HEALTH AND WELLBEING BOARD AGENDA

14 March 2016
2.00 p.m.
in Committee Room 'B'
Civic Centre, Hartlepool.

MEMBERS: HEALTH AND WELLBEING BOARD

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors C Akers-Belcher, 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 19 January 2016

4. **ITEMS FOR DECISION**

4.1 SEND (Children with Special Education Needs and Disabilities) Strategy (*Director of Child and Adult Services)*

4.2 Better Childhood Programme (*Director of Child and Adult Services and Director of Public Health)*

5. **ITEMS FOR INFORMATION**

5.1 NHS Planning Process 2016/17 *(Chief Officer of Hartlepool and Stockton-on-Tees CCG)*

5.2 Better Care Fund 2015/16 Quarter 3 Return (*Director of Child and Adult Services)*

5.3 Update on Healthy Weight Strategy – Presentation by Director of Public Health

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

Date of next meeting –Additional Meeting – 8 April 2016 at 10.30 am. at the Civic Centre, Hartlepool.

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

19 January 2016

The meeting commenced at 2.00 pm in the Civic Centre, Hartlepool

Present:

Dr Schock (In the Chair)

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors Carl Richardson, Chris Simmons and Paul Thompson
Representative of Hartlepool and Stockton-on-Tees Clinical Commissioning Group – Karen Hawkins (as substitute for Alison Wilson)
Director of Public Health, Hartlepool Borough Council - Louise Wallace
Director of Child and Adult Services, Hartlepool Borough Council – Jill Harrison (as substitute for Sally Robinson)
Representatives of Healthwatch – Margaret Wrenn

Other Members:
Chief Executive, Hartlepool Borough Council – Gill Alexander
Representative of Hartlepool Voluntary and Community Sector – Tracy Woodhall
Representative of Tees Esk and Wear Valley NHS Trust – David Brown (as substitute for Martin Barkley)
Representative of Cleveland Police – Temporary Assistant Chief Constable Ciaron Irvine (as substitute for Simon Nickless)

Also in attendance:
Desmond Dongo – Chair, Hartlepool Asylum Seeker and Refugee Group,
Zoe Sherry, Healthwatch
Stephen Thomas – Development Officer, Healthwatch

Hartlepool Borough Council Officers:
Simon Howard, Public Health Speciality Registrar
Rob Smith, Principal Regeneration Officer
Joan Stevens, Scrutiny Manager
Amanda Whitaker, Democratic Services Team

46. Apologies for Absence

Councillor C Akers-Belcher, Leader of Council (Chair)
Representative of Hartlepool and Stockton-on-Tees Clinical Commissioning Group – Alison Wilson

Representative of Healthwatch – Ruby Marshall

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

47. Declarations of interest by Members

Dr Schock declared a potential prejudicial interest in agenda items 5.1 and 5.2 and advised that she would leave the meeting during consideration of those items.

The Board agreed that Councillor Richardson would chair the meeting during consideration of items 5.1 and 5.2.

48. Minutes

The minutes of the meeting held on 30 November 2015 were confirmed

Referring to matters arising from the minutes, the Director of Public Health referred to minute 43 and advised that a sub group had met recently to progress the issues highlighted in the Chief Fire Officer's presentation. A report would be submitted to a future meeting of the Board.

With reference to minute 49 of the meeting held on 2 March 2015, the representative of Hartlepool Voluntary and Community Sector advised the Board that the issue she had brought to the attention of the Board, in relation to the provision of palliative care drugs to the Hartlepool and District Hospice, had not been resolved. The Associate Director of Commissioning and Delivery, Hartlepool and Stockton-on-Tees Clinical Commissioning Group, advised that she would pursue the matter.

Further to minute 47, Dr Schock vacated the Chair.

Councillor Richardson in the Chair.

49. North East Urgent and Emergency Care Vanguard – December 2015 (*Chief Officer, Hartlepool and Stockton-on-Tees Clinical Commissioning Group*)

The Board was informed of the North East Urgent and Emergency Care Vanguard and the associated governance arrangements for the newly formed Regional Urgent and Emergency Care Network (UECN) Group. The report included background information and provided details of the formation, membership and aims and structure of the Network Group.

The Board was advised that in January 2015 the NHS had announced the

'Vanguard' Programme where organisations and partnerships had been invited to apply to become 'vanguard' sites for the development of new models of care, described within the NHS Five Year Forward view. The Urgent Care Vanguard programme had been announced in July and the North East Vanguard application had been subsequently successful. Vanguards would spearhead national work on the transformation of urgent and emergency care, benefiting from a programme of support and investment from the £200m transformation fund. It was essential that the key deliverables identified were progressed at pace and implemented across the region in preparation for national roll out. The Network would build upon existing UEC initiatives as well as developing new models of care producing an overall urgent care strategy for the region building on and supplementing existing local (CCG and Local Authority) strategies. NHS England had recognised the challenges faced by vanguard sites and had developed a bespoke support package comprising of eight key enables as illustrated in the report.

It was noted that there was a national programme of support for vanguards with a clear driving principle of co-production. Following the successful Vanguard application a national site visit of subject matter experts had taken place. The objectives of the sessions were set out in the report and discussions from breakout sessions had been recorded within the site visit outcome summary. A regional UEC vanguard visioning event had been held also which reaffirmed the vision and principles of the North East UEC vanguard. In addition, the first Urgent & Emergency Care Clinical Reference Group had been held on the 6th November. A table, set out in the report, set out the expected key deliverables which should be achieved by April 2016.

The Board was informed that the first of two 'value propositions' had been submitted on the 30th November. The submission had identified the high level key deliverables that would be achieved by 31st March 2016. The second more detailed value proposition would identify the deliverables for 16/17. A series of workshops had been scheduled to progress the logic models which in turn would inform the value proposition. A draft value proposition would be submitted on the 8th of January.

It had been agreed that a Vanguard Programme Board would be established and that all provider organisations would have a nominated representative. The first Board had been convened on the 16th of December 2015. The work stream leads would progress the 15/16 schemes within each work stream. Highlight reports will be presented to the Strategic Network group with regular briefs to all stakeholders.

The Associate Director of Commissioning and Delivery, Hartlepool and Stockton-on-Tees Clinical Commissioning Group, provided assurance that the 'Vanguard' Programme would complement existing pieces of work including the Health and Social Care Plan. The Assistant Director agreed to respond to clarification sought from an Elected Member regarding substitution arrangements on the Programme Board.

Decision

The update was noted by the Board.

50. Integrated Urgent Care Update (December 2015) (*Chief Officer, Hartlepool and Stockton-on-Tees Clinical Commissioning Group*)

Further to minute 9 of the meeting of the Board held on the 22nd June 2015, the report provided the Board with an update on NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG) development of an Integrated Urgent Care Service (IUCS) and an outline of next steps. In order to ensure delivery of the timeframe and to enable a service to commence in October 2016, the CCG would be required to commence procurement on 5th January 2016 in order to meet the agreed procurement timetable and offer time for service mobilisation. The Board was reminded that the CCG had been required, following receipt of correspondence from NHS England (NHSE) in June of 2015 (Gateway 03568), to 'pause' any procurement in relation to urgent care services. This was to allow receipt of the publication of the NHSE Commissioning Standards for Integrated Urgent Care.

The Board was advised that whilst awaiting the publication of the commissioning standards, the CCG had identified a number of additional developments that would impact on the original procurement timescales and which posed a risk to the CCG progressing within the timescale to commence procurement on the 5th January 2016. Following receipt of the standards and upon identification of the number of developments outlined in section 3 the CCG Governing Body determined a required extension of timescales for procurement was required. The impact of this decision being that the IUCS would now commence in April 2017, six months later than originally intended.

Outlined in the report were factors that have been considered by the CCG Governing Body in relation to the extension of the procurement timescales in terms of commissioning standards, Vanguard, Hartlepool Plan, Collaboration with other CCGs, Workforce implications, NHS England Dental Review and NHS Planning Guidance. The Board was advised verbally that NHS Planning Guidance 2016/17-2020/2021 – Delivering the Forward View had been received on 22 December and an impact assessment was being undertaken.

During the debate which followed presentation of the report, Board Members highlighted a number of issues which had been discussed at a recent meeting of the Local Health and Social Care Plan Working Group. Clarification was sought whether immediate improvements could be sought in terms of integration of services as part of the extension of the current contract. The Associate Director of Commissioning and Delivery, Hartlepool and Stockton-on-Tees Clinical Commissioning Group, acknowledged that communication concerns had been highlighted at the Working Group meeting and consideration would be given, therefore, to the Communications Plan. The Assistant Director added that following the meeting of the Working Group, a meeting was to be arranged with the North Tees and Hartlepool NHS

Foundation Trust to attempt to improve the working arrangements and communication between the out of hours service and the minor injuries unit and that the Clinical Commissioning Group were working with other organisations to address the issues highlighted at the working group. In response to assurance sought from the Council's Chief Executive that commissioned services would be in accordance with the Local Health and Social Care Plan, it was confirmed that feedback from the Working Group would be included where appropriate in specifications. In terms of the location of urgent care, the Assistant Director responded that availability of premises were being considered although it was highlighted that there were some challenges particularly if premises were not owned by the commissioner and that this would be determined through the procurement process that the CCG was required to undertake. Any views expressed regarding the location of urgent care would be considered but ultimately the final decision would be that of the provider. However the CCG would ensure through the procurements that any premises solutions identified by the Provider were fit for purpose and accessible.

Decision

The report was noted.

Dr Schock in the Chair

51. Healthwatch Hartlepool Asylum Seeker and Refugee Health Consultation Report (*Healthwatch Hartlepool*)

The Board was advised of the outcomes of the recent health focused consultation events undertaken by Healthwatch Hartlepool with the town's asylum seeker and refugee community. The asylum seeker and refugee consultation had been included in the 2015/16 work programme of Healthwatch Hartlepool as a result of some concerns raised with Healthwatch regarding access to and provision of health related services to members of this community. The report set out the findings of the report.

The report concluded that there was a lack of clear information and guidance for members of the asylum seeker and refugee community in Hartlepool around the availability and entitlement to health care. Health structures and provision were considered complex, as were the national regulations which governed this area. It was apparent from the consultation that significant improvement was needed.

Board Members were advised that mental health was a major area of concern. Cultural sensitivities and stigma could be a barrier to both adults and children accessing treatment and pathways in to services could be confusing and unclear. Language difficulties, inconsistency in GP patient experience

and lack of awareness of psychological therapies could also be barriers which prevented access to appropriate care.The trauma, upheaval and shock which was part of the lives of refugees and asylum seekers impacted deeply on family wellbeing and lifestyles. This could have hugely detrimental effects on physical and mental health and personal and family life.

Translation and interpretation services were often key to individuals and families being able to access information around health care, housing, education and a host of other issues. Sensitive and skilled translation and interpretation services were considered to be key but it appeared that on occasions the skills of interpreters were questionable and regional/dialect variations could cause problems.

The Healthwatch report included the following recommendations:-

- There must be a coordinated and concerted effort to ensure that access to culturally sensitive mental health services is improved for those requiring support within the asylum seeker and refugee community in Hartlepool. This must include the development of a more joined-up approach to care and support provision between all provider agencies and more effective communication and sensitivity to the needs of this community.

- HAST CCG, as a matter of urgency should seek to improve information dissemination and communication with asylum seeker and refugee communities in Hartlepool and ensure that individuals and families are aware of health related service and how to access them.

- Attention must be given to improving methods of engagement with asylum seekers and refugees, including translation and interpreting services, by all agencies involved in the provision of health services to which this community are entitled.

- Hartlepool Borough Council and HAST CCG should engage with representatives of the asylum seeker and refugee communities in Hartlepool to find ways of promoting healthier lifestyles (e.g diet and exercise) within and beyond the community.

The Healthwatch Development Officer introduced Desmond Dongo, Chair of Hartlepool Asylum Seeker and Refugee Group and Zoe Sherry, Healthwatch, who had contributed to the report. Support was expressed of the findings of the report.

Board Members debated issues arising from the report including access to psychological services which the representative of Hartlepool voluntary and community sector agreed to refer to voluntary groups. The Director of Public Health undertook to discuss issues with her Team to ensure resources were

available in line with services available to other Groups. A suggestion was made by the Associate Director of Commissioning and Delivery, Hartlepool and Stockton-on-Tees Clinical Commissioning Group, that issues are referred to the appropriate multi agency group and that an action plan is produced. The Chair of Children's Services Committee agreed to a suggestion made by an Elected Member that the issue raised, with particular reference to access to psychological services, be referred to the Council's Children's Services Committee.

Decision

(i) That Board noted the contents the HealthWatch Hartlepool Asylum Seeker and Refugee Consultation Report, considered the recommendations contained within and agreed that an update report be submitted to a future meeting of the Board.

(ii) Issues highlighted in the meeting regarding access to psychological services be referred to the Council's Children's Services Committee.

52. Wider Determinants Health/Regeneration Masterplan – Presentation by Director of Regeneration and Neighbourhoods

The Council's Principal Regeneration Officer gave a detailed presentation to the Board outlining the main aspects of the Hartlepool Regeneration Masterplan. The Hartlepool Regeneration Masterplan represented an in-depth piece of work looking in detail at what could be achieved on specific sites within the Marina, Hartlepool Waterfront and wider town centre. Despite the challenges that the town was facing due to the current economic climate there were a number of opportunities and developments which set the context for the preparation of the Masterplan which were highlighted to the Board. The Masterplan identified three main sub-areas to drive the regeneration of the town; the Waterfront/Marina, the Innovation and Skills Quarter at Church Street and the Town Centre. A key cross cutting theme was connectivity and ensuring that these areas were well connected to each other and beyond. All of the projects within the Masterplan were designed to be implemented together as part of a cohesive Regeneration Programme for Hartlepool. The delivery would be an ongoing and sustained process over the next 15 years.

The Masterplan had been developed considering a number of strategic aims which were set out in the report and resulted from a series of public consultations and stakeholder events. It was noted that 407 responses had been received in response to the consultation on the draft Masterplan in addition to feedback from the stakeholder event on the 20th January which attracted approximately 100 businesses. The consultation feedback had helped shape the proposals in the Masterplan along with discussions with

investors, developers and funders from both the public and private sectors.

The Principal Regeneration Officer highlighted the key three areas of the Waterfront, Church Street and the Town Centre and outlined the potential developments in each of the three areas which included schemes such as the National Museum of the Royal Navy North, Jacksons Landing, Trincomalee Wharf, Cleveland College of Art and Design, the Innovation and Skills Quarter, and Mars Pension Fund (owners of Middleton Grange shopping centre) investment proposals and the potential of new leisure facilities. The Principal Regeneration Officer stressed that one of the key issues that faced many of these potential schemes was connectivity between them and the town centre and public transport. The Masterplan looked at the potential changes around the main traffic and pedestrian routes that may be required to link the development areas together to avoid them being isolated from each other and the town centre.

In terms of wider health implications arising from the Masterplan, the Board considered the following issues:-

- Shared ownership and delivery of the Masterplan and Vision- everyone has a role!
- How can the health agenda support the delivery of the Masterplan and Vision? E.g STEM Centre.
- What opportunities are there to become actively involved: resources/future plans?
- What impact will decisions have on the Masterplan area?

Following the presentation, the Principal Regeneration Officer reiterated the opportunities to link regeneration and the wider health implications.

Decision

The presentation was noted.

Meeting concluded at 3.40 p.m.

CHAIR

HEALTH AND WELLBEING BOARD

14 March 2016

Report of: Director of Child and Adult Services

Subject: SEND (Children with Special Education needs and Disabilities) STRATEGY

1. PURPOSE OF REPORT

1.1 The SEND strategy and terms of reference for the SEND group were considered and agreed at a meeting of the Children's Strategic Partnership on 23 February 2016. The Partnership agreed that given the importance of this work the information received should be referred to the Health and Wellbeing Board for consideration. The Health and Wellbeing Board are being asked to:

- Agree the terms of reference and governance arrangements for the SEND group;
- Agree the SEND Strategy; and
- Note the information regarding the forthcoming SEND inspection arrangements.

2. BACKGROUND

2.1 Over the last few years there have been significant reforms to legislation and policy in relation to children with special educational needs and disabilities.

2.2 In September 2011 Hartlepool was asked to be a pathfinder to trial and pilot the reforms before the changes became legislation for the reforms. Hartlepool initially worked with Darlington to pilot new ways of working and more recently have rolled out the changes as required by Children and families Act 2014 and subsequently the New Special Education Needs and Disability Code of Practice: 0-25 years.

2.3 The changes (as set out in the Young Persons' Guide to the Children and Families Act 2014) include:

- Get education, health care and social care services working together;
- Tell children, young people and their parents what they need to know about their disability or special educational needs
- Make sure children, young people and families know what help they can get when a child or young person has special educational needs or a disability;
- Make sure that different organisations work together to help children and young people with special educational needs;
- Give children and young people and their parents more say about the help they get;
- Set up one overall assessment to look at what special help a child or young person needs with their education, and their health and social care needs, all at the same time;
- Give a child or young person just one plan for meeting their education, health and social care needs, which can run from birth to age 25 if councils agree that a young person needs more time to get ready for adulthood;
- Make sure children, young people and their parents can choose some of the help they need;
- Provide ways to help sort things out if a child or young person or their parent needs help to appeal about the help they get.

3. SEND GROUP

3.1 The LDD/SEN group was previously a multi agency group set up to oversee the development of an action plan which was a multi agency group. However this group did not report to any governance structures. It is proposed that in order to ensure that all partners have oversight of the progress of this strategy and plan that this group reports to the Children's Strategic Partnership bi-annually. It is also proposed for the group to be renamed SEND group to ensure that all partners understand the role and aim of the group.

3.2 Terms of reference have been drafted for the SEND group and are attached as **Appendix A**. These terms of reference were compiled by all the partners attending the meeting.

4. SEND STRATEGY

4.1 The SEND group has recently spent time looking at all current legislation, policy and JSNA (Joint Strategic Needs Assessment) to develop a strategy to ensure that all partners are meeting the requirements of the new reforms. The draft strategy is attached as **Appendix B** and includes a one year action plan.

5. SEND INSPECTION

5.1 Ofsted and CQC (Care Quality Commission) intend to inspect local areas to evaluate how effectively local areas meet their responsibilities towards disabled children and young people who have special educational needs. Ofsted and CQC have published a consultation to ask for views about how these inspections will be managed. The consultation closed in January and the inspection framework is due to be published this month.

5.2 Ofsted and CQC will inspect local areas on their ability to implement the reforms as set out previously in this report. The inspection will cover local authority and health commissioners and providers, together with all of the area's early years settings, schools and post 16 further education sector.

5.3 Inspections will begin in May 2016. Local areas will be expected to provide a self evaluation on how effectively it meets its responsibilities for SEND. The inspection will last five days and will focus on how services contribute to meeting the needs of children and young people who are being assessed for, or are subject to, education, health an care plans.

6. RECOMMENDATIONS

6.1 For the Health and Wellbeing Board to endorse the terms of reference for the SEND group and the governance processes for this group.

6.2 For the Health and Wellbeing Board to note the SEND Strategy and secure strategic sign up to deliver the strategy.

6.3 For the Health and Wellbeing Board to note the information regarding the forthcoming SEND inspection arrangements.

7. CONTACT OFFICER

Danielle Swainston, Assistant Director, Children's Services, 01429 523732 danielle.swainston@hartlepool.gov.uk

Louise Allen, Head of Service, SEND, 01429 523209, louise.allen@hartlepool.gov.uk

SEND Group

TERMS OF REFERENCE

1. Governance

   This group is a sub group of the Children's Strategic Partnership. The Children's Strategic Partnership, which is a multi agency partnership, will have oversight of the progress of the plan. The Children's Strategic Partnership is not a decision making board and therefore any decisions that are required will follow individual organisations governance processes e.g Children's Services Policy Committee for the council.

2. Purpose of the group:

   - To complete SEND JSNA
   - Need to develop SEND Strategy and recommend to Children's Strategic Partnership
   - To review government policy / practice guidance to inform organisations in their practice
   - To ensure that services co-ordinate their services to ensure a seamless service for children with disabilities and their families
   - To consider children, young People's and parents views in the development of the strategy and action plan
   - To identify best practice and work across the partnership
   - To establish Task and Finish Groups to meet objectives in Strategy
   - Implementation of Strategy through development of action plan / work plan
   - To carry out regular self assessment to understand impact of partnership services
   - To review Information, Advice and Support Service and monitor effectiveness of this service
   - Provide annual report which sets out priorities for resources / service and any barriers to achieving outcomes.
   - Ensure co-production within all decision making

3. Membership

To be chaired by Assistant Director, Children's Services (HBC)

Head of Service SEND
Strategic Commissioner Children's Services (HBC)
CCG
1 Hart / 1 Mind / 1 Future Parent rep
Public Health
North Tees and Hartlepool NHS Foundation Trust
Tees Esk and Wear Valley Trust
Learning Disability Partnership Board
Schools Representative – Mainstream and Special
IASS (Information, Advice and Support Services) Lead
SEND Manager HBC
Care Co-ordination lead
School Improvement Team
Youth Service
Educational Psychology
Voluntary Sector
Midwifery
OT / Physio
Speech and Language

This group will make links to SENCO Forum to ensure that schools are fully involved in development of strategy and implementation of action plan.

4. Responsibilities of the members of the group

It is the responsibility of the member of the group to:

- Ensure they share and implement across their organisations;
- Ensure that they represent the views of their organisation in the development and review of the strategy and action plan.

Completed: January 2016

Review Date: January 2017

HARTLEPOOL SEND STRATEGY
2016- 2019

Contents

1. Vision

"All children, young people and young adults with Special Education Needs and Disabilities will enjoy a happy, safe and healthy childhood that prepares us well for adult life and enables us to be the best we can be."

(Written by children and young people)

2. Principles

- We will work to protect children from significant harm;
- We will keep children and their families at the heart of everything we do;
- We understand that every child and every family is different. We will assess each child and their family so that we can offer services to suit their needs. We will do this using an approach called the "team around the child" model;
- We will respect each child and their family and always treat them with dignity;
- We will not make changes to the services we provide without good reason;
- We believe we can make the biggest difference to a child's quality of life by providing a service as soon as we find out that the child needs support from us;
- We will check our services often to make sure they are as good as they can be. We will make changes to our services if we need to;
- Our workers will be skilled and will do their jobs well. Managers will give support and guidance to the staff in their teams. All workers will get high quality training as part of their job
- Our services will work together to make each child's quality of life better.

3. National and Local Context

3.1 National Context

This strategy has been developed in line with the legal requirements and responsibilities set out in the Children and Families Act 2014, and subsequently the Special Education Needs and Disability Code of Practice: 0 – 25 years. For children and young people with special educational needs or disability the Act aims to:

- Get education, health care and social care services working together;

- Tell children, young people and their parents what they need to know about their disability or special educational needs
- Make sure children, young people and families know what help they can get when a child or young person has special educational needs or a disability;
- Make sure that different organisations work together to help children and young people with special educational needs;
- Give children and young people and their parents more say about the help they get;
- Set up one overall assessment to look at what special help a child or young person needs with their education, and their health and social care needs, all at the same time;
- Give a child or young person just one plan for meeting their education, health and social care needs, which can run from birth to age 25 if councils agree that a young person needs more time to get ready for adulthood;
- Make sure children, young people and their parents can choose some of the help they need;
- Provide ways to help sort things out if a child or young person or their parent needs help to appeal about the help they get.

(Young Person's guide to the Children and Families Act 2014)

From September 2014 their is duty for Local Authorities and CCGs (Clinical Commissioning Groups) to jointly commission services for children with SEND. The recently published Department of health manadte fpr the NHS commissioning Board includes a specific objective to ensure children with SEND have access to services identified in their agreed plan and that parents, families and carers have the option of a personal budget based on a single assessment across health, social care and education.

Significant reforms also took place recently to arrangements for funding for schools. The intention of this reform was to:

- Achieve maximum delegation of funding to schools;
- Simplify the way Local Authorities and the Education Funding Agency fund schools and academies so that it is more consistent and better focused on the needs of pupils;
- Create greater consistency between local funding formula.

The new system for funding SEND was established as follows:

- Local authorities are given a budget for children and young people with higher level needs. This budget is called the High Needs Block and funds all additional provision across early years, schools and post-16 education and training.
- Mainstream schools are expected to spend up to £6,000 out of their existing "base" budget to meet SEND needs before the local authority provides additional "top up" funding out of the High Needs Pupil Block.
- Special Schools pre 16 are funded at £10k per place plus any additional banded top up funding.

3.2 Local context

In September 2011 Hartlepool was successful in a joint bid with Darlington to become one of 20 SEN Pathfinder Areas to test the proposals in the Green Paper - Support and Aspiration: A new approach to Special Educational Needs and Disability published in May 2011. The new approach was to provide an integrated streamlined process, which better involved children, young people and their families. The implementation of the new Education, Health and Care (EHC) Plans, which replace the existing Special Educational Needs Statements and Learning Difficulty Assessments, by bringing services together and focusing on improving outcomes. This also included the offer of a personal budget for families with an EHC plan who requested it and improved access to information.

As part of the Pathfinder work, Hartlepool tested the following areas to share with other local authority areas to support them to implement the reforms.

- Joint assessments and single education/health/social care plan (0-25 yr olds)
- Personal budgets (education/health/social care)
- Support to parents and young people
- Support to vulnerable children

Hartlepool, as a pathfinder, was expected to achieve the following:

- All Looked After Children with a statement or requiring statutory assessments to have an EHC Plan completed;
- Any new statutory assessments, particularly those children under 7 to go through the Single Coordinated process (EHC Plan)
- Year 9 students with a statement for Autistic Spectrum Disorder to be transferred across to an EHC Plan

To enable the local authority to carry out this work, a number of Task and Finish Groups were established, together with a main steering group to ensure work was on target to meet the deadlines set by DFE. The four Task Groups included:

- Joint Assessment/Single Plan - to explore the process, develop and implement the EHC Plan and Guidance;
- Personal Budgets - to develop and pilot for young people to access as part of the EHC Plan;
- Support to Parents/Young People - In partnership develop and implement the local offer of services for families to have access to information from one point;
- Support to Vulnerable Children – Looked After Children (LAC) through the transfer of an existing Statement and/ or new assessment for a EHC Plan.

The Task Groups were multi agency and included parents/ carers and young people.

4. Governance

The most recent Code of Practice sets out very clearly that the responsibility for ensuring effective support for children with special educational needs and disabilities is shared between education, health and social care. It is therefore critical that partnership arrangements need to be robust and rigorous to ensure that children and their families receive the right service at the right time regardless of organisational boundaries.

The Health and Wellbeing Board is responsible for the oversight of this SEND strategy and it is expected that the Children's Strategic Partnership will be the partnership group that oversees the effectiveness of this plan. A SEND group (which was previously the LDD/SEN group) will be a sub group of the Children's Strategic Partnership.

The Hartlepool Education Commission Report, launched in October 2015, sets out the key recommendations to ensure that every child and young person has the best possible chance to grow into successful, fulfilled and responsible citizens as members of a vibrant local community. The report focuses on collaborative, partnership working involving all stakeholders to provide co-ordinated support to all learners and their families. The recommendations highlight the need to;

- develop and support an integrated family support and early intervention programme that stimulates early child development;
- develop a model that that secures continuity and progressions at key transition points

- improve the emotional and physical well being of young people through a revised curriculum for life.

In addition to the work of the Education Commission, the CAMHS Local Transformation Plan further supports the drive to support and improve the mental health of priority groups of children and young people which includes children and young people with a learning disability. This will ensure better integration of services towards one assessment, one plan and increased access for vulnerable young people to specialist services where required and appropriate.

5. Needs analysis

See attached Joint Strategic Needs Assessment.

6. What children, young people and parents have told us

Parents have worked together to say what they would like from services as follows:

- Treat our children as individuals
- Earn our respect
- Demonstrate that you care
- Show a genuine interest in **all** family members
- Negotiate with us practical suggestions that could work for us
- Support us emotionally
- Listen to us, be there so that we can sound off and explore issues and problems.
- Be approachable
- Do what you promise to do and respond to us when we contact you
- Take what we say seriously
- We need to feel that we have some control of what and how we access support to make changes
- As parents we need to be there to support each other
- We need to have some control around what happens in meetings about our children.
- We need to have acknowledgement of referral requests and timescales in which we can expect a response.
- As parents we need to have our expertise in relation to our children acknowledged.
- We need practitioners to see things from our perspective.
- We need practitioners to consider how their expectations impact on us as a family

7. Priorities

1. A clear understanding of needs to ensure effective commissioning of integrated services.

2. Children, young people, young adults and parents inform commissioning of services and shape services to ensure personalisation of their support.

3. Effective assessment and early identification that leads to children/young people/adults having an integrated plan which is regularly reviewed with clear outcomes.

4. Services will be seamless to ensure effective transitions.

5. Ensure parents, Carers, Children and Young People are provided with Independent, advice and support through the EHC Plan process and SEN Support

8. How will we know we have been successful?

Short term

- Parents, children and young people get right support at right time; feel that they are listened to and in control
- Planned and well managed transition points
- A joined up, transparent and accountable system

Measured by:
Timeliness of transfer from statements to EHC plans
Number of EHC plans that are completed on time
LA data
Parent Surveys
Feedback from Independent Support and IASS
Number of personal budgets
SEN appeals and outcomes

Medium/ Longer term

- Improved progression and attainment for all ages
- Clear and appropriate expectations and aspirations leading to fulfilled lives
- More resilient families
- Increased employment
- Choice and control over living arrangement/ independent living
- Participation in the community

Measured by:

Attainment/ progression data

Numbers of Looked After Children within SEND cohort

Outcomes for Looked After Children

Destinations after Key Stage 4 and Key Stage 5

Employment status for adults with LDD

Accommodation status for adults with LDD

ACTION PLAN 2016 - 2017

PRIORITY ONE: UNDERSTANDING OF NEEDS TO ENSURE EFFECTIVE COMMISSIONING OF SERVICES. SERVICES WILL BE FLEXIBLE, RESPONSE ENOUGH.

Objective	Action	Responsibility	Timescales	Progress
Understand the SEND population and the needs	Produce a Joint Strategic Needs Assessment	Deborah Clark	April 2016	
	Review information held in JSNA to see if there are any gaps in the information and explore ways of gathering this information	Rachel S/ Ruth K	April 2016	
Understand whether provision available is meeting children and young people's needs	Complete a sufficiency assessment of provision	Rachel S/ Ruth K	September 2016	
	Carry out deep dive of a number of ASD cases to understand detailed needs to inform commissioning of specialised provision	Rachel S/ Louise A/Jacqui	April 2016	
	Carry out an options appraisal to identify and gaps in ASD provision	Rachel S/ Ruth K	September 2016	
	Review of ASD pathway	Ruth K/ Jacqui	September 2016	
Ensure that provision available can meet children's needs and increase the choice of provision	Work with regional colleagues to develop commissioning frameworks NE12 Tees Valley Residential	Rachel S	April 2016	
	Work with the market to increase choice of provision for children with special educational needs and disabilities	Rachel S	March 2017	
Ensure that provision is of highest quality, responsive and value for money	Review terms of reference of commissioned placements panel to ensure multi agency decision making is effective and meeting children's needs	Rachel/ Ruth K	May 2016	
	Review commissioning process to ensure • Robust evaluation/ monitoring of	Rachel/ Ruth	May 2016	

	contracts • Establishments of visits to commissioned provision to ensure complaint with LA/ health requirements • Develop process to involve parents, children and young people in the evaluation			
	Work with health to establish monitoring processes for placements that are jointly funded.	Rachel S/ Ruth K	September 2016	
To ensure that resources are targeted appropriately	Carry out mapping process to identify all children being supported which includes type of provision and cost of provision	Rachel S/ Louise A/ Kay F	April 2016	
	Establish clear processes to ensure that the number of children being supported is robustly monitored	Louise A, Rachel S, Sandra S	June 2016	

PRIORITY TWO: CHILDREN, YOUNG PEOPLE/YOUNG ADULTS AND PARENTS SHAPE SERVICES TO INFORM COMMISSIONING OF SERVICES AND ENSURE PERSONALISATION OF THEIR SUPPORT

Objective	Action	Responsibility	Timescales	Progress
To understand what children and young people need and want from services	Work with CYP to develop principles for all our work – Catcote, Springwell, Bases, VCS, Schools, CEVG, OSS colleges.	Louise A, Sarah W	September 2016	
	Review current children/ young people groups to ensure that CYP views are being listened to and acted upon within the strategy	Sarah W	July 2016	
	Review LA service user engagement strategy to ensure that children with special education needs and disabilities are represented	Sarah W	July 2016	
	Identify other opportunities to listen to parents e.g. schools	Sarah W, Tracy	July 2016	
	Further develop links with Young Carers to get views of young people.	Louise/ SENCO forum	September 2016	
Parents to contribute to the development of the strategy	1 Hart, 1 Mind, 1 Future sessions to discuss strategy and views to be shared at SEND group	Christine F	Ongoing	
	Collate views from parent to inform the identification of trends and contribute to commissioning of services	Christine F	March 2017	
Children, young people and parents to shape their own plans	Review EHC planning process to see how children's views are collected.	Sarah W, Louise, Danielle	September 2016	
	Explore ways of improving children/ young people's voice within planning	Louise, Sarah	September 2016	
	Person centred planning training to be delivered to the children's workforce	Sarah W	September 2016	

PRIORITY THREE: EFFECTIVE ASSESSMENT/EARLY IDENTIFICATION THAT LEADS TO CHILDREN/ YOUNG PEOPLE/YOUNG ADULTS WHO WILL HAVE AN INTEGRATED PLAN – REGULARLY REVIEWED/ OUTCOMES CLEAR.

Objective	Action	Responsibility	Timescales	Progress
To ensure that pathways are straight forward and easily accessed	Carry out audit of all current pathways to understand family's journey through services • LA • Wider partnership	Danielle S	July 2016	
For families to have ONE plan	Task and finish group to be established to review processes across social care and SEN in relation to plans	Louise A, HBC management team	July 2016	
	Task and finish group to review processes across social care and health particularly in relation to plans	Louise A	Dec 2016	
To ensure that children that need support are identified at the earliest opportunity	Implement Better Childhood • Establish rebranded Early Help Assessment to ensure that children are being supported at the earliest possible opportunity • Work with schools to ensure that children that need support are being identified as early as possible • Develop 2 year old integrated check and develop an effective partnership response to the outcomes of each individual check	Jane Young/ Chris Rooney Deborah C, Gill S, Janet S	June 2016 Ongoing from June 2016 Sept 2016	
Ensure that the children's workforce are skilled in working with families, assessment and planning	Deliver training/ practice clinics to the workforce • Assessment skills • Outcome based planning • Person centred planning	Sarah W	March 2017	
	Establish a multi agency QA process to evaluate effectiveness of plans	Louise A	December 2016	

PRIORITY FOUR: SEAMLESS SERVICES TO ENSURE EFFECTIVE TRANSITIONS.

Objective	Action	Responsibility	Timescales	Progress
Understand what a child with special needs or a disability journey through services looks like	iMPOWER to carry out research looking at preparing adulthood	Neil, Louise, Sarah W	June 2016	
	iMPOWER to provide recommendations for changes across the system to ensure that young people's transition to adulthood is based on individual needs and effective	Neil, Louise, Sarah W	June 2016	
	Review service delivery across children and adults services based on recommendations from iMPOWER work	Danielle, Jill H	March 2017	
Families receive a seamless service and young people are prepared for adulthood	Terms of reference for transitions group to be reviewed	Sarah W, Neil H and Louise A	July 2016	
	Carry out audit of all current pathways to understand family's journey through services • LA • Wider partnership	Danielle S	July 2016	
	Explore whether it is possible to start planning for a child's life as early as possible to ensure that services are planning effectively e.g procurement of specialist equipment	Ruth, Louise, Neil	March 2017	

PRIORITY FIVE: ENSURE PARENTS, CARERS, CHILDREN AND YOUNG PEOPLE ARE PROVIDED WITH INDEPENDENT, ADVICE AND SUPPORT THROUGH THE EHC PLAN PROCESS AND SEN SUPPORT

Objective	Action	Responsibility	Timescale	Progress
Ensure that the IASS & IS provides impartial, confidential and relevant information, advice and support to parents, carers, children and young people between the ages of 0 -25 years who may have SEN and/ or a Disability	The IASS is located in premises separately from the LA SEND Team and ideally not in the main LA or CCG premises The IASS has a separate phone line, emailing service Information and policies with identifiable branding	Tracy Liveras	Immediate April 2016	
The IASS/IS is planned, monitored , reviewed and evaluated an prompt actions are taken to improve services and meet the service users needs	Distribution of service user feedback questionnaires Production of an annual report to inform the SEND Strategy group of service usage and recommendations on service improvements Produce a local offer annual report	Tracy Liveras	Ongoing July 2016 August 2016	
The IASS provides impartial, accurate and up to date information and high quality advice relevant to service user needs	Produce and review on a regular basis factsheets, and policies relating to SEND support for parents and young people Provide direct links to both the IASS webpage and The Local Offer of Services webpage to provide accessible and up to date information for service users and actively involve service users around changes, access and improvements of access to information	Tracy Liveras	Ongoing	
The IASS/IS offers	Compliance with Data Protection Law	Tracy Liveras	Ongoing	

confidential support to service users	Service confidentiality policy Provision of confidential phone line and email address			
The IASS offers impartial support tailored to the individual (up to and including SEND Tribunal), including casework support and representation	Availability of trained personnel to support individual cases Provision of access to mediation and disagreement resolution services	Tracy Liveras	Ongoing	
Staff, independent supporters and volunteers are appropriately trained and have accurate and up to date knowledge of: Education, social care and health law related to SEND, including National and local policy and practice in meeting SEN & Disability	All staff and volunteers to complete IS and IASS on line legal training, including face to face training to enable confident delivery of the service and support to services Staff to access appropriate training to enable continuous personal development and enable staff to support families appropriately	Tracy Liveras	Level 3 Module to be completed May 2016	
The IASS to work closely with the parent led forum to influence change and design of the service	To attend the Parent Forum on a regular basis and work with them to influence change in service and raise awareness of the service families can access	Tracy Liveras	Ongoing	
The IASS offers to early years settings, schools and colleges, statutory and voluntary agencies training on: Working with parents,	Co deliver SEND Key Working with a parent trainer through the short break and education annual training programmes to both practitioners within the education, health and care fields, including the voluntary sector and parents to gain a better understanding of person centred	Tracy Liveras	Ongoing	

children and young people The law relating to SEN and Disability, as it applies to education, health and care	approaches and working with families Deliver presentations to school SENCO Forums and multi discipline teams within educational, health, care and voluntary sector to raise the profile of the service and for practitioners to gain a better understanding of the service to sign post to parents and young people			
The IASS offers training to parents on: Working with professionals and involvement in decision making The law relating to SEN and Disability, as it applies to education, health and care In collaboration with parent carer forums, contributing to strategic development	Co deliver SEND Key Working with a parent trainer through the short break and education annual training programmes to both practitioners within the education, health and care fields, including the voluntary sector and parents to gain a better understanding of person centred approaches and working with families Co deliver confident, resilient parent workshops to build the confidence of parents to challenge decisions and process Provide drop in services for parents linked to the parent forum	Tracy Liveras	March 2017	

HEALTH AND WELLBEING BOARD

14 March 2016

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

Subject: BETTER CHILDHOOD PROGRAMME

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1. PURPOSE OF REPORT

1.1 For members to approve the implementation of the first phase of the transformation programme Better Childhood Programme.

2. BACKGROUND

2.1 The Better Childhood Programme (BCP) is a cross public sector transformation programme supported by Cleveland Police, the CCG and Hartlepool Borough Council. As part of this programme Hartlepool Borough Council and its partners have developed proposals for the redesign and integration of their services in Hartlepool with the aim of:

- Improving outcomes and life chances for children, young people and families
- Improving the resilience of families and communities and reducing family breakdown
- Supporting more families through early intervention and prevention
- Moving from a culture of 'identification and referral' to one where workers 'own and intervene'
- Reducing demand for specialist services, bringing numbers of Looked After Children in line with statistical neighbours.

2.2 The first part of the programme, from July to October 2015 involved a thorough analysis into demand for children's services in Hartlepool, identifying key causes and drivers, and comparing Hartlepool with its statistical neighbours. This demonstrated a need to do things differently if we are to better support families in building their resilience and in maximising our collective efforts, at a time of shrinking resources. This analysis has led to the development of a new model of integrated support. From November 2015 to January 2016 children, families and professionals from a range of agencies

have collaborated to redesign a new integrated model for early intervention in Hartlepool.

2.3 A report was presented to Children's Services Committee on 1 December 2015 providing an update on the Better Childhood Programme. It set out work that had been undertaken to review demand for children's services and work that was ongoing to redesign services with partners.

3. PROPOSALS

3.1 The Better Childhood Programme document, attached as **Appendix A**, sets out all the work undertaken through the programme and includes the case for change, the redesign work carried out with children, families, workers and partners, overall vision, proposed structures, and timelines for implementation.

3.2 In support of this redesign we have carried out interviews and focus groups with a wide range of children and families, and have used this to develop case studies and common themes. We identified the following common themes from this engagement, which have provided the basis for service redesign activity:

What children and young people said?	**What will be different in the new model**
Don't want worker to change	One worker will be dedicated to working with each family
Want someone to talk to about problems	Workers will have more time to speak to children & families to understand problems. Teams will include professional counsellors
Want worker to listen to us and act on what we have said	Workers will make sure they talk to children to understand their aspirations & problems
More aspirations	Aspirations for children has been set as a priority 'obsession' for the council & partners
Create records about us with us	Finding out information and planning support will be done with families & children - not too them.

3.3 The Children's Strategic Partnership has developed a vision and priorities for the Better Childhood Programme (page 7 of **Appendix A**) and the vision states:

"Our ambition as a children's partnership is to enable all children and families in Hartlepool to have opportunities to make the most of their life chances and be supported to be safe in their homes and communities."

The priorities are:

1. *Children and young people have opportunities to make the most of their life chances and are safe.*

2. *Improving family relationships, strengths, skills and ability to cope.*

3. *Reducing the impact of domestic violence, mental health, drugs and alcohol misuse on children and families.*

4. *Helping parents, carers and young people to gain skills and get jobs.*

3.4 Consultation has taken place with children, young people and parents to understand what services could have done differently to make their lives better. This information has been used by the workforce (in both HBC and NHS trust) to redesign services as set out in the document attached (Appendix A).

3.5 The work undertaken with children and families was also used to develop design principles that underpin all the proposed changes. These are:

How families will be supported

- Children and families at the heart of service design and decision making with a focus on relationships between family members and professionals.
- One worker should hold the relationship, coordinate other interventions and follow families through to a place where their resilience is improved, where this is possible.

How teams will operate

- Service needs to be focused on building the resilience and capacity of universal services and communities.
- Service needs to reduce demand into specialist services and measure impact against this, with improved analysis of 'root cause' issues - to better respond, first time, to the challenges facing families.
- Teams need to be able to respond to need at a local level.

How services will be accessed

- Multi-agency locality teams, based in communities located around schools and learning communities at a local level.

3.6 The proposal is for the Early Help Teams (HBC), Effective Interventions team (HBC), Health Visitors (NHS Trust), Community Nursery Nurses (NHS Trust), School Nurses (NHS Trust) and Family Nurse Partnership (NHS Trust) to be redesigned to four integrated locality teams alongside a specialist team. The locality teams will support children and families at an Early Help level with the specialist team offering intensive support to those families that need it.

3.7 It is hoped that these teams can be in place for 1 April 2016, however a project plan is in place to monitor the implementation and if needed timescales will be adapted.

4. EARLY HELP ASSESSMENTS

4.1 The research carried out by iMPOWER throughout the summer indicated that partners did not like the current early help assessment and this was acting as a barrier to identifying needs as early as possible. Work has been undertaken with all partners to review the current assessment and develop a new one. This will continue to be developed over the next few months.

5. RECOMMENDATIONS

5.1 For members to approve the implementation of the first phase of the transformation programme Better Childhood Programme.

6. BACKGROUND PAPERS

None

7. CONTACT OFFICER

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Danielle.swainston@hartlepool.gov.uk

Better Childhood Programme

1. Context and background

1.1 Summary

The Better Childhood Programme (BCP) is a cross public sector transformation programme supported by Cleveland Police, the CCG and Hartlepool Borough Council. As part of this programme Hartlepool Borough Council and its partners have developed proposals for the redesign and integration of their services in Hartlepool with the aim of:

- Improving outcomes and life chances for children, young people and families
- Improving the resilience of families and communities and reducing family breakdown
- Supporting more families through early intervention and prevention
- Moving from a culture of 'identification and referral' to one where workers 'own and intervene'
- Reducing demand for specialist services, bringing numbers of Looked After Children in line with statistical neighbours.

The first part of the programme, from July to October 2015 involved a thorough analysis into demand for children's services in Hartlepool, identifying key causes and drivers, and comparing Hartlepool with its statistical neighbours. This demonstrated a need to do things differently if we are to better support families in building their resilience and in maximising our collective efforts, at a time of shrinking resources. This analysis has led to the development of a new model of integrated support. From November 2015 to January 2016 children, families and professionals from a range of agencies have collaborated to redesign a new integrated model for early intervention in Hartlepool.

This document provides an overview of the research carried out, the case for change and the model for service delivery.

1.2 Case for change

In Summer 2015 iMPOWER, HBC and partners carried out analysis to better understand demand for children's services in Hartlepool and to help determine how we could better support families at a lower level. This included seeking to understand the core drivers for demand for specialist services in Hartlepool and the common issues in families that have led to them requiring more intensive support or for children becoming looked after. Overall, this analysis demonstrated that a more integrated approach with a focus on the root causes which drive family breakdown is needed to have more impact on outcomes and reduce demand for specialist services.

The findings of this work included that:

- 48% of Looked after Children could definitely or possibly have been avoided with the right intervention at an earlier stage (based on a review of 25% of LAC cases)
- Hartlepool has higher number of Looked after Children and Social Care Assessments, than its statistical neighbours, with many of these assessments not requiring subsequent ongoing social care support

- There is confusion over pathways of support both from partners and staff within the council, leading to a significant percentage of professionals believing that the best way to access early help support is through making a referral to social care
- Over 75% of cases reviewed showed four or more services involved, but not enough evidence of active work that was achieving impact
- Domestic violence, substance misuse and bereavement are core drivers for future specialist services, with this particularly prevalent in younger children
- While there are lots of services involved with families, they are very rarely seeking to tackle or prevent these core issues.

In 2015 the NSPCC produced a publication investigating the role of universal services in addressing and responding to neglect ('Tackling child neglect in universal services'). Findings from this national report support the case for an alternative approach:

- The most common way for practitioners to provide early help for child neglect was by signposting families to other agencies, sometimes with little other action taken.
- While signposting is an important component of early help provision, it needs be done alongside other aspects of early help, like taking time to understand a child and family's needs, and developing a relationship with them that supports them to engage with other services.
- Workload and time pressures were considered to be a significant barrier to providing early help for the practitioners, in particular for those working in health services.
- Staff shortages, high caseloads and pressures to meet targets mean that practitioners have less time, for example, to consider the wellbeing of children in a more holistic way, to develop relationships with children and parents or to monitor children when they have concerns.

The Local Authority and partners face significant reductions to budgets as a result of the Comprehensive Spending Review. A primary ambition of the council and wider partnership is to support frontline services, where possible. Reducing demand for services through a more integrated and focused approach offers a way of achieving these reductions in budget without making significant cuts to services. The analysis completed over the summer of 2015 demonstrated the potential to avoid, reduce and remove unnecessary demand through the children's system and at the same time support more families through earlier intervention.

1.3 Voice of the child

In support of this redesign we have carried out interviews and focus groups with a wide range of children and families, and have used this to develop case studies and common themes. We identified the following common themes from this engagement, which have provided the basis for service redesign activity:

What children and young people said?	**What will be different in our new model**
Don't want worker to change	One worker will be dedicated to working with each family
Want someone to talk to about problems	Workers will have more time to speak to children & families to understand problems. Teams will include professional counsellors
Want worker to listen to us and act on what we have said	Workers will make sure they talk to children to understand their aspirations & problems

What children and young people said?	What will be different in our new model
More aspirations	Aspirations for children has been set as a priority 'obsession' for the council & partners
Create records about us with us	Finding out information and planning support will be done with families & children - not too them.

1.4 Aims of service redesign

Our analysis in phase 1 of Better Childhood demonstrated the need to integrate our services at a local level. A significant number of contacts and referrals to the council come from universal services such as schools. Engagement with our partners has shown that there is a lack of understanding around local early help provision and some duplication due to a lack of integrated working.

As a result, we are seeking to integrate a number of our services around four key localities, centred around children's centre reach areas and school clusters. A core ambition of this approach will be to:

- Build the confidence and resilience of universal services to support families at a local level
- Improve the active participation of communities to support families
- Provide more pro-active intervention in local areas to reduce future demand for specialist services.

1.5 Overview of current structure and services in scope

Our proposal is that the implementation and development of the proposed Locality Model is phased, with a range of directly delivered and commissioned services integrating with the Locality Model over the next 6 – 12 months. The intention is that the new locality teams will 'go live' from April 2016.

The following services are in the scope of this phase of redesign and are directly affected by the proposals for an integrated model.

Team	Summary of existing role
Early Help Team North/ South	• Support families with additional needs to improve outcomes and resilience.
Effective Interventions Team	• Provide specific interventions and support to cases held by a Social Worker. • Provide flexible support and intervention around parenting, behaviour and routines.
Children's Centres Team (including Contact team)	• Delivering a programme of groups for families, targeting a wide range of outcomes. • Delivering universal plus pathway, including outreach visits. • Contact service supervises visits between parents and looked after children.
0-5 Public Health Service (Health Visiting and Family	• Provide health focused support, advice and guidance to families with children aged 0-5.

Nurse Partnership)	• This includes a series of mandated visits, assessment of health needs, and referral to other professionals where required. • Deliver national FNP in Hartlepool providing structured, intensive support to teenage parents with young children.
5-19 Public Health Service (School Nursing).	• Providing health assessment, interventions and support asses at a universal, targeted and specialist levels.

The following services are not in the scope of redesign but work will be undertaken to align them to the proposed model:

- Safeguarding and Support Teams
- Youth Offending Team
- Youth Service
- Attendance Team
- NEET/ One stop shop Team.

The following services are under consideration for the next phase of redesign and integration with the proposed locality model where appropriate:

- Domestic violence services
- Substance misuse services
- Mental health services
- Housing services.

1.6 How redesign proposals were developed

From November 2015 to January 2016 Hartlepool Borough Council and its partners have undertaken work to understand existing services and develop proposals for a new integrated model, able to improve outcomes for children and families, and reduce demand for specialist services.

In developing this model we have sought to include a wide variety of children, families and staff to ensure it is fit for purpose and achieving our goals. This has included:

- Engagement with children and families about the nature of support they have been receiving and how they would like to see this support delivered in the future. This has helped shape the detailed design principles for our new teams.
- A number of whole service workshops with Hartlepool Borough Council staff to set out the case for change and the potential high level model that was initially developed
- A series of workshops with health visitors, school nurses and Family Nurse Partners on design principles and potential models.
- A number of detailed ‘re-design’ sessions have taken place which have been attended by a cross section of frontline staff from a variety of different teams, including health, police and schools. These sessions have helped to develop the model that we are seeking to implement.
- A wider ‘Practitioner Reference Group’ has met to consider proposals developed by the redesign group to add further scrutiny and input from frontline staff and partners
- A design authority has met regularly, attended by the commissioners of services to ensure strategic buy in to the model

- The Children's Strategic Partnership (CSP) has been engaged throughout the development of this model and will continue to lead this model.

The model proposed in this document is therefore directly shaped by the children and families we are seeking to support and by the frontline staff that will deliver it. Details of engagement activity completed are set out in the table below.

Key group	Activity
Children and families	Discussion took place with a range of children and parents. Including: • Interviews/ focus groups with over 25 children and over 15 parents focused on a) capturing experience of existing services and b) testing proposals for change • Development and analysis of over 10 case studies from interviews/ focus groups with children and families, directly informing the design of the proposed service model.
Service Redesign Group	A Service Redesign Group was established with representatives from a range of council services (including those not in the scope of this redesign) and representatives from several partner agencies. This group: • Reviewed feedback from children and families • Reviewed demand analysis best practice from other areas • Developed vision and design principles • Developed core obsessions and performance indicators • Identified interventions to assess need and deliver support • Identified locality areas and teams • Determined level of resource and specialisms in each team • Determined purpose of teams and roles in locality model • Identified how these teams can best build the resilience of communities and universal services.
Practitioner Reference Group	A Practitioner Reference Group was established with representatives from a range of council services and representatives from other agencies. This group: • Supported the activities above by reviewing and testing proposals developed by the Service Redesign Group • Shared proposals with wider teams and feeding back to Practitioner Reference Group • Provided Service Redesign Group with feedback, insight and challenge.
Children's services staff workshops	• Two workshops were held with HBC staff in Nov 2015. Key findings from analysis of service demand and initial feedback from children and families were presented. Initial views were sought on how best to respond to these challenges.
Health Visiting and School Nursing staff workshops	• Two workshops were held with Health Visitors and School Nurses in Nov 2015. Key findings from analysis of service demand and initial feedback from children and families were presented. Initial views were sought on how best to respond to these challenges.

Key group	Activity
Children's Strategic Partnership	• Case for change and early proposals were presented to the Children's Strategic Partnership on 17th November 2015. • Proposed service model was presented to Children's Strategic Partnership and agreed in principle on 25th Jan 2016.

1.7 Design principles

It was important that all of the information captured through discussion with children, young people, parents, worker and research was used to shape the design of the model. In support of this design principles were created by the Service Redesign Group and Practitioner Reference Group, that were used to test proposed models.

Key design principles agreed:

A) How families will be supported

- Children and families at the heart of service design and decision making with a focus on relationships between family members and professionals.
- One worker should hold the relationship, coordinate other interventions and follow families through to a place where their resilience is improved, where this is possible

B) How teams will operate

- Service needs to be focused on building the resilience and capacity of universal services and communities
- Service needs to reduce demand into specialist services and measure impact against this, with improved analysis of 'root cause' issues - to better respond, first time, to the challenges facing families.
- Teams need to be able to respond to need at a local level

C) How services will be accessed

- Multi-agency locality teams, based in communities located around schools and learning communities at a local level.

2. Proposed service model

2.1 Vision and aims of service model

Through engagement with children, families, professionals and partner agencies the Children's Strategic Partnership have established an aim, vision and a set of collective obsessions to drive the delivery and design of services for children and young people. These 'obsessions' directly respond to the findings from phase 1 of the programme. They provide the basis for measuring the impact of the changes we are seeking to deliver:

Our aim

The Better Childhood Programme is focused on improving relationships across families and services to strengthen family resilience and reduce family breakdown

Our vision

Our ambition as a children's partnership is to enable all children and families in Hartlepool to have opportunities to make the most of their life chances and be supported to be safe in their homes and communities

Our Collective Obsessions

To deliver our vision we intend to focus collectively on a number of key obsessions

1. Children and young people have opportunities to make the most of their life chances and are safe
2. Improving family relationships, strengths, skills and ability to cope
3. Reducing the impact of domestic violence, mental health, drugs and alcohol misuse on children and families
4. Helping parents, carers and young people to gain skills and get jobs

How we will deliver them

- Support children and families to identify their needs at the earliest opportunity;
- Have a fully integrated workforce and approach to early intervention and support;
- Focus on building effective relationships and stability of workers – parents with workers, children with workers and inter-professional relationships;
- Support universal services and our wider workforce, to be confident and skilled in assessing and manage risk and delivering effective interventions to support families;
- Child and parent voices are asked for, listened to and shape delivery of services; and;
- Improve the definition, capturing and monitoring of outcomes – evidencing impact.

2.2 Core obsessions and performance indicators

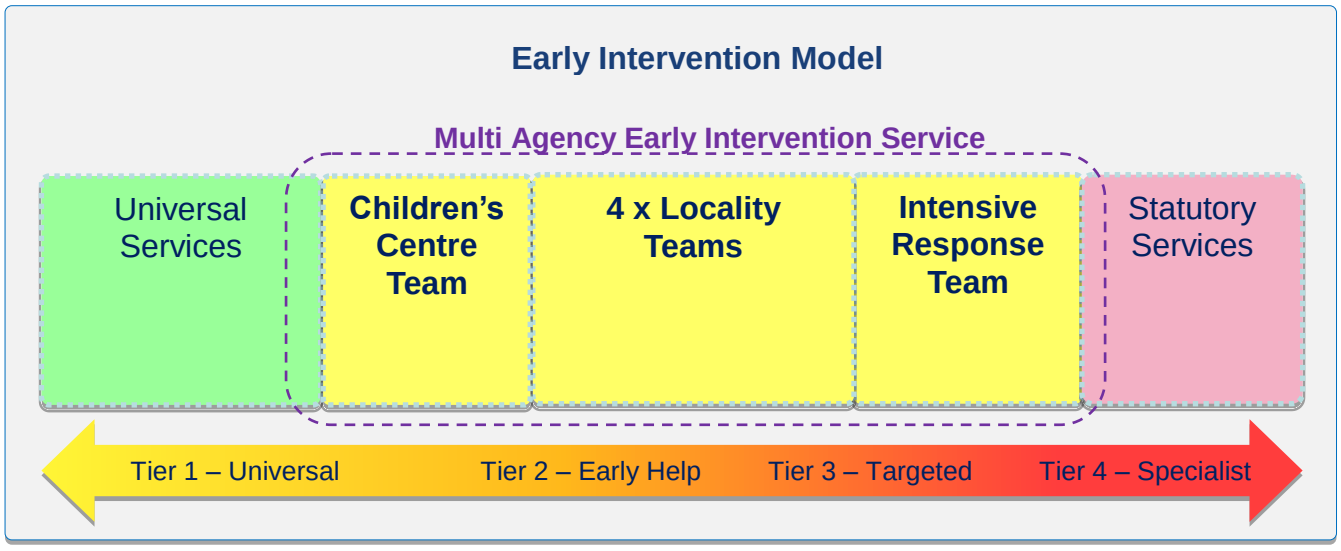
It is critical that the new delivery model is measured against the core obsessions that the partnership is seeking to deliver. A key component of the teams will be to deliver against these obsessions at a local level – enabling us to directly understand the impact we are making for children and families across the borough.

At the Service Redesign and Practitioner Reference Group sessions a set of performance indicators were identified against the core obsessions established by the Children's Strategic Partnership. These proposed indicators in the table below will form the basis of an outcomes and performance framework for the Early Intervention Service.

Collective obsession	**Performance indicators for Early Intervention Service**
Children and Young People have Opportunities to make the post of their life chances and to be safe	• Improved school attendance • Increase in mothers who breastfeed children • Reduction in teenage pregnancy • Reduction in incidents ASB among families and children • Reduction in child sexual exploitation
Improving family relationships to reduce the number of children and families in need requiring a specialist worker	• Reduction in children becoming looked after or subject to CP/ CiN plan • Improvement in family relationships/ functioning (tbc) • Reduction in entrants into the youth justice system
Reducing the impact of domestic violence, mental health, drugs and alcohol misuse on children and families	• Reduction in incidents/ impact of substance misuse for families • Reduction in incidents/ impact of domestic violence for families • Improvement in emotional well-being (tbc)
Helping parents, carers and young people to gain skills and get jobs	• Increase in parents sustaining employment • Reduction in those who are NEET

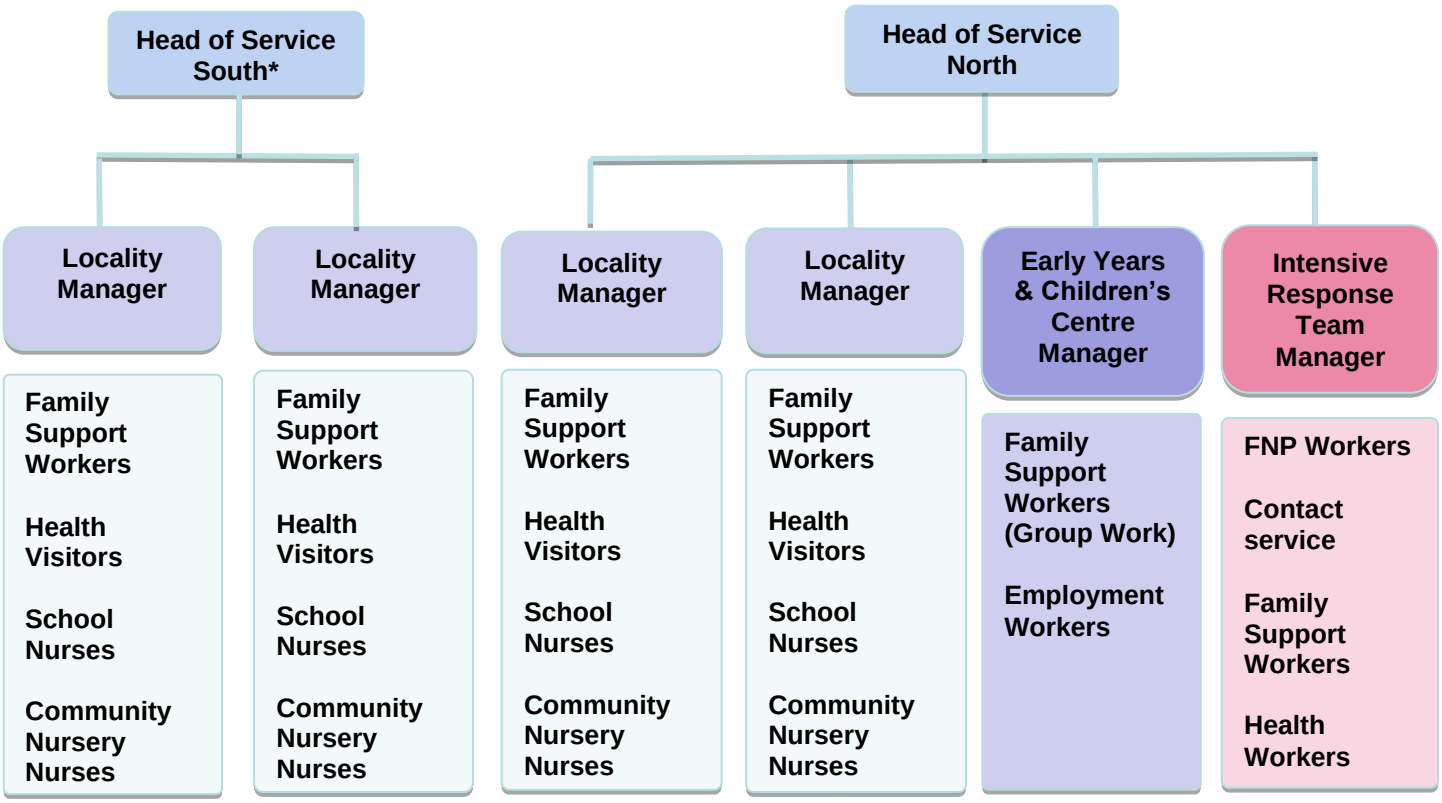
2.3 Overview of service model

The diagram below sets out an overview of the proposed model for early intervention to deliver the core obsessions and outcomes agreed, in response to the design principles developed by practitioners.



2.4 Structure chart

The chart below sets out how teams will be organised and the roles that will be included in the teams.



*Also managing Youth Offending Team and Troubled Families Team.

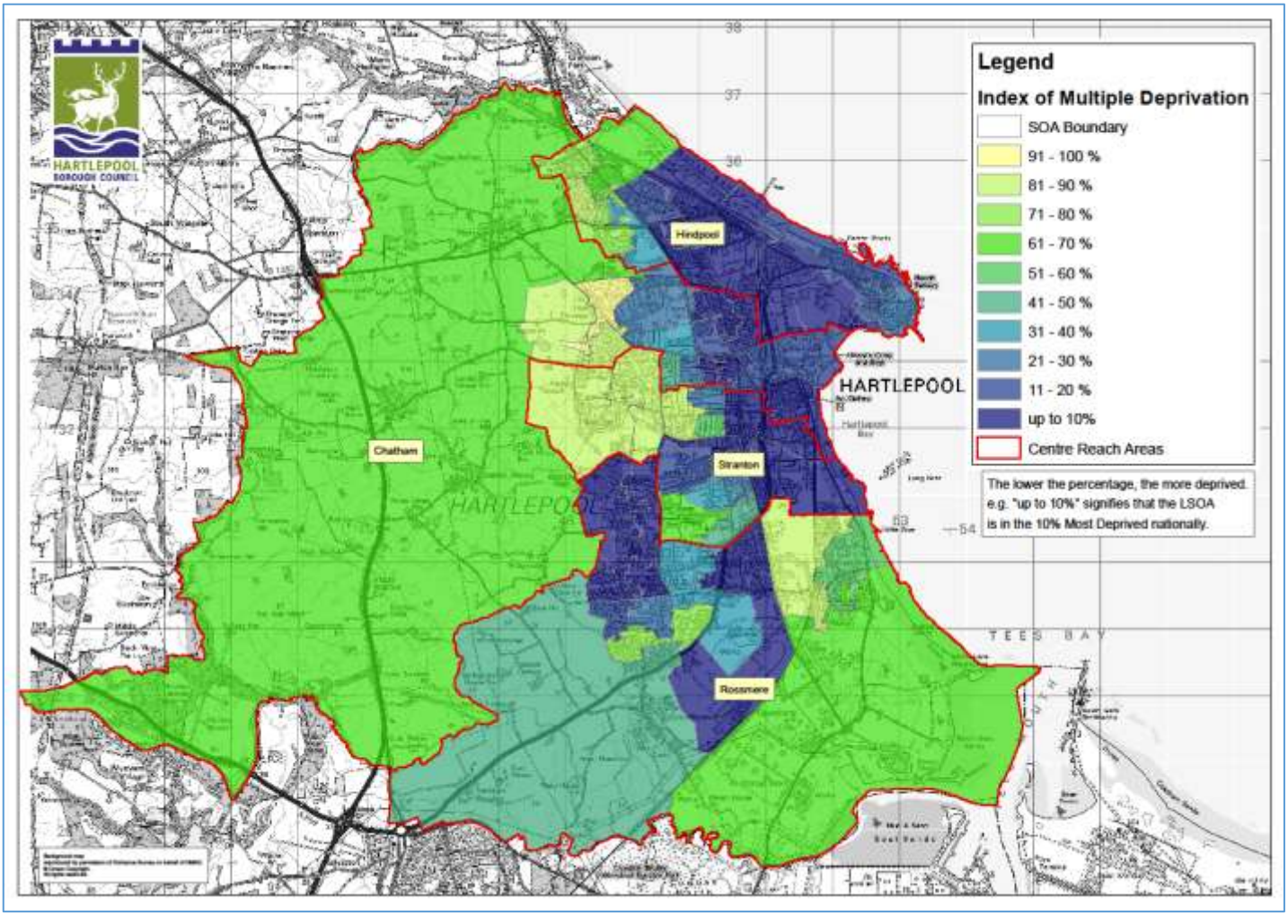
2.5 Summary of proposed teams

Team	Summary
Locality Teams	These teams will work with children and families with additional needs to tackle root cause issues, achieve positive outcomes, and improve family resilience: • Support Workers will act as a Key Worker for a number of families – providing the majority of support including coordination of plan, routines, debt advice, parenting etc. • Some Support Workers will act as a Key Worker for a smaller number of cases and use released capacity to deliver interventions on other cases and support universal services/ communities • Health Visitors will provide more intensive Key Worker support work for a reduced number of families.
Intensive Response Team	This team will deliver evidence based intensive interventions to families with children being worked with by a Social Worker to improve outcomes, and reduce the risk of entry into care. This will include: • Delivering structured, intensive and evidence led interventions around behaviour, routine and parenting

Team	Summary
	• Delivering parenting interventions e.g. Mellow Parenting, Triple P. • Delivering/ commissioning Multi-Systemic Therapy and other family therapy interventions • Commissioning other evidence based interventions (e.g. family group conferencing) • Delivery of licensed FNP programme • Incorporating relevant roles from existing commissioned services. The Contact service will be incorporated into the Intensive Response Team. Dedicated management for this team will be continued and the service will continue to be delivered from Children's Centres
Children's Centre Team	Children's Centres workers in these teams will remain in the same team, delivering group work for families and parents across the borough. They will, however, work closely with Locality Teams, jointly delivering a range of groups across localities in collaboration with Locality Teams.

2.6 Localities covered

Our proposed Locality Teams will work with children and families in four locality areas. The proposal is to match to the four Children's Centre Reach Areas outlined below (Hindpool, Chatham, Stranton, Rossmere). It was felt this would be most appropriate model due to Children's centres and health already aligning to these North and South areas. This will be further explored with the detail of the models



2.7 What this means for teams in scope

Team	Key implications	Rationale
Early Help Teams, North and South **Effective Interventions Team**	Staff will be allocated to one of four Locality Teams or to the Intensive Response Team. This could mean working from a different base and being line managed by a different Locality Team Manager. Depending on which team they are allocated to staff could be: **A) Delivering Key Worker support in Locality Teams** Workers will deliver Key Worker support to a lower number of families with additional needs. Some workers with lower caseloads will be available to support a proportion of social cases. Some Support Workers will be supported to have a specialist role and will: • Hold additional 'specialisms' around DV, Substance Misuse, Bereavement, Emotional/ Mental well-being, Parenting and Adolescents • Provide short term interventions in cases held by other key workers, as required • Act as 'community champions' owning relationships with key universal services community members and supporting pro-active work in localities where new issues emerge **B) Delivering focused interventions in the Intensive Response Team** This team will deliver evidence based intensive interventions to families with children working with a Social Worker to improve outcomes, and reduce the risk of entry into care. The Family Nurses **(Family Nurse Partnership)** will also be aligned to the intensive response team to ensure expertise is shared for the most vulnerable through the delivery of the licensed FNP programme. This team would be centrally managed and work across the borough.	Reduction in average caseload size is designed to allow more intensive work with families to increase impact on outcomes. Allocating Specialist roles to workers and freeing up their capacity to provide interventions on other cases and support for universal services/ communities is a direct response to the design principles agreed. The rationale behind these changes is to move towards a more structured and evidence based approach to improving outcomes for families and reducing the risk of entry into care.
Health Visitors	As above, staff will be allocated to one of four Locality Teams or to the Intensive Response Team. This could mean working from a different base and being line managed by a different Locality Team Manager. Depending on which team they are	These changes will allow Health Visitors to work more intensively with families and deliver interventions directly, rather than through referral to other services.

Team	Key implications	Rationale
	allocated to staff could be: **Delivering universal and targeted support in Locality Teams** In the new model Health Visitors will continue to deliver their core universal offer to all families in the locality (supported by the Locality Team). Where families require additional support this will be provided by the Health Visitor or a worker in the Locality Team, with the Health Visitor acting as the conduit. The Health Visitor caseload for Universal Plus (additional needs) cases will be reduced. This will allow Health Visitors to provide a more intensive key worker support, and deliver a range of interventions including parenting, routines, behaviour, debt advice and basic support on domestic abuse or substance misuse. **Delivering specialist support in the Intensive Response Team** Cases open to Social Care requiring the input of a Health Visitor is currently being discussed. Potentially there could a dedicated health resource within the Intensive Response Team.	This reflects staff feedback at Health Workshops requesting capacity if freed to spend more time working with fewer families.
Family Nurse Partnership Workers	**Delivering specialist support in the Intensive Response Team** FNP workers will be co-located with a borough-wide Intensive Response Team (including a number of family support workers and contact workers) supporting children and families who are being worked with by Social Care. This will ensure there is a whole family approach to our most vulnerable families. There have been discussions about the potential for FNP to broaden their eligibility however this is still in progress to understand whether this fits within the current remit of FNP. The FNP nurses will continue to deliver the FNP licensed programme until any broadening of the criteria can be agreed.	There are significant opportunities from using the specialist skills and experience of FNP workers to support families and avoid children entering care. These workers would also be able to develop other workers in the team to deal effectively with issues such as attachment and weaning.
School Nursing	Some staff will be aligned and bases with Locality Teams in the North. Others will be aligned and based with Locality Teams in the South. Staff will be: **Delivering universal and targeted work across**	Basing School Nurses in locality teams will support integrated working between these workers, Health Visitors and Support Workers. Enabling a joined up approach will help to reduce the number of workers involved and the

Team	Key implications	Rationale
	Locality Teams School Nursing staff will be split between the two Locality Teams in the North and the two Locality Teams in the South. School Nurses will continue to work at a universal and targeted levels across schools in Hartlepool. **Supporting locality teams** They will also work with other workers in locality team and identify other children or young people requiring additional support (& may support joint assessments). They won't hold cases in Locality Teams in the way that Family Support Workers and Health Visitors will. **Delivering specialist work in the Intensive Response Team** Cases open to social care that require a named School Nurse will be managed through dedicated resource in the Intensive Response Team.	impact of intervention overall.
Children's Centres Team (including Contact Team)	A number of staff will remain in Children's Centre Teams and work closely with the four Locality Teams. **Change to management of universal plus pathway** It is proposed that the universal plus pathway (UPP) is reviewed against current health pathways to ensure that locality workers (HBC and health) promote the Children's Centres to families. **Relocating Contact service in Intensive Response Service** The Contact service will be incorporated into the Intensive Response Team. The service will continue to be delivered from Children's Centres and venues that promote positive interactions between parents, children and siblings.	Locality Teams managing universal plus pathway will allow opportunities for the integration of this work with that of Health Visitors and Family Support Workers Integrating the Contact service into the Intensive Response Team will realise opportunities for this service to focus on and support reunification of children with families, supporting the overall aims of the model.

2.8 Management, supervision and governance

A) Locality Management

Locality team will be managed by a Locality Team Manager who could be from a number of disciplines. This manager will oversee case work and day to day management arrangements of team members including signing off leave, absence and day to day case supervision.

B) Clinical Supervision

In addition, it is envisaged that there will separate clinical supervision for certain team members as required (e.g. School Nurses, Health Visitors & specialist roles within locality teams). Annual reviews will be undertaken with input from the locality manager and clinical supervisor

C) Local Governance

It is envisaged that localities will develop partnership forums. The forum will be responsible for overseeing the key target outcomes for the locality. This forum could include Head Teachers, Community leaders and some parents or carers.

3. Next steps

3.1 Timeline

Timescale	Key activity
Summer 2015	Completion of demand analysis
Oct 2015 – Jan 2016	Development of proposed model in collaboration with professionals
Feb – Mar 2016	Consultation on proposed model Development of ways of working and pathways Workforce development planning.
Mar – Apr 2016	Implementation of model, including: • Phasing of roles into new model • Transition of caseload management
Apr – Jul 2016	Embedding new teams and ways of working Development of pathways
Apr – Sep 2016 +	Developing and implementing plans for integration of other services into proposed locality model. Monitoring and Evaluation of the model against performance management framework Potential development of partnership governance and forums for localities.

HEALTH AND WELLBEING BOARD

14 March 2016

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

Subject: NHS PLANNING PROCESS 2016/17

1. PURPOSE OF REPORT

1.1 The purpose of this paper is to outline the planning requirements released by NHS England and how NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG) and its partners are progressing against these requirements.

1.2 As with last year there is an expectation that commissioners will work with their providers and other organisations e.g. local authorities to develop local plans. Assumptions related to activity and outcomes must be aligned. Plans must reflect the local Joint Health and Wellbeing Strategy and commissioners must demonstrate that providers and local communities have been fully engaged in the process.

2. BACKGROUND

2.1 Each year NHS England produces a framework which CCG commissioners use to work with providers and local authority partners to develop robust and ambitious plans in order to secure high quality services, reduce health inequalities and improve health outcomes for patients and public.

2.2 This year the document sets out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. It also reflects the settlement reached with the Government through its new Mandate to NHS England **(**annex 2 of the guidance)**.** The Mandate, for the first time is not solely for the commissioning system, but sets objectives for the NHS as a whole.

2.3 The guidance requires that NHS organisations are required to produce two separate but connected plans:

- a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
- a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

In addition it will be requirement to update the Better Care Fund Plan.

3. PROPOSALS

Key messages

3.1 This is a new, different planning process that supports local change, transcends boundaries and looks beyond one year though there are specific asks for 2016/17.

3.2. Operational Plans for 2016/17

3.2.1 The 2016/17 Operational Plan should be regarded as year one of the five year STP, and there is an expectation of significant progress on transformation through the 2016/17 Operational Plan. A basic planning rationale was submitted to NHSE on the 8th February which explained the basis for the performance trajectories provided at the same time and a further revised and more detailed document will be submitted on March 2nd before final submission on the 11th April.

3.2.2 By April 2016, commissioner and provider plans for 2016/17 will need to be agreed by NHS England and NHS Improvement, based on local contracts that must be signed by March 2016 covering activity, capacity, finance and 2016/17 deliverables from the emerging STP.

3.2.4 The guidance outlines Goals for 2020, deliverables for 16/17 and a series of Must Do's also for 16/17. These are outlined below.

3.3 The nine 'must dos' for 2016/17

1. Develop a high quality and agreed STP, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim (better health, transformed quality of care delivery and sustainable finances) as set out in the Forward View.

2. Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the Right Care programme in every locality.

3. Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.

4. Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in

A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice.

6. Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the two new mental health access standards: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

9. Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts.

3.4 The Five Year Local Health System Sustainability and Transformation Plan (STP)

3.4.1 The guidance also asks that every health and care system will come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View; this will be called the Sustainability and Transformation Plan (STP). STPs will cover the period between October 2016 and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016.

3.4.2 Locally the STP has been defined as covering; Hartlepool and Stockton on Tees, South Tees, Darlington, Hambleton, Richmond and Whitby, North Durham as well as Durham Dales, Easington and Sedgefield CCGs. This was submitted to NHSE on the 29th January 2016 and supported by local

Trusts and Local Authorities at the North of Tees Partnership Board early January 16.

3.4.3 An important factor to note is that the STP will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. Many of these streams of transformation funding form part of the new wider national Sustainability and Transformation Fund (STF). The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards.

3.4.4 While the STP needs to address the list of national challenges set out in the guidance there is a clear message that the list should not be seen simply as a narrow template for what constitutes a good local plan, the most important initial task is to create a clear overall vision and plan for our area.

3.4.5 The guidance details the 'national challenges' to help us set out ambitions for our populations – these are about reducing:

- The Health and Wellbeing Gap
- The Care and Quality gap
- The Finance and Efficiency Gap

and are the basis on which we are developing our Plan for 2016/17. Addressing the national challenges is essential in gaining sign off of the plan, and importantly attracting additional national investment.

4 Better Care Fund

4.1 The CCG and Local Authority need to agree a joint plan to continue to deliver the requirements of the Better Care Fund (BCF) in 2016/17, building on the 2015/16 BCF plan, and taking account of what has worked well in meeting the objectives of the fund, and what has not.

4.2 CCGs have already been advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care.

5 Financial planning guidance

5.1 Guidance to date has indicated that:

- Contracts will need to be closed off by the end of March
- Plans will clearly need to identify the efficiency gap to meet the planning parameters, with an emphasis on risk assessment and scenario planning.
- Plans will need to contain final planning assumptions including fixed allocations for next three years
- Plans will need to build on triangulation work undertaken in 2015/16 with clear links between activity and finance (including QIPP plans) and commissioners and providers

6 Assurance

6.1 There will be a new, more joined-up approach to planning including NHSE and NHS Improvement (Monitor and the NHSTDA) ,to ensure detailed, credible and robust plans with evidence of them being jointly owned and delivered by commissioners and providers.

6.2 This will include organisations being asked to self – assess their readiness for shared planning, identifying issues that will require support, both for its operational plan and the STP.

7 Timetable

Event	Date
Localities to submit proposals for STP footprints	By 29 January
First submission of full draft 16/17 Planning Templates (activity and finance) and Planning Rationale (basis for Operational Plan)	8th February
Better Care Fund Plan Submission	15th February
AO meetings	22nd -26th February
Publish National Tariff	March
Interim activity and finance plans submitted.	2nd March
Boards of providers and commissioners approve budgets and final plans	By 31st March
National deadline for signing of contracts	31st March
Submission of final 16/17 Operational Plans, aligned with contracts	11th April
Final activity plans submitted.	11th April
Submission of full STPs	End June
Assessment and Review of STPs	End July

8 Next Steps

8.1 **Transformational Footprint/STP:** The first key milestone was to submit our proposed STP transformation footprint **(as per paragraph 4.2.4)** to NHS England by Friday 29 January 2016, for national agreement. In addition a checkpoint meeting is to held with CCG AOs and Trust Chief Executives week commencing the 22nd February.

8.2 This checkpoint meeting will cover the following issues:

- Plans for service transformation and the impact these will have on health outcomes of local populations and how will this reduce inequalities within the local health economy?
- How will the STP deliver improvements in the three elements of the quality of care (safety, effectiveness, and patient experience) and are there any areas (speciality/unit) in particular that require rapid

transformation to ensure the clinical sustainability of services in the long term?
- The scale of the financial challenge and has consideration been given to how the transformation funding is committed to enable this ?
- What is your local timeline to ensure production of the STP by end of June including the practicalities i.e. coordination, governance and sign off by all key stakeholders.

8.3 All contracts are to be signed off and agreed by the 31st March 2016 with final submission of 16/17 Operational Plans, aligned with contracts and activity by the 11th April 2016

8.4 The final versions of the STPs will be submitted by the end of June 2016 with regional and national review completing by the end of July 2016.

9 Commissioning Intentions 16/17

9.1 As a result of this guidance the CCG will now need to tailor their commissioning intentions for 2016/17 to meet the requirements and deliverables of both the first year operational plan and the five year STP.

9.2 The CCG will need to review the additional requirements set out in the plan, particularly around mental health and prevention against the current plans to ensure compliance. Given the scale and pace of change in the nature and setting of care, our commissioning intentions take on a greater importance this year. We need to develop clear plans to change volumes, pathways and settings of care. This must also be done through a “single commissioner voice” where the CCG and its co-commissioners and the Council are speaking “as one” to our key Providers. Success also requires that we secure genuine Provider “buy in” to the changes and that plans are developed which recognise risks and issues and result in a joint system-wide commitment to implementation.

9.3 Alongside ensuring delivery of the planning requirements the CCG will also utilise the RightCare approach to identify specific areas of focus. NHS England has committed significant funding to rolling out the RightCare approach to all CCGs over the next two years. In order to provide close support to CCGs and ensure successful implementation, this will happen in three waves. NHS Hartlepool and Stockton-on-Tees have been selected as a wave one CCG. This means that the CCG will receive early access to RightCare Delivery Partner support from January 2016.

8.4 The Rightcare team have already identified a number of high level clinical pathways that require further investigation and this work will be incorporated into the 2016/17 CCG workplan, these include;

- cancer
- musculoskeletal
- respiratory
- endocrine

- genito urinary

Fortnightly meetings are being held with CCG and Local Authority representatives to ensure a partnership approach to the development of the STP reviewing the priority areas.

10. RECOMMENDATIONS

10.1 It is recommended that the Health and Wellbeing Board:

- Consider and comment on the requirements in the planning guidance on the need to develop a clear overall shared vision and plan for our area.
- Note the actions that have been taken to date in the local health and social care community to meet the needs of the 16/17 Planning period.

11. FINANCIAL IMPLICATIONS

Financial planning is required as part of the annual planning process and financial plans have been agreed with the CCG Governing Body. The plans will be developed in order to determine the required commissioning that will need to be undertaken in order to make best use of resource and to create a sustainable health economy in Hartlepool and Stockton-on-Tees.

LEGAL IMPLICATIONS

All statutory responsibilities will be delivered. The annual plan is a statutory duty set that is required to be delivered by CCGs.

RISK ASSESSMENT

Key risks will be identified and included within the CCG risk register.

CONSULTATION

The CCG will comply with statutory duties in relation to consultation and will consult where appropriate on any required service change.

12 Background papers

Delivering the Forward View – NHS Planning Guidance: 2016/17-2020/21

(Appendix 1)

13. CONTACT OFFICER

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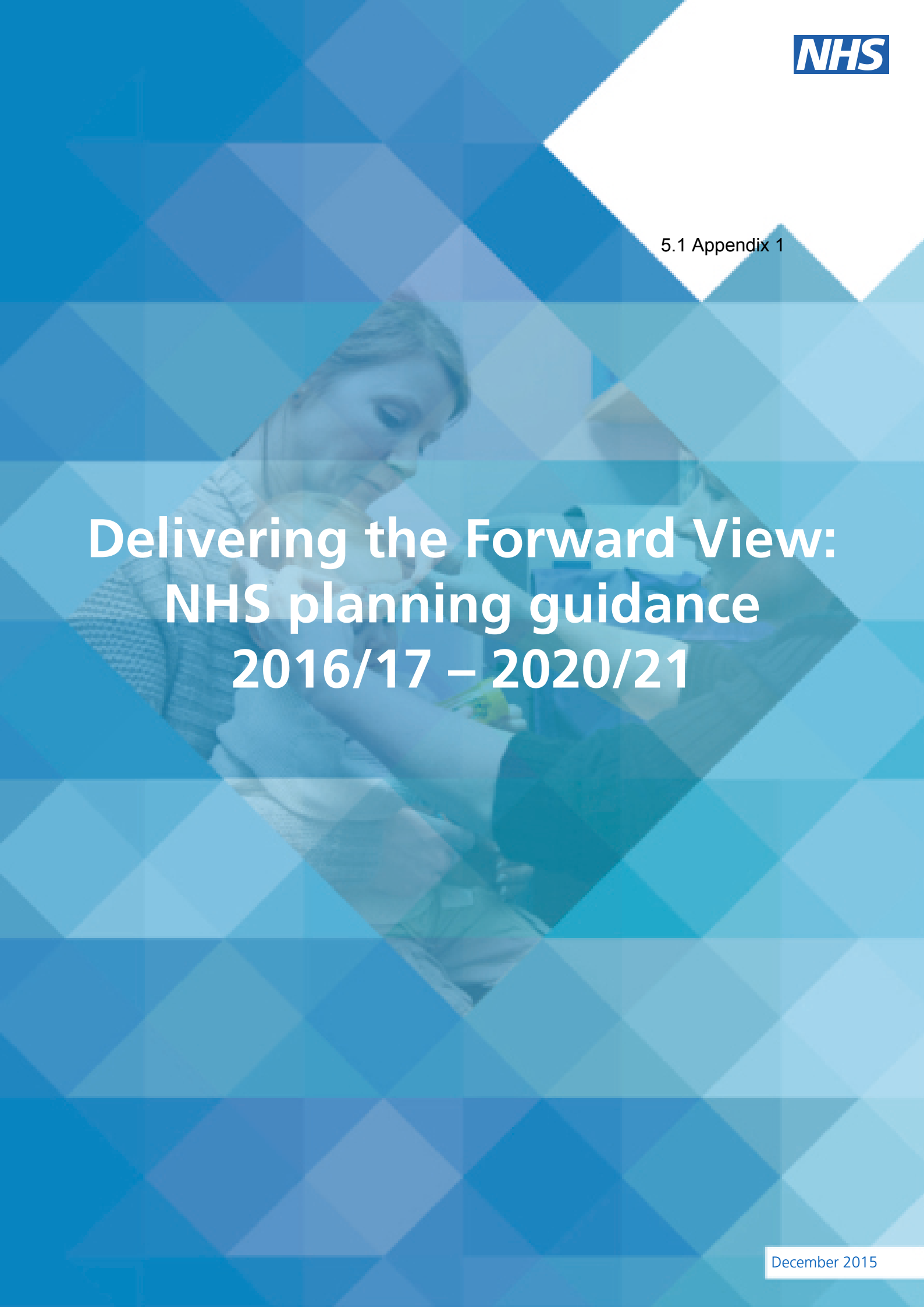
5.1 Appendix 1



Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

December 2015

Delivering the Forward View: NHS planning guidance

2016/17 – 2020/21

Version number: 1

First published: 22 December 2015

Prepared by: NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), Public Health England (PHE).

This document is for: Commissioners, NHS trusts and NHS foundation trusts.

Publications Gateway Reference: 04437

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England*
- NHS Improvement (Monitor and the NHS Trust Development Authority)
- Health Education England (HEE)
- The National Institute for Health and Care Excellence (NICE)
- Public Health England (PHE)
- Care Quality Commission (CQC)

*The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Introduction

1. The Spending Review provided the NHS in England with a credible basis on which to accomplish three interdependent and essential tasks: first, to implement the Five Year Forward View; second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients.

2. It included an £8.4 billion real terms increase by 2020/21, front-loaded. With these resources, we now need to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap.

3. In this document, authored by the six national NHS bodies, we set out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. We reflect the settlement reached with the Government through its new Mandate to NHS England (annex 2). For the first time, the Mandate is not solely for the commissioning system, but sets objectives for the NHS as a whole.

4. We are requiring the NHS to produce two separate but connected plans:

   - a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
   - a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

5. The scale of what we need to do in future depends on how well we end the current year. The 2016/17 financial challenge for each trust will be contingent upon its end-of-year financial outturn, and the winter period calls for a relentless focus on maintaining standards in emergency care. It is also the case that local NHS systems will only become sustainable if they accelerate their work on prevention and care redesign. We don't have the luxury of waiting until perfect plans are completed. So we ask local systems, early in the New Year, to go faster on transformation in a few priority areas, as a way of building momentum.

Local health system Sustainability and Transformation Plans

6. We are asking every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View. STPs will cover the period between October 2016[1] and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016. We are asking the NHS to spend the next six months delivering core access, quality and financial standards while planning properly for the next five years.

Place-based planning

7. Planning by individual institutions will increasingly be supplemented with planning by place for local populations. For many years now, the NHS has emphasised an organisational separation and autonomy that doesn't make sense to staff or the patients and communities they serve.

8. System leadership is needed. Producing a STP is not just about writing a document, nor is it a job that can be outsourced or delegated. Instead it involves five things: (i) local leaders coming together as a team; (ii) developing a shared vision with the local community, which also involves local government as appropriate; (iii) programming a coherent set of activities to make it happen; (iv) execution against plan; and (v) learning and adapting. Where collaborative and capable leadership can't be found, NHS England and NHS Improvement[2] will need to help secure remedies through more joined-up and effective system oversight.

9. Success also depends on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards.

10. As a truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity including: (i) specialised services, where the planning will be led from the 10 collaborative commissioning hubs; and (ii) primary medical care, and do so from a local CCG perspective, irrespective of delegation arrangements. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

[1] For the period October 2016 – March 2017, the STP should set out what actions are planned but it does not need to revisit the activity and financial assumptions in the 2016/17 Operational Plan.

[2] NHS Improvement will be the combined provider body, bringing together Monitor and the NHS Trust Development Authority (TDA).

Access to future transformation funding

11. For the first time, the local NHS planning process will have significant central money attached. The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.

12. The Spending Review provided additional dedicated funding streams for transformational change, building up over the next five years. This protected funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health. Many of these streams of transformation funding form part of the new wider national Sustainability and Transformation Fund (STF). For 2016/17 only, to enable timely allocation, the limited available additional transformation funding will continue to be run through separate processes.

13. The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards. The process will be iterative. We will consider:

    (i) the quality of plans, particularly the scale of ambition and track record of progress already made. The best plans will have a clear and powerful vision. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance. They will systematically borrow good practice from other geographies, and adopt national frameworks;

    (ii) the reach and quality of the local process, including community, voluntary sector and local authority engagement;

    (iii) the strength and unity of local system leadership and partnerships, with clear governance structures to deliver them; and

    (iv) how confident we are that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities.

Content of STPs

14. The strategic planning process is intended to be developmental and supportive as well as hard-edged. We set out in annex 1 of this document a list of 'national challenges' to help local systems set out their ambitions for their populations. This list of questions includes the objectives set in the Mandate. Do not over-interpret the list as a narrow template for what constitutes a good local plan: the most important initial task is to create a clear overall vision and plan for your area.

15. Local health systems now need to develop their own system wide local financial sustainability plan as part of their STP. Spanning providers and commissioners, these plans will set out the mixture of demand moderation, allocative efficiency, provider productivity, and income generation required for the NHS locally to balance its books.

Agreeing 'transformation footprints'

16. The STP will be the umbrella plan, holding underneath it a number of different specific delivery plans, some of which will necessarily be on different geographical footprints. For example, planning for urgent and emergency care will range across multiple levels: a locality focus for enhanced primary care right through to major trauma centres.

17. The first critical task is for local health and care systems to consider their transformation footprint – the geographic scope of their STP. They must make proposals to us by Friday 29 January 2016, for national agreement. Local authorities should be engaged with these proposals. Taken together, all the transformation footprints must form a complete national map. The scale of the planning task may point to larger rather than smaller footprints.

18. Transformation footprints should be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required, and how it best fits with other footprints such as local digital roadmaps and learning disability units of planning. In future years we will be open to simplifying some of these arrangements. Where geographies are already involved in the Success Regime, or devolution bids, we would expect these to determine the transformation footprint. Although it is important to get this right, there is no single right answer. The footprints may well adapt over time. We want people to focus their energies on the content of plans rather than have lengthy debates about boundaries.

19. We will issue further brief guidance on the STP process in January. This will set out the timetable and early phasing of national products and engagement events that are intended to make it much easier to answer the challenges we have posed, and include how local areas can best involve their local communities in creating their STPs, building on the 'six principles' created to support the delivery of the Five Year Forward View. By spring 2016, we intend to develop and make available roadmaps for national transformation initiatives.

20. We would welcome any early reactions, by Friday 29 January 2016, as to what additional material you would find most helpful in developing your STP. Please email england.fiveyearview@nhs.net, with the subject title 'STP feedback'. We would also like to work with a few local systems to develop exemplar, fast-tracked plans, and would welcome expressions of interest to the above inbox.

National ‘must dos’ for 2016/17

21. Whilst developing long-term plans for 2020/21, the NHS has a clear set of plans and priorities for 2016/17 that reflect the Mandate to the NHS and the next steps on Forward View implementation.

22. Some of our most important jobs for 2016/17 involve partial roll-out rather than full national coverage. Our ambition is that by March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care. There are three distinct challenges under the banner of seven day services:

(i) reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends. During 16/17, a quarter of the country must be offering four of the ten standards, rising to half of the country by 2018 and complete coverage by 2020;

(ii) improving access to out of hours care by achieving better integration and redesign of 111, minor injuries units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital; and

(iii) improving access to primary care at weekends and evenings where patients need it by increasing the capacity and resilience of primary care over the next few years.

23. Where relevant, local systems need to reflect this in their 2016/17 Operational Plans, and all areas will need to set out their ambitions for seven day services as part of their STPs.

The nine ‘must dos’ for 2016/17 for every local system:

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.

2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.

3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.

4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.

6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

24. We expect the development of new care models will feature prominently within STPs. In addition to existing approaches, in 2016/17 we are interested in trialing two new specific approaches with local volunteers:
    - secondary mental health providers managing care budgets for tertiary mental health services; and
    - the reinvention of the acute medical model in small district general hospitals.

Organisations interested in working with us on either of these approaches should let us know by 29 January 2016 by emailing england.fiveyearview@nhs.net

Operational Plans for 2016/17

25. An early task for local system leaders is to run a shared and open-book operational planning process for 2016/17. This will cover activity, capacity, finance and 2016/17 deliverables from the emerging STP. By April 2016, commissioner and provider plans for 2016/17 will need to be agreed by NHS England and NHS Improvement, based on local contracts that must be signed by March 2016.

26. The detailed requirements for commissioner and provider plans are set out in the technical guidance that will accompany this document. All plans will need to demonstrate:

    - how they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance);
    - their planned contribution to the efficiency savings;
    - their plans to deliver the key must-dos;
    - how quality and safety will be maintained and improved for patients;
    - how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan; and
    - how they link with and support with local emerging STPs.

    The 2016/17 Operational Plan should be regarded as year one of the five year STP, and we expect significant progress on transformation through the 2016/17 Operational Plan.

27. Building credible plans for 2016/17 will rely on a clear understanding of demand and capacity, alignment between commissioners and providers, and the skills to plan effectively. A support programme is being developed jointly by national partners to help local health economies in preparing robust activity plans for 2016/17 and beyond.

Allocations

28. NHS England's allocations to commissioners are intended to achieve:

    - greater equity of access through pace of change, both for CCG allocations and on a place-based basis;

    - closer alignment with population need through improved allocation formulae including a new inequalities adjustment for specialised care, more sensitive adjustments for CCGs and primary care, and a new sparsity adjustment for remote areas; and

    - faster progress with our strategic goals through higher funding growth for GP services and mental health, and the introduction of the Sustainability and Transformation Fund.

29. In line with our strategic priorities, overall primary medical care spend will rise by 4-5 percent each year. Specialised services funding will rise by 7 percent in 2016/17, with growth of at least 4.5 percent in each subsequent year. The relatively high level of funding reflects forecast pressures from new NICE legally mandated drugs and treatments.

30. To support long-term planning, NHS England has set firm three year allocations for CCGs, followed by two indicative years. For 2016/17, CCG allocations will rise by an average of 3.4 percent, and we will make good on our commitment that no CCG will be more than 5 percent below its target funding level. To provide CCGs with a total place-based understanding of all commissioned spend, alongside allocations for CCG commissioned activities, we will also publish allocations for primary care and specialized commissioned activity.

    NHS England will in principle support any proposals from groups of CCGs, particularly in areas working towards devolution who wish to implement a more accelerated cross-area pace-of-change policy by mutual agreement.

31. Mirroring the conditionality of providers accessing the Sustainability and Transformation Fund, the real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign off of a robust STP during 2016/17.

Returning the NHS provider sector to balance

32. During 2016/17 the NHS trust and foundation trust sector will, in aggregate, be required to return to financial balance. £1.8 billion of income from the 2016/17 Sustainability and Transformation Fund will replace direct Department of Health (DH) funding. The distribution of this funding will be calculated on a trust by trust basis by NHS Improvement and then agreed with NHS England.

33. NHS England and NHS Improvement are working together to ensure greater alignment between commissioner and provider financial levers. Providers who are eligible for sustainability and transformation funding in 2016/17 will not face a double jeopardy scenario whereby they incur penalties as well as losing access to funding; a single penalty will be imposed.

34. Quarterly release of these Sustainability Funds to trusts and foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation. The three conditions attached to the transitional NHS provider fund have to be hard-edged. Where trusts default on the conditions access to the fund will be denied and sanctions will be applied.

35. Deficit reduction in providers will require a forensic examination of every pound spent on delivering healthcare and embedding a culture of relentless cost containment. Trusts need to focus on cost reduction not income growth; there needs to be far greater consistency between trusts' financial plans and their workforce plans in 2016/17. Workforce productivity will therefore be a particular priority as just a 1 percent improvement represents £400 million of savings. All providers will be expected to evidence the effective use of e-rostering for nurses, midwives, Health Care Assistants (HCAs) and other clinicians to make sure the right staff are in the right place at the right time to ensure patients get the right hours of care and minimum time is wasted on bureaucracy. This approach will enable providers to reduce their reliance on agency staffing whilst compliance with the agency staffing rules will also reduce the rates paid. In addition, providers will need to adopt tightly controlled procurement practices with compliance incentives and sanctions to drive down price and unwarranted variation. For example, all providers will be expected to report and share data on what they are paying for the top 100 most common non-pay items, and be required to only pay the best price available for the NHS.

36. Capital investments proposed by providers should be consistent with their clinical strategy and clearly demonstrate the delivery of safe, productive services with a business case that describes affordability and value for money. Given the constrained level of capital resource available from 2016/17, there will be very limited levels of financing available and the repayment of existing and new borrowing related to capital investment will need to be funded from within the trust's own internally generated capital resource in all but the most exceptionally pre-agreed cases. Trusts will need to procure capital assets more efficiently, consider alternative methods of securing assets such as managed equipment services, maximize disposals and extend asset lives. In January, the DH will be issuing some revisions to how the PDC dividend will be calculated and a number of other changes to the capital financing regime.

Efficiency assumptions and business rules

37. The consultation on the tariff will propose a 2 percent efficiency deflator and 3.1 percent inflation uplift for 2016/17 (the latter reflecting a step change in pension-related costs). This reflects Monitor and NHS England's assessment of cost inflation including the effect of pension changes. To support system stability, we plan to remain on HRG4 for a further year and there will also be no changes to specialist top- ups in 2016/17; the specialised service risk share is also being suspended for 2016/17. We will work with stakeholders to better understand the impact of the move to HRG4+ and other related changes in 2017/18. For planning purposes, an indicative price list is being made available on the Monitor website. The consultation on the tariff will also include the timetable for implementing new payment approaches for mental health.

38. As notified in Commissioning Intentions 2016/2017 for Prescribed Specialised Services, NHS England is developing a single national purchasing and supply chain arrangement for specialised commissioning high cost tariff excluded devices with effect from April 2016. Transition plans will be put in place prior to this date with each provider to transition from local to national procurement arrangements.

39. The 2 percent efficiency requirement is predicated upon the provider system meeting a forecast deficit of £1.8 billion at the end of 2015/16. Any further deterioration of this position will require the relevant providers to deliver higher efficiency levels to achieve the control totals to be set by NHS Improvement.

40. For 2016/17 the business rules for commissioners will remain similar to those for last year. Commissioners (excluding public health and specialised commissioning) will be required to deliver a cumulative reserve (surplus) of 1 percent. At the very least, commissioners who are unable to meet the cumulative reserve (surplus) requirement must deliver an in-year break-even position. Commissioners with a cumulative deficit will be expected to apply their increase in allocation to improving their bottom line position, other than the amount necessary to fund nationally recognised new policy requirements. Drawdown will be available to commissioners in line with the process for the previous financial year. CCGs should plan to drawdown all cumulative surpluses in excess of 1 percent over the next three years, enabling drawdown to become a more fluid mechanism for managing financial pressures across the year-end boundary.

41. Commissioners are required to plan to spend 1 percent of their allocations non-recurrently, consistent with previous years. In order to provide funds to insulate the health economy from financial risks, the 1 percent non-recurrent expenditure should be uncommitted at the start of the year, to enable progressive release in agreement with NHS England as evidence emerges of risks not arising or being effectively mitigated through other means. Commissioners will also be required to hold an additional contingency of 0.5 percent, again consistent with previous years.

42. CCGs and councils will need to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) in 2016/17. The plan should build on the 2015/16 BCF plan, taking account of what has worked well in meeting the objectives of the fund, and what has not. CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care; further guidance on the BCF will be forthcoming in the New Year.

43. Commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase. Where CCGs collaborate with specialised commissioning to improve service efficiency, they will be eligible for a share of the benefits.

44. NHS England and NHS Improvement continue to be open to new approaches to contracting and business rules, as part of these agreements. For example, we are willing to explore applying a single financial control total across local commissioners and providers with a few local systems.

Measuring progress

45. We will measure progress through a new CCG Assessment Framework. NHS England will consult on this in January 2016, and it will be aligned with this planning guidance. The framework is referred in the Mandate as a CCG scorecard. It is our new version of the CCG assurance framework, and it will apply from 2016/17. Its relevance reaches beyond CCGs, because it's about how local health and care systems and communities can assess their own progress.

Timetable

Timetable	Date
Publish planning guidance	22 December 2015
Publish 2016/17 indicative prices	By 22 December 2015
Issue commissioner allocations, and technical annexes to planning guidance	Early January 2016
Launch consultation on standard contract, announce CQUIN and Quality Premium	January 2016
Issue further process guidance on STPs	January 2016
Localities to submit proposals for STP footprints and volunteers for mental health and small DGHs trials	By 29 January 2016
First submission of full draft 16/17 Operational Plans	8 February 2016
National Tariff S118 consultation	January/February 2016
Publish National Tariff	March 2016
Boards of providers and commissioners approve budgets and final plans	By 31 March 2016
National deadline for signing of contracts	31 March 2016
Submission of final 16/17 Operational Plans, aligned with contracts	11 April 2016
Submission of full STPs	End June 2016
Assessment and Review of STPs	End July 2016

Please note that we will announce the timetable for consultation and issuing of the standard contract separately. A more detailed timetable and milestones is included in the technical guidance that will accompany this document.

Annex 1: Indicative 'national challenges' for STPs

STPs are about the holistic pursuit of the triple aim – better health, transformed quality of care delivery, and sustainable finances. They also need to set out how local systems will play their part in delivering the Mandate (annex 2).

We will publish further guidance early in 2016 to help areas construct the strongest possible process and plan.

We will also make available aids (e.g. exemplar plans) and some hands-on support for areas as they develop their plans.

The questions below give an early sense of what you will need to address to gain sign-off and attract additional national investment.

We are asking local systems first to focus on creating an overall local vision, and the three overarching questions – rather than attempting to answer all of the specifics right from the start. We will be developing a process to offer feedback on these first, prior to development of the first draft of the detailed plans.

A. How will you close the health and wellbeing gap?

This section should include your plans for a 'radical upgrade' in prevention, patient activation, choice and control, and community engagement.

Questions your plan should answer:

1. How will you assess and address your most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local government?

    - How rapidly could you achieve full local implementation of the national Diabetes Prevention Programme? Why should Public Health England (PHE) and NHS England prioritise your geographical area (e.g. with national funding to support the programme)?

    - What action will you take to address obesity, including childhood obesity?

    - How will you achieve a step-change in patient activation and self-care? How will this help you moderate demand and achieve financial balance? How will you embed the six principles of engagement and involvement of local patients, carers, and communities developed to help deliver the Five Year Forward View?

2. How will you make real the aspiration to design person-centred coordinated care, including plans to ensure patients have access to named, accountable consultants?

3. How will a major expansion of integrated personal health budgets and implementation of choice – particularly in maternity, end-of-life and elective care – be an integral part of your programme to hand power to patients?

4. How are NHS and other employers in your area going to improve the health of their own workforce – for example by participating in the national roll out the Healthy NHS programme?

B. How will you drive transformation to close the care and quality gap?

This section should include plans for new care model development, improving against clinical priorities, and rollout of digital healthcare.

Questions your plan should answer:

1 What is your plan for sustainable general practice and wider primary care? How will you improve primary care infrastructure, supported in part through access to national primary care transformation funding?

2. How rapidly can you implement enhanced access to primary care in evenings and weekends and using technology? Why should NHS England prioritise your area for additional funding?

3. What are your plans to adopt new models of out-of-hospital care, e.g Multi-specialty Community Providers (MCPs) or Primary and Acute Care Systems (PACS)? Why should NHS England prioritise your area for transformation funding? And when are you planning to adopt forthcoming best practice from the enhanced health in care homes vanguards?

4. How will you adopt new models of acute care collaboration (accountable clinical networks, specialty franchises, and Foundation Groups)? How will you work with organisations outside your area and learn from best practice from abroad, other sectors and industry?

5. What is your plan for transforming urgent and emergency care in your area? How will you simplify the current confusing array of entry points? What's your agreed recovery plan to achieve and maintain A&E and ambulance access standards?

6. What's your plan to maintain the elective care referral to treatment standard? Are you buying sufficient activity, tackling unwarranted variation in demand, proactively offering patient choice of alternatives, and increasing provider productivity?

7. How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?

8. How will you improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health?

9. What steps will your local area take to improve dementia services?

10. As part of the Transforming Care programme, how will your area ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital? How far are you closing out-moded inpatient beds and reinvesting in continuing learning disability support

11. How fast are you aspiring to improve the quality of care and safety in your organisations as judged by the Care Quality Commission (CQC)? What is your trajectory for no NHS trust and no GP practice to have an overall inadequate rating from the Care Quality Commission (CQC)?

12. What are you doing to embed an open, learning and safety culture locally that is ambitious enough? What steps are you taking to improving reporting, investigations and supporting patients, their families and carers, as well as staff who have been involved in an incident?

13. What plans do you have in place to reduce antimicrobial resistance and ensure responsible prescribing of antibiotics in all care settings? How are you supporting prescribers to enable them issue the right drugs responsibly? At the same time, how rapidly will you achieve full implementation of good practice in reducing avoidable mortality from sepsis?

14. How will you achieve by 2020 the full-roll out of seven day services for the four priority clinical standards?

15. How will you implement the forthcoming national maternity review, including progress towards new national ambitions for improving safety and increased personalisation and choice?

16. How will you put your Children and Young People Mental Health Plan into practice?

17. How quickly will you implement your local digital roadmap, taking the steps needed to deliver a fully interoperable health and care system by 2020 that is paper-free at the point of care? How will you make sure that every patient has access to digital health records that they can share with their families, carers and clinical teams? How will you increase your online offer to patients beyond repeat prescriptions and GP appointments?

18. What is your plan to develop, retrain and retain a workforce with the right skills, values and behaviours in sufficient numbers and in the right locations to deliver your vision for transformed care? How will you build the multidisciplinary teams to underpin new models of care? How ambitious are your plans to implement new workforce roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice?

19. What is your plan to improve commissioning? How rapidly will the CCGs in your system move to place-based commissioning? If you are a devolution area, how will implementation delivery real improvements for patients?

20. How will your system be at the forefront of science, research and innovation? How are you implementing combinatorial innovation, learning from the forthcoming test bed programme? How will services changes over the next five years embrace breakthroughs in genomics, precision medicine and diagnostics?

C. How will you close the finance and efficiency gap?

This section should describe how you will achieve financial balance across your local health system and improve the efficiency of NHS services.

Questions your plan should answer:

1. How will you deliver the necessary per annum efficiency across the total NHS funding base in your local area by 2020/21?

2. What is your comprehensive and credible plan to moderate demand growth? What are the respective contributions in your local system of: (i) tackling unwarranted variation in care utilisation, e.g. through RightCare; (ii) patient activation and self-care; (iii) new models of care; and (iv) urgent and emergency care reform implementation?

3. How will you reduce costs (as opposed to growing income) and how will you get the most out of your existing workforce? What savings will you make from financial controls on agency, whilst ensuring appropriate staffing levels? What are your plans for improving workforce productivity, e.g. through e-rostering of nurses and HCAs? How are you planning to reduce cost through better purchasing and medicines management? What efficiency improvements are you planning to make across primary care and specialised care delivery?

4. What capital investments do you plan to unlock additional efficiency? How will they be affordable and how will they be financed?

5. What actions will you take as a system to utilise NHS estate better, disposing of unneeded assets or monetising those that could create longer-term income streams? How does this local system estates plan support the plans you're taking to redesign care models in your area?

Annex 2: The Government's mandate to NHS England 2016/17

The table below shows NHS England's objectives with an overall measurable goal for this Parliament and clear priority deliverables for 2016-17. The majority of these goals will be achieved in partnership with the Department of Health (DH), NHS Improvement and other health bodies such as Public Health England (PHE), Health Education England (HEE) and the Care Quality Commission (CQC). It also sets out requirements for NHS England to comply with in paragraph 6.2.

Read the full Mandate to NHS England

1. Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.	
1.1 CCG performance	**Overall 2020 goals:** • Consistent improvement in performance of CCGs against new CCG assessment framework.
	2016-17 deliverables: • By June, publish results of the CCG assessment framework for 2015-16, which provides CCGs with an aggregated Ofsted style assessment of performance and allows them to benchmark against other CCGs and informs whether NHS England intervention is needed. • Ensure new Ofsted-style CCG framework for 2016-17 includes health economy metrics to measure progress on priorities set out in the mandate and the NHS planning guidance including overall Ofsted-style assessment for each of cancer, dementia, maternity, mental health, learning disabilities and diabetes, as well as metrics on efficiency, core performance, technology and prevention. • By the end of Q1 of 2016-17, publish the first overall assessment for each of the six clinical areas above.

2. To help create the safest, highest quality health and care service.	
2.1 Avoidable deaths and seven-day services	**Overall 2020 goals:** • Roll out of seven-day services in hospital to 100 percent of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week. • Achieve a significant reduction in avoidable deaths, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements. • Support NHS Improvement to significantly increase the number of trusts rated outstanding or good, including significantly reducing the length of time trusts remain in special measures. • Measurable progress towards reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries that are caused during or soon after birth by 50 percent by 2030 with a measurable reduction by 2020. • Support the NHS to be the world's largest learning organisation with a new culture of learning from clinical mistakes, including improving the number of staff who feel their organisation acts on concerns raised by clinical staff or patients. • Measurable improvement in antimicrobial prescribing and resistance rates.
	2016-17 deliverables: • Publish avoidable deaths per trust annually and support NHS Improvement to help trusts to implement programme to improve from March 2016 baseline. • Rollout of four clinical priority standards in all relevant specialties to 25 percent of population. • Implement agreed recommendations of the National Maternity Review in relation to safety, and support progress on delivering Sign up to Safety. • Support the Government's goal to establish global and UK baseline and ambition for antimicrobial prescribing and resistance rates.

2.2 Patient experience	**Overall 2020 goals**: • Maintain and increase the number of people recommending services in the Friends and Family Test (FFT) (currently 88-96 percent), and ensure its effectiveness, alongside other sources of feedback to improve services. • 50-100,000 people to have a personal health budget or integrated personal budget (up from current estimate of 4,000). • Significantly improve patient choice, including in maternity, end-of-life care and for people with long-term conditions, including ensuring an increase in the number of people able to die in the place of their choice, including at home.
	2016-17 deliverables: • Produce a plan with specific milestones for improving patient choice by 2020, particularly in maternity, end-of-life care (including to ensure more people are able to achieve their preferred place of care and death), and personal health budgets. • Building on the FFT, develop proposals about how feedback, particularly in maternity services, could be enhanced to drive improvements to services at clinical and ward levels.
2.3 Cancer	**Overall 2020 goals:** • Deliver recommendations of the Independent Cancer Taskforce, including: o significantly improving one-year survival to achieve 75 percent by 2020 for all cancers combined (up from 69 percent currently); and o patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.
	2016-17 deliverables: • Achieve 62-day cancer waiting time standard. • Support NHS Improvement to achieve measurable progress towards the national diagnostic standard of patients waiting no more than six weeks from referral to test. • Agree trajectory for increases in diagnostic capacity required to 2020 and achieve it for year one. • Invest £340 million in providing cancer treatments not routinely provided on the NHS through the Cancer Drugs Fund, and ensure effective transition to the agreed operating model to improve its effectiveness within its existing budget.

3. To balance the NHS budget and improve efficiency and productivity	
3.1 Balancing the NHS budget	**Overall 2020 goals**: • With NHS Improvement, ensure the NHS balances its budget in each financial year. • With the Department of Health and NHS Improvement, achieve year on year improvements in NHS efficiency and productivity (2-3 percent each year), including from reducing growth in activity and maximising cost recovery.
	2016-17 deliverables: • With NHS Improvement ensure the NHS balances its budget, with commissioners and providers living within their budgets, and support NHS Improvement in: o securing £1.3 billion of efficiency savings through implementing Lord Carter's recommendations and collaborating with local authorities on Continuing Healthcare spending; o delivering year one of trust deficit reduction plans and ensuring a balanced financial position across the trust sector, supported by effective deployment of the Sustainability and Transformation Fund; and o reducing spend on agency staff by at least £0.8 billion on a path to further reductions over the Parliament. • Roll-out of second cohort of RightCare methodology to a further 60 CCGs. • Measurable improvement in primary care productivity, including through supporting community pharmacy reform. • Work with CCGs to support Government's goal to increase NHS cost recovery up to £500 million by 2017-18 from overseas patients. • Ensure CCGs' local estates strategies support the overall goal of releasing £2 billion and land for 26,000 homes by 2020.

4. To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.	
4.1 Obesity and diabetes	**Overall 2020 goals:** • Measurable reduction in child obesity as part of the Government's childhood obesity strategy. • 100,000 people supported to reduce their risk of diabetes through the Diabetes Prevention Programme. • Measurable reduction in variation in management and care for people with diabetes.
	2016-17 deliverables: • Contribute to the agreed child obesity implementation plan, including wider action to achieve year on year improvement trajectory for the percentage of children who are overweight or obese. • 10,000 people referred to the Diabetes Prevention Programme.
4.2 Dementia	**Overall 2020 goals:** • Measurable improvement on all areas of Prime Minister's challenge on dementia 2020, including: o maintain a diagnosis rate of at least two thirds; o increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral; and o improve quality of post-diagnosis treatment and support for people with dementia and their carers.
	2016-17 deliverables: • Maintain a minimum of two thirds diagnosis rates for people with dementia. • Work with National Institute for Health Research on location of Dementia Institute. • Agree an affordable implementation plan for the Prime Minister's challenge on dementia 2020, including to improve the quality of post-diagnosis treatment and support.

5. To maintain and improve performance against core standards	
5.1 A&E, ambulances and Referral to Treatment (RTT)	**Overall 2020 goals:** • 95 percent of people attending A&E seen within four hours; Urgent and Emergency Care Networks rolled out to 100 percent of the population. • 75 percent of Category A ambulance calls responded to within 8 minutes. • 92 percent receive first treatment within 18 weeks of referral; no-one waits more than 52 weeks.
	2016-17 deliverables: • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for A&E. • Implement Urgent and Emergency Care Networks in 20 percent of the country designated as transformation areas, including clear steps towards a single point of contact. • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for ambulance responses; complete Red 2 pilots and decide on full roll-out. • With NHS Improvement, meet the 18-week referral-to-treatment standard, including implementing patient choice in line with the NHS Constitution; and reduce unwarranted variation between CCG referral rates to better manage demand.
6. To improve out-of-hospital care.	
6.1 New models of care and general practice	**Overall 2020 goals:** • 100 percent of population has access to weekend/evening routine GP appointments. • Measurable reduction in age standardised emergency admission rates and emergency inpatient bed-day rates; more significant reductions through the New Care Model programme covering at least 50 percent of population. • Significant measurable progress in health and social care integration, urgent and emergency care (including ensuring a single point of contact), and electronic health record sharing, in areas covered by the New Care Model programme. • 5,000 extra doctors in general practice.

	2016-17 deliverables: • New models of care covering the 20 percent of the population designated as being in a transformation area to: o provide access to enhanced GP services, including evening and weekend access and same-day GP appointments for all over 75s who need them; and o make progress on integration of health and social care, integrated urgent and emergency care, and electronic record sharing. • Publish practice-level metrics on quality of and access to GP services and, with the Health and Social Care Information Centre, provide GPs with benchmarking information for named patient lists. • Develop new voluntary contract for GPs (Multidisciplinary Community Provider contract) ready for implementation in 2017-18.
6.2 Health and social care integration	**Overall 2020 goals:** • Achieve better integration of health and social care in every area of the country, with significant improvements in performance against integration metrics within the new CCG assessment framework. Areas will graduate from the Better Care Fund programme management once they can demonstrate they have moved beyond its requirements, meeting the government's key criteria for devolution. • Ensure the NHS plays its part in significantly reducing delayed transfers of care, including through developing and applying new incentives.
	2016-17 deliverables: • Implement the Better Care Fund (BCF) in line with the BCF Policy Framework for 2016-17. • Every area to have an agreed plan by March 2017 for better integrating health and social care. • Working with partners, achieve accelerated implementation of health and social care integration in the 20 percent of the country designated as transformation areas, by sharing electronic health records and making measurable progress towards integrated assessment and provision. • Work with the Department of Health, other national partners and local areas to agree and support implementation of local devolution deals. • Agree a system-wide plan for reducing delayed transfers of care with overall goal and trajectory for improvement, and with local government and NHS partners implement year one of this plan.

	2016-17 requirements: • NHS England is required to: o ring-fence £3.519 billion within its allocation to CCGs to establish the Better Care Fund, to be used for the purposes of integrated care; o consult the Department of Health and the Department for Communities and Local Government before approving spending plans drawn up by each local area; and o consult the Department of Health and the Department for Communities and Local Government before exercising its powers in relation to failure to meet specified conditions attached to the Better Care Fund as set out in the BCF Policy Framework.
6.3 Mental health, learning disabilities and autism	**Overall 2020 goal:** • To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce). • Access and waiting time standards for mental health services embedded, including: o 50 percent of people experiencing first episode of psychosis to access treatment within two weeks; and o 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks.
	2016-17 deliverables: • 50 percent of people experiencing first episode of psychosis to access treatment within two weeks. • 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks. • Increase in people with learning disabilities/autism being cared for by community not inpatient services, including implementing the 2016-17 actions for Transforming Care. • Agree and implement a plan to improve crisis care for all ages, including investing in places of safety. • Oversee the implementation of locally led transformation plans for children and young people's mental health, which improve prevention and early intervention activity, and be on track to deliver national coverage of the children and young people's Improving Access to Psychological Therapies (IAPT) programme by 2018. • Implement agreed actions from the Mental Health Taskforce.

7. To support research, innovation and growth.	
7.1 Research and growth	**Overall 2020 goals:** • Support the Department of Health and the Health Research Authority in their ambition to improve the UK's international ranking for health research. • Implement research proposals and initiatives in the NHS England research plan. • Measurable improvement in NHS uptake of affordable and cost-effective new innovations. • To assure and monitor NHS Genomic Medicine Centre performance to deliver the 100,000 genomes commitment.
	2016-17 deliverables: • Implement the agreed recommendations of the Accelerated Access Review including developing ambition and trajectory on NHS uptake of affordable and cost-effective new innovations.
7.2 Technology	**Overall 2020 goals:** • Support delivery of the National Information Board Framework 'Personalised Health and Care 2020' including local digital roadmaps, leading to measurable improvement on the new digital maturity index and achievement of an NHS which is paper-free at the point of care. • 95 percent of GP patients to be offered e-consultation and other digital services; and 95 percent of tests to be digitally transferred between organisations.
	2016-17 deliverables: • Minimum of 10 percent of patients actively accessing primary care services online or through apps, and set trajectory and plan for achieving a significant increase by 2020. • Ensure high quality appointment booking app with access to full medical record and agreed data sharing opt-out available from April 2016. • Robust data security standards in place and being enforced for patient confidential data. • Make progress in delivering new consent-based data services to enable effective data sharing for commissioning and other purposes for the benefit of health and care. • Significant increase in patient access to and use of the electronic health record.

7.3 Health and work	**Overall 2020 goal:** • Contribute to reducing the disability employment gap. • Contribute to the Government's goal of increasing the use of Fit for Work.
	2016-17 deliverables: • Continue to deliver and evaluate NHS England's plan to improve the health and wellbeing of the NHS workforce. • Work with Government to develop proposals to expand and trial promising interventions to support people with long-term health conditions and disabilities back into employment.

#FutureNHS

HEALTH AND WELLBEING BOARD

14 March 2016

Report of: Director of Child & Adult Services

Subject: Better Care Fund: 2015/16 Q3 Return

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1. PURPOSE OF REPORT

1.1 To present to the Health and Wellbeing Board the 2015/16 Q3 return.

2. BACKGROUND

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

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

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

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

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

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

3. BCF Q3 RETURN

3.1 BCF performance reports are submitted to NHS England on a quarterly basis as follows:

Submission Date	Reporting Period
26 February 2016	Q3: October – December 2015
27 May 2016	Q4: January – March 2016

3.2 The Hartlepool 2015/16 Q3 return was submitted on 26 February and is attached at **Appendix 1.**

3.3 The Q3 return indicates that all national conditions are being achieved. There are some indicators where performance is not currently on target, which relate to 'permanent admissions to care homes of people aged 65 and over' and 'proportion of older people still at home 91 days after discharge from hospital into re-ablement / rehabilitation services'. There are issues with the definitions for both of these indicators and how the data is collected, which are currently being reviewed.

3.4 Local performance indicators continue to demonstrate improvements in terms of uptake of assistive technology, proportion of reablement goals achieved and a high proportion of carers accessing support.

4. 2016/17 PLANNING REQUIREMENTS

4.1 Guidance was published on 23 February 2016 regarding Better Care Fund Planning Requirements for 2016/17. The guidance sets out eight conditions which local areas need to meet in order to access funding. These are:

- That a BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review, should be signed off by the HWB itself, and by the constituent Council and CCG.
- A demonstration of how the area will meet the national condition to maintain provision of social care services in 2016-17.
- Confirmation of agreement on how plans will support progress on meeting the 2020 standards for seven-day services, to prevent unnecessary non-elective admissions and support timely discharge;
- Better data sharing between health and social care, based on the NHS number;

- A joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;
- That a proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and
- Agreement on a local action plan to reduce delayed transfers of care.

4.2 The planning requirements are identified as follows:

- A short, jointly agreed narrative plan including details of how they are addressing the national conditions;
- Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;
- A scheme level spending plan demonstrating how the fund will be spent;
- Quarterly plan figures for the national metrics.

4.3 The timetable for submissions is as follows:

First BCF submission, agreed by CCG and LA – • BCF planning template only.	2 March 2016
Assurance of BCF plans.	March 2016
Second BCF submission following assurance and feedback, agreed by CCG and LA – • Revised BCF planning return • High level narrative plan.	21 March 2016
Assurance status of draft plans confirmed	By 8 April 2016
Final BCF plans submitted, following sign off by Health & Wellbeing Board.	25 April 2016
Section 75 agreement in place and signed.	30 June 2016

4.4 The assurance process and approval of plans will be achieved through regional teams working with the Better Care Support Team to provide assurance to the national Integration Partnership Board (jointly chaired by DH and DCLG whose membership includes NHS England, LGA and ADASS) that the above process has been implemented to ensure that high quality plans are in place which meet national policy requirements and have robust risk-sharing agreements where appropriate. This will include offering assurance that appropriate support and assurance arrangements are in place for high risk areas.

4.5 In accordance with the legal framework set out in section 223GA of the NHS Act 2006, final decisions on approval will be made by NHS England in consultation with DH and DCLG. These decisions will be based on the advice of the moderation and assurance process set out above. Where plans are not initially approved NHS England will implement a programme of support to help areas to achieve approval (and / or meet relevant conditions) ahead of April 2016.

5. RISK IMPLICATIONS

5.1 A risk register was completed as part of the original BCF plan and mitigating actions identified. No additional risks have been identified.

6. FINANCIAL CONSIDERATIONS

6.1 The BCF Pooled Budget is hosted by Hartlepool Borough Council and governed through the Pooled Budget Partnership Board. The Council's Chief Finance Officer is the named Pooled Fund Manager.

6.2 It was a requirement that BCF Plans included an element of funding for 'Payment by Performance'. This funding is released based on quarterly performance in terms of reducing non elective hospital admissions. Based on current performance data in relation to non elective admissions, the Q3 element of this funding has been released and will now be utilised to support implementation of the BCF plan.

6.3 As shown in **Appendix 1,** there continues to be slippage against some of the planned areas of spend, however it is anticipated all funding will be fully committed by the end of the financial year and used to support delivery of the BCF Plan.

7. LEGAL CONSIDERATIONS

7.1 None identified.

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

8.1 None identified.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 None identified.

10. STAFF CONSIDERATIONS

10.1 No staff considerations identified.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 No asset management considerations identified.

12. RECOMMENDATIONS

12.1 It is recommended that the Health and Wellbeing Board notes the 2015/16 Q3 return, which was submitted on behalf of the Health and Wellbeing Board using delegated authorities as previously agreed.

13. REASONS FOR RECOMMENDATIONS

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

14. BACKGROUND PAPERS

14.1 Technical Guidance Annex 4: Better Care Fund Planning Requirements for 2016-17 (February 2016)
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

15. CONTACT OFFICER

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Cover

Q3 2015/16	
Health and Well Being Board	**Hartlepool**
completed by:	Jill Harrison
E-Mail:	jill.harrison@hartlepool.gov.uk
Contact Number:	01429 523911
Who has signed off the report on behalf of the Health and Well Being Board:	Cllr Christopher Akers-Belcher (Chair)

boxes below have turned green you should send the template to

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	24
4. Non-Elective and P4P	5
5. I&E	17
6. Metrics	9
7. Understanding support needs	13
8. New Integration Metrics	67
9. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Hartlepool

Have the funds been pooled via a s.75 pooled budget?	Yes
If it has not been previously stated that the funds had been pooled can you now confirm that they have?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question which is pre-populated, the data is from the Q1/Q2 data collection previously filled in by the HWB.

National Conditions

Selected Health and Well Being Board: Hartlepool

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a date **and** a comment in the box to the right

Condition	Q4 Submission Response	Q1 Submission Response	Q2 Submission Response	Please Select (Yes, No or No - In Progress)	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Commentary on progress
1) Are the plans still jointly agreed?	Yes	Yes	Yes	Yes		
2) Are Social Care Services (not spending) being protected?	Yes	Yes	Yes	Yes		
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	Yes	Yes	Yes	Yes		
4) In respect of data sharing - confirm that:						
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes	Yes	Yes	Yes		
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	Yes	Yes	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	No - In Progress	No - In Progress	No - In Progress	Yes		
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	No - In Progress	No - In Progress	No - In Progress	Yes		
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes	Yes	Yes	Yes		

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Footnotes:
Source: For each of the condition questions which are pre-populated, the data is from the quarterly data collections previously filled in by the HWB.

Better Care Fund Revised Non-Elective and Payment for Performance Calculations

Selected Health and Well Being Board: Hartlepool

	Baseline				Plan					Actual							Planned Absolute Reduction (cumulative) [negative values indicate the plan is larger than the baseline]				Maximum Quarterly Payment				Performance against baseline				Suggested Quarterly Payment								
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	% change [negative values indicate the plan is larger than the baseline]	Absolute reduction in non elective performance	Total Performance Fund Available	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Total Performance fund	Total Performance and ringfenced funds	Q4 Payment locally agreed	Q1 Payment locally agreed	Q2 Payment locally agreed
D. REVALIDATED: HWB version of plans to be used for future monitoring.	2,349	2,372	2,358	2,496	2,409	2,241	2,227	2,362	2,318	2,318	2,252	2,299	2,236	3.5%	336	£500,640	-60	71	202	336	£0	£105,790	£195,190	£199,660	31	120	59	260	£0	£105,790	£195,190	£199,660	£500,640	£1,922,000	£0	£105,790	£195,190

Which data source are you using in section D? (MAR, SUS, Other)	MAR	If other please specify	
Cost per non-elective activity	£1,490		

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Suggested quarterly payment (taken from above)*	£0	£105,790	£195,190	£199,660
Actual payment locally agreed	£0	£105,790	£195,190	£199,660

If the actual payment locally agreed is different from the suggested quarterly payment (taken from above) please explain in the comments box (max 750 characters)	N/A

	Total Unreleased Funds			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Suggested amount of unreleased funds**	£0	£0	£0	£0
Actual amount of locally agreed unreleased funds	£0	£0	£0	£0

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Confirmation of what if any unreleased funds were used for (please use drop down to select):	not applicable	not applicable	not applicable	not applicable

Footnotes:

##########
*Suggested quarterly payment (taken from above) has been calculated using the technical guidance provided here http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/. The key steps to calculating the quarterly payment are:
a. take the cumulative activity reduction against the baseline at quarter end and divide it by the cumulative Q3 2015/16 target reduction;
b. multiply that by the size of the performance pot available; and
c. subtract any performance payments made for the year to date.
The minimum payment in a quarter is £0 (there will not be a negative payment or 'claw back' mechanism) and the maximum paid out by the end of each quarter cannot exceed the planned cumulative performance pot available for release each quarter.

**Unreleased funds refers to funds that are withheld by the CCG and not released into the pooled budget, due to not achieving a reduction in non-elective admissions as set out in your BCF plan. As payments are based on a cumulative quarter end value a negative (-) quarter actual value indicates the use of surplus funds from previous quarters.
HWBs should consider whether there is a need to make adjustments to Q3 payments where over or under payments may have occurred in Q4 2014/15, Q1 2015/16 or Q2 2015/16 due to changes made to NEA baselines and targets.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Hartlepool

Income

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£2,208,000	£1,942,000	£1,663,000	£1,663,000	£7,476,000	£7,476,000
	Forecast	£1,646,000	£1,379,000	£1,710,000	£2,741,000	£7,476,000	
	Actual*	£1,646,000	£1,379,000				

Q3 2015/16 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£2,208,000	£1,942,000	£1,663,000	£1,663,000	£7,476,000	£7,476,000
	Forecast	£1,646,000	£1,379,000	£1,710,000	£2,741,000	£7,476,000	
	Actual*	£1,646,000	£1,379,000	£1,710,000			

Please comment if there is a difference between either annual total and the pooled fund	N/A

Expenditure

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£1,869,000	£1,869,000	£1,869,000	£1,869,000	£7,476,000	£7,476,000
	Forecast	£1,195,000	£1,684,000	£1,604,000	£2,993,000	£7,476,000	
	Actual*	£1,195,000	£1,684,000				

Q3 2015/16 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£1,869,000	£1,869,000	£1,869,000	£1,869,000	£7,476,000	£7,476,000
	Forecast	£1,195,000	£1,684,000	£2,253,000	£2,344,000	£7,476,000	
	Actual*	£1,195,000	£1,684,000	£2,253,000			

Please comment if there is a difference between either annual total and the pooled fund	N/A

Commentary on progress against financial plan:	There is currently slippage in some planned areas of spend but it is still anticipated that funding will be fully committed over the remainder of the financial year and utilised to support delivery of the BCF plan.

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB.

National and locally defined metrics

Selected Health and Well Being Board:	Hartlepool

Admissions to residential Care	% Change in rate of permanent admissions to residential care per 100,000
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	Current performance data indicates that target set for this metric is unlikely to be achieved, due to the fact that the target was set prior to the collection methodology being changed. In real terms, if the old methodology is used, admissions are reducing and performance is on target.

Reablement	Change in annual percentage of people still at home after 91 days following discharge, baseline to 2015/16
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Current data indicates that the target is not being met. There is an issue in relation to how short term and permanent admissions to residential care are captured which is impacting on this indicator. This is currently being reviewed and it is expected that perfomance will imperove, although the taregt may not be achieved.

Local performance metric as described in your approved BCF plan / Q1 / Q2 return	Estimated diagnosis rate for people with Dementia (NHS Outcomes Framework 2.6.i)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	This indicator continues to be comfortably achieved.

Local defined patient experience metric as described in your approved BCF plan / Q1 /Q2 return	Aggregate of 3 Measures (percentage): Measure 1 - ASCOF 3A: Overall satisfaction of people who use services with their care and support. Measure 2 - ASCOF 3B: Overall satisfaction of carers with social services. Measure 3 - Percentage of patients responding 'very good' or 'fairly good' out of the total patients responding to
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	Data not available to assess progress
Commentary on progress:	Data not available to assess progress as the metric relies on information form annual surveys.

Footnotes:

Source: For the local performance metric which is pre-populated, the data is from a local performance metric collection previously filled in by the HWB.
For the local defined patient experience metric which is pre-populated, the data is from a local patient experience previously filled in by the HWB.

Support requests

Selected Health and Well Being Board:	Hartlepool

Which area of integration do you see as the greatest challenge or barrier to the successful implementation of your Better Care plan (please select from dropdown)?	3.Developing underpinning integrated datasets and information systems

Please use the below form to indicate whether you would welcome support with any particular area of integration, and what format that support might take.

Theme	Interested in support?	Preferred support medium	Comments - Please detail any other support needs you feel you have that you feel the Better Care Support Team may be able to help with.
1. Leading and Managing successful better care implementation	No		
2. Delivering excellent on the ground care centred around the individual	No		
3. Developing underpinning integrated datasets and information systems	Yes	Case studies or examples of good practice	
4. Aligning systems and sharing benefits and risks	No		
5. Measuring success	Yes	Case studies or examples of good practice	
6. Developing organisations to enable effective collaborative health and social care working relationships	No		

New Integration Metrics

Selected Health and Well Being Board: Hartlepool

1. Proposed Metric: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Hospital	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Social Care	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution
From Mental Health	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Shared via interim solution
From Specialised Palliative	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Shared via interim solution	Not currently shared digitally

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	In development	In development	In development	In development
Projected 'go-live' date (dd/mm/yy)	31/05/16	01/04/17	01/04/17	01/04/17	01/04/17	01/04/17

3. Proposed Metric: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot commissioned and planning in progress

4. Proposed Metric: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the beginning of the quarter	50
Rate per 100,000 population	54

Number of new PHBs put in place during the quarter	6
Number of existing PHBs stopped during the quarter	0
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	39%

Population (Mid 2015)	92,901

5. Proposed Metric: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - in some parts of Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	No - nowhere in the Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2012-based (published May 2014).
http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/stb-2012-based-snpp.html

Narrative

Selected Health and Well Being Board:	Hartlepool

Remaining Characters	31,076

Please provide a brief narrative on overall progress in delivering your Better Care Fund plan at the current point in time, please also make reference to performance on any metrics not directly reported on within this template (i.e. DTOCs).
Implementationcontinues to progressing well: • Weekend working pilot for Social Workers supporting the hospital discharge process continues, supported by additional weekend capacity commissioned from independent home care providers using system resilience funding. • Health and social care first contact teams are co-located. Further work is underway to establish how these teams work more cohesively and how capacity is enhanced, including clinical input / triage and closer links with falls prevention. • An enhanced early intervention service has been developed to free up Rapid Response Nursing capacity to focus on admission prevention. • The Hartlepool Now site was formally launched in October as the first contact point for signposting and early intervention. • Enhanced support for care homes and home care providers in relation to medicines management has been commissioned and options for further support and training for care homes are being explored. • Potential to implement an enhanced Intensive Community Liaison model in care homes in relation to dementia is being explored, which will increase proactive work and be focused on maintaining placements and admission prevention. • The target in relation to DTOC has not been met in Q2 or Q3 (following a significant reduction in Q1) although data demonstrates a reduction in numbers for the year to date in comparison to the same time period last year. There continue to be no DTOC attributable to social care. • Local performance measures continue to demonstrate improvements in terms of uptake of assistive technology and proportion of reablement goals achieved, and a high proportion of carers are accessing support.