

Better Health at Work Award coverage is good but certain employment sectors are under-represented

More employers could provide health awareness campaigns

Making Every Contact Count (MECC) is a key national programme

What have we done?

Awareness campaigns via Better Health at Work

Workplace healthy lifestyle support for staff.

Brief intervention training

Health advocates induction training

Workplace Healthy Heart Checks

Healthy Communities Programme

Support from health trainer

What are we going to do?

Better links to occupational health: signposting

Ongoing recruitment for Better Health at Work Award

Ongoing workplace health checks and screening

Further support and development of the health trainer service

MECC and brief intervention training for front line staff

How we are going to measure the outcome?

No. of workplace health advocates trained

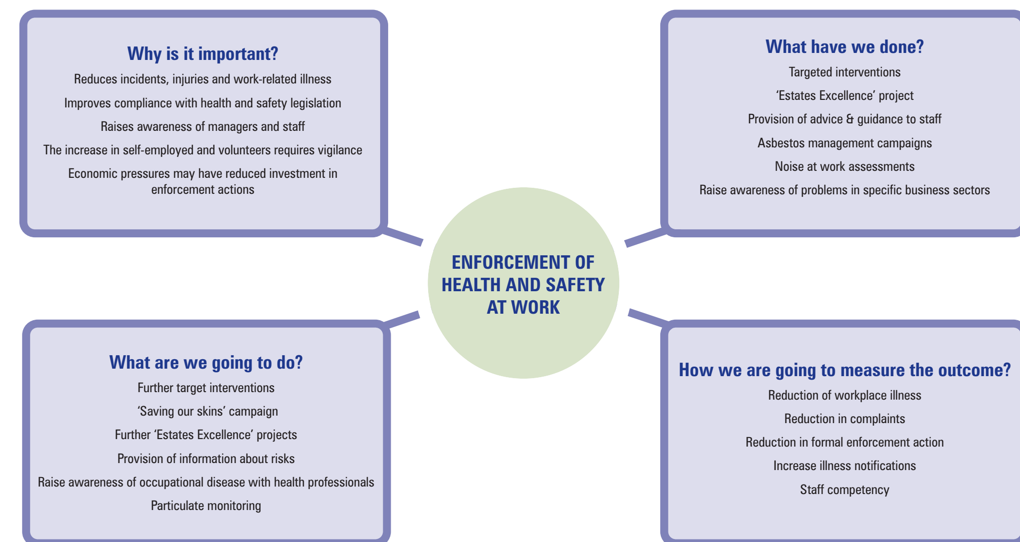
Signposting from health checks / screening into other services

No. of staff trained in public health brief intervention skills

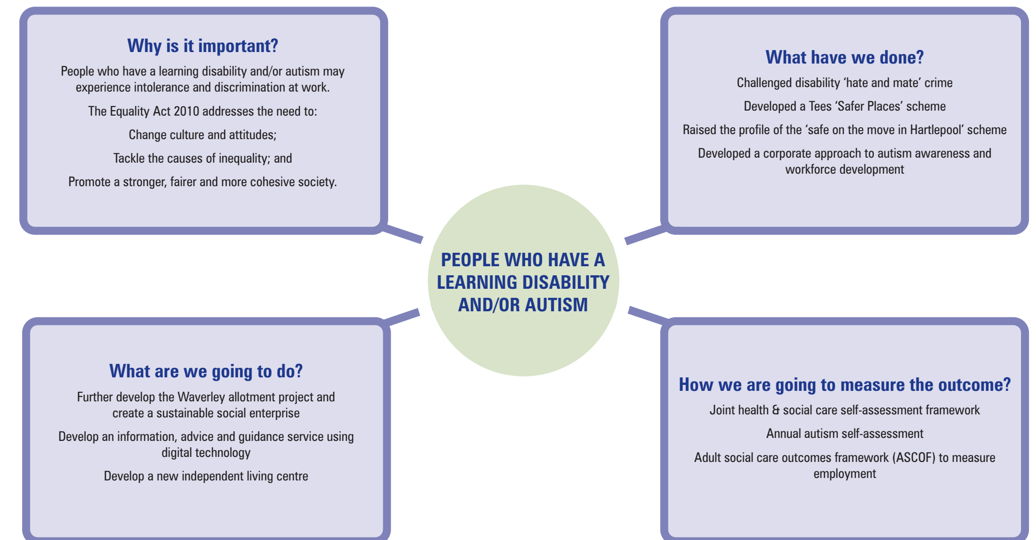
Workplaces and staff engaged in Better Health at Work Award

No. of staff accessing health trainer service

Roles and Responsibilities



Roles and Responsibilities



Why is it important?

People who have a learning disability and/or autism may experience intolerance and discrimination at work.

The Equality Act 2010 addresses the need to:

Change culture and attitudes;

Tackle the causes of inequality; and

Promote a stronger, fairer and more cohesive society.

What have we done?

Challenged disability 'hate and mate' crime

Developed a Tees 'Safer Places' scheme

Raised the profile of the 'safe on the move in Hartlepool' scheme

Developed a corporate approach to autism awareness and workforce development

PEOPLE WHO HAVE A LEARNING DISABILITY AND/OR AUTISM

What are we going to do?

Further develop the Waverley allotment project and create a sustainable social enterprise

Develop an information, advice and guidance service using digital technology

Develop a new independent living centre

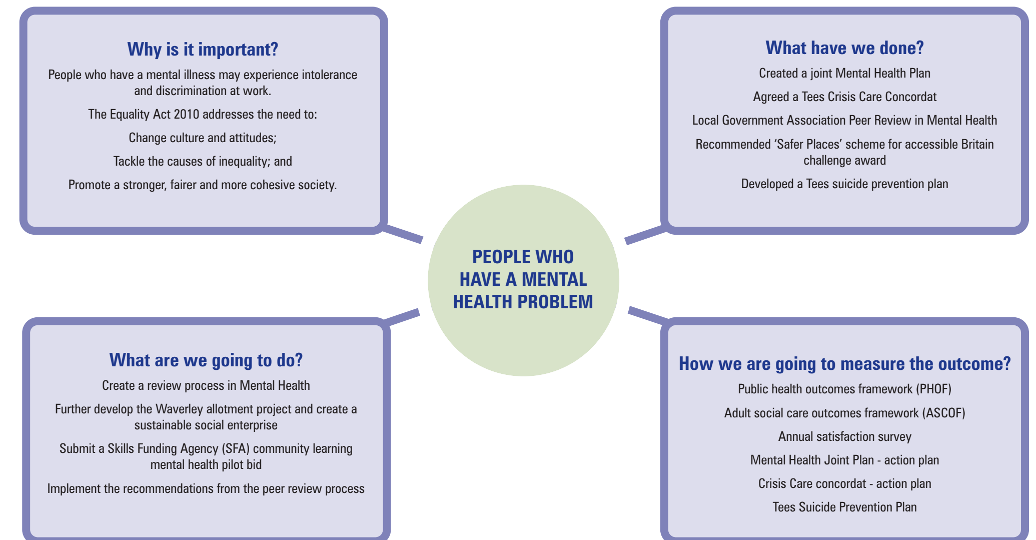
How we are going to measure the outcome?

Joint health & social care self-assessment framework

Annual autism self-assessment

Adult social care outcomes framework (ASCOF) to measure employment

Roles and Responsibilities



Why is it important?

People who have a mental illness may experience intolerance and discrimination at work.

The Equality Act 2010 addresses the need to:

Change culture and attitudes;

Tackle the causes of inequality; and

Promote a stronger, fairer and more cohesive society.

What have we done?

Created a joint Mental Health Plan

Agreed a Tees Crisis Care Concordat

Local Government Association Peer Review in Mental Health

Recommended 'Safer Places' scheme for accessible Britain challenge award

Developed a Tees suicide prevention plan

PEOPLE WHO HAVE A MENTAL HEALTH PROBLEM

What are we going to do?

Create a review process in Mental Health

Further develop the Waverley allotment project and create a sustainable social enterprise

Submit a Skills Funding Agency (SFA) community learning mental health pilot bid

Implement the recommendations from the peer review process

How we are going to measure the outcome?

Public health outcomes framework (PHOF)

Adult social care outcomes framework (ASCOF)

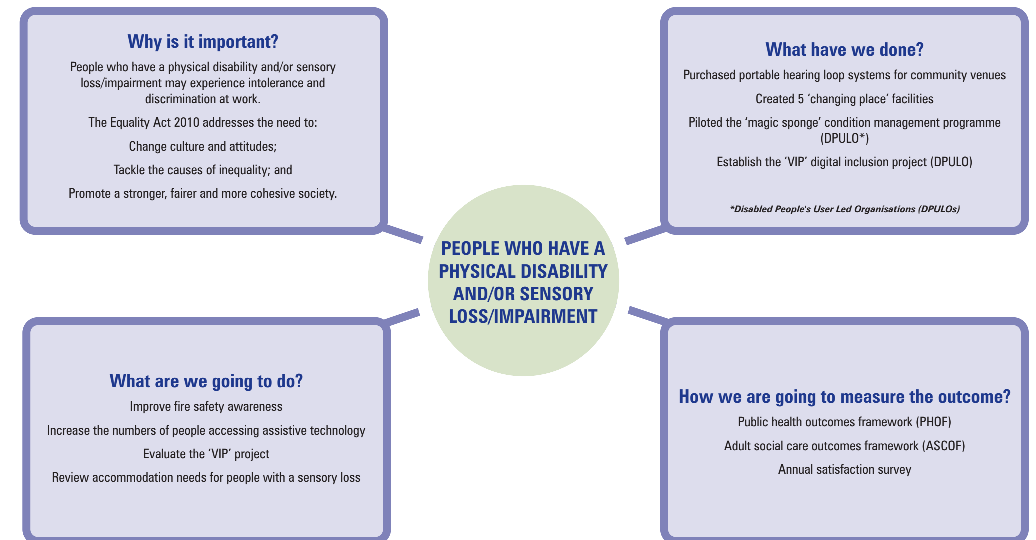
Annual satisfaction survey

Mental Health Joint Plan - action plan

Crisis Care concordat - action plan

Tees Suicide Prevention Plan

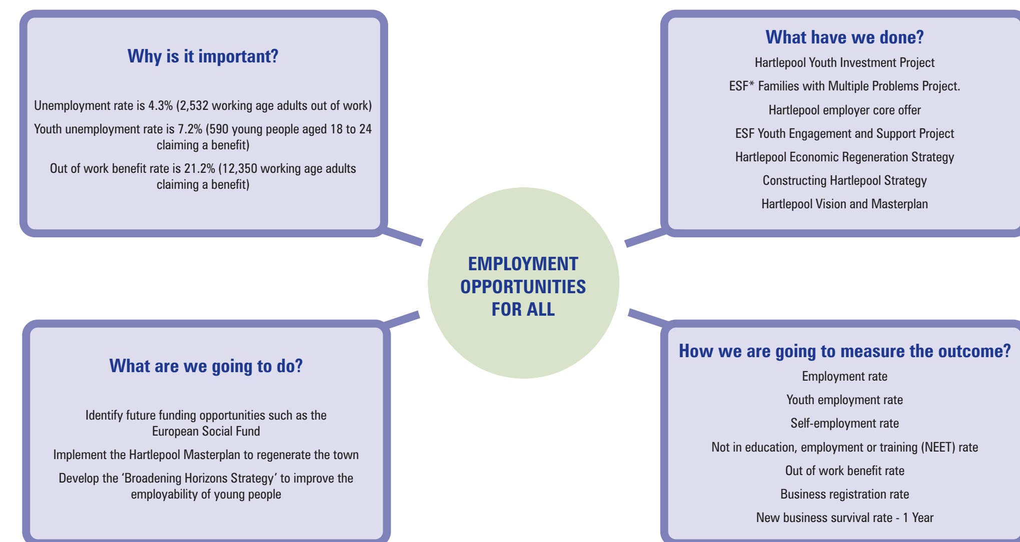
Roles and Responsibilities



Roles and Responsibilities

Chapter 5

Roles and Responsibilities



A Success Story

Chapter 6

Chapter 6 focuses on a case study where a resident of Hartlepool tells their story about how the council aided them into improving their health and wellbeing through achieving employment.

Gary was referred to Hartlepool Borough Council's Employment Link Team from the Adult Social Work Team in 2011. Gary has a learning disability and wanted to move away from being supported within a day centre setting and wanted to be in sustained employment.

When the Employment Link Team started working with Gary, an assessment of his needs was completed which developed an individual action plan. This identified Gary had low confidence, a limited grasp of literacy and numeracy skills, poor social skills and little self-esteem. The team worked closely with him to establish a relationship and discussed the work experience opportunities which were available to him. Gary expressed an interest in working outdoors, with a passion for horticulture.

It was at this time Gary was made aware of the Waverley Allotments Project, which is a specialist project for adults with a learning disability or mental health condition. It is a user led project, which was established in 2007 by a group of disabled adults who wanted to work outdoors. It offers 3.5 acres of land within the Rift House area, which enables service users to access therapeutic, employment and training and commercial services.

To ensure the placement met his needs, Gary visited the Waverley Allotment Project where he participated in some of the horticulture work, discussed his potential role and looked at the facilities. He thoroughly enjoyed this experience and started his formal work experience placement in September 2011. This was successful in improving his confidence by being part of a team and developing his employability skills.

Gary continued to access the Waverley Project as a volunteer until March 2012, when funding became available to provide 14 adults with employment. He was successful in securing a position and this role gave him paid work alongside specialist training. After a thorough assessment of his needs, he started a NVQ Level 2 in Horticulture supported by Adult Education, alongside specialist support to improve his literacy and numeracy skills.

Gary successfully completed the qualification, which involved him receiving specialist tuition from expert horticultural staff and complimented the practical skills he was receiving at the Waverley Project. He undertook a range of activities as part of his role including crop rotation, sowing seeds, pest control, ground maintenance, fruit and vegetable cultivation and landscaping.

To ensure he progressed into sustained employment after the project, he participated in a dedicated pre-employment training programme. This offered intensive one to one support from the Employment Link Team alongside jobsearch, interview techniques and CV compilation.

All of this advice and support allowed Gary to progress into paid sustained employment in a horticulture role within a local company. As well as achieving his ambition of attaining paid employment, the course and service assisted in developing his understanding of his condition, increased his self-esteem and self-worth and gave him a purpose, enabling him to be an active citizen, moving people's perception from service user to employee.

Church Street

Hartlepool Waterfront

Port Estate

Queens Meadow

The Headland

Town Centre

Seaton Carew

Wynyard

The Future

I hope that you have found this report informative and stimulating. It has attempted to consider the relationship between health and work and how multi-faceted that relationship is.

It is clear that there are great benefits to both physical and mental health and wellbeing provided through legislation and regulation at work. However, the report has also highlighted how employers and employees can take responsibility for improving and protecting health.

Employers are well placed to support their staff in a range of ways as demonstrated and recognised by the North East Better Health at Work award.

Ensuring everyone has an equal opportunity to work is enshrined in legislation, and in Hartlepool there are some outstanding examples of how opportunities are created.

Hartlepool Borough Council's Employment Link Team has successfully supported more than 15% of known adults with learning disabilities into employment, significantly higher than the national average of 8%.

Looking to the future, there is ambition for economic growth and job creation in Hartlepool.

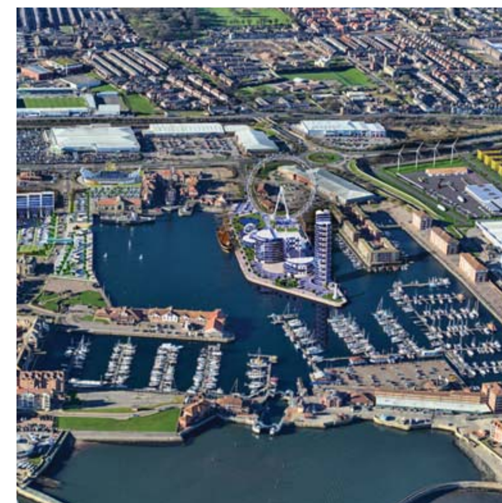
Already, since the launch of the Hartlepool Youth Investment Project in September 2012, partners have reduced the Hartlepool youth unemployment rate by 12%, the largest reduction in Great Britain.

Employment is often referred to as a determinant of health. Work is a significant contributor to determining whether people experience a good quality of life and health. Moreover, a higher quality job where the employee has an element of control further improves quality of life and health.

The Hartlepool Vision was launched in 2014. This presents the ambition for Hartlepool over the next twenty years and complements the emerging Masterplan, which will lead to major developments and regeneration in Hartlepool. From a public health perspective this is welcomed, given the positive relationship between having a job, the income it provides and overall wellbeing (quality of life and life expectancy).

It is perhaps fitting to leave the final word to Professor Sir Michael Marmot who suggests that we should seek to:

Create fair employment and good work for all.



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Foreword

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[2] Is work good for your health and well-being? Waddell & Burton, DWP / TSO (2006)

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[2] Marmot, M.G. and Shipley, M.J. Do socioeconomic differences in health persist after retirement? 25 year follow up of civil servants from the first Whitehall study. BMJ, 1996; 313: 1177-80

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Chapter 2 - Historical Overview

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Chapter 3 - Health and Employment Status

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Chapter 4 - Heath and Wellbeing at Work

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[2] Website:**https://www.rsph.org.uk/en/policy-and-projects/awards/public-health-ministers-award/**, accessed June 2015

Chapter 5 - Roles and Responsibilities

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Chapter 6 - Success Stories

[1] Hartlepool Borough Council. (2015). Waverley Allotment Project. Available at: http://waverleyterraceallotments.org/ (Accessed on Thursday 9th April 2015)

This document is also available in other languages, Braille, large print and audio format upon request.

Bengali

এই ডকুমেন্ট অন্য ভাষায়, বড় প্রিন্ট আকারে এবং অডিও টেপ আকারেও অনুরোধে পাওয়া যায়।

Cantonese

本文件也可應要求，製作成其他語文或特大字體版本，也可製作成錄音帶。

Hindi

अनुरोध पर यह दस्तावेज़ अन्य भाषाओं में, बड़े अक्षरों की छपाई और सुनने वाले माध्यम पर भी उपलब्ध है

Kurdish

ئەم بەڵگەیە هەروەها بە زمانەکانی کە، بە چاپی درشت و بە شریتی تەسجیل دەس دەکەویت

Arabic

هذه الوثيقة متاحة أيضا بلغات أخرى والأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

Polish

Dokument ten jest na życzenie udostępniany także w innych wersjach językowych, w dużym druku lub w formacie audio.

Urdu

درخواست پر یہ دستاویز دیگر زبانوں میں، بڑے حروف کی چھپائی اور سننے والے ذرائع پر بھی میسر ہے۔

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