HEALTH AND WELLBEING BOARD AGENDA

Monday 16 January 2017

at 10.00 a.m.

in Committee Room 'B'
Civic Centre, Hartlepool

MEMBERS: HEALTH AND WELLBEING BOARD

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors C Akers-Belcher, Buchan, Clark and Thomas
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group (2) – Dr Timlin 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) – Dr Tim Butler
Representative of Hartlepool Voluntary and Community Sector (1) – Tracy Woodhall
Representative of Tees, Esk and Wear Valley NHS Trust (1) – Colin Martin
Representative of Cleveland Police, Temporary Assistant Chief Constable Ciaron Irvine

Observer – Statutory Scrutiny Representative, Hartlepool Borough Council, Councillor Tennant**.**

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

   3.1 To confirm the minutes of the meeting held on 5 December 2016
   3.2 To receive the minutes of the meeting of the Children's Strategic Partnership held on 27th September 2016

4. **ITEMS FOR CONSIDERATION**

4.1 Urgent and Emergency Care Update - Presentation (*Clinical Commissioning Group)*
4.2 Healthwatch Hartlepool Dementia Diagnosis Consultation Report (*Healthwatch)*
4.3 Better Care Fund: 2016/17 Q2 Return (*Director of Child and Adult Services)*

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

FOR INFORMATION: -

Date of next meeting – Monday 13 February 2017 at 10.00 a.m. at the Civic Centre, Hartlepool.

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

5 December 2016

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:
Dr Timlin, Hartlepool and Stockton-on-Tees Clinical Commissioning Group (In the Chair)

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillor Buchan
Representative of Hartlepool and Stockton-on-Tees Clinical Commissioning Group – Alison Wilson
Director of Public Health, Hartlepool Borough Council - Louise Wallace
Director of Child and Adult Services, Hartlepool Borough Council – Sally Robinson
Representatives of Healthwatch – Ruby Marshall and Margaret Wrenn

Other Members:
Representative of Hartlepool Borough Council - Councillor Carl Richardson (as substitute for Councillor Steve Thomas)
Representative of Tees Esk and Wear Valley NHS Trust – David Brown
Observer – Statutory Scrutiny Representative, Hartlepool Borough Council, Councillor Tennant

Also in attendance:-
Representatives of the NHS England – Ben Clark and Glen Wilson
Representative of Cleveland Police – Chief Superintendent Gordon Lang
Observer, Hartlepool Borough Council - Councillor Brenda Harrison
Representative of Teeswide Safeguarding Adults Board – Ann Baxter
Hartlepool Borough Council Officers:
Joan Stevens, Scrutiny Manager
Denise Wimpenny, Democratic Services Team

24. Apologies for Absence

Councillors C Akers-Belcher and Thomas, Hartlepool Borough Council, Dr Tim Butler, NHS England, Colin Martin, Tees Esk and Wear Valley, Cairon Irvine, Cleveland Police and Fiona Anderson, Hartlepool & Stockton Health, GP Federation representative.

25. Declarations of interest by Members

None

26. Minutes

(i) The minutes of the meeting held on 17 October 2016 were confirmed.
(ii) The minutes of the meeting of the Children's Strategic Partnership held on 28 June 2016 were received.

27. Teeswide Safeguarding Adults Board Annual Report 2015-16 (*Teeswide Safeguarding Adults Board*)

28. Teeswide Safeguarding Adults Board Strategic Business Plan 2016/17 (*Teeswide Safeguarding Adults Board*)

The Chair of the Teeswide Safeguarding Adults Board, presented the Teeswide Safeguarding Adults Board Annual Report 2015/16 and Strategic Business Plan 2016/17, copies of which were appended to the report.

The Annual Report considered the activities of the Board against its five strategic aims over the past year. It provided a summary of work undertaken across Tees to protect the most vulnerable people in the community, and highlighted the challenges faced.

The Strategic Business Plan summarised the priorities identified throughout the consultation process, informing the development of the 2016-17 objectives and actions. The Board looked forward to working with current partners and developing new relationships to ensure the safeguarding arrangements helped and protected adults.

Following presentation of the reports, Board Members expressed their support for the report and whilst they were pleased to note the work that had been undertaken to date to improve communication and engagement, it was noted that further work was needed to improve awareness of adult safeguarding issues. Members discussed the most appropriate methods of raising awareness of this issue, particularly with hard to reach groups and the need to increase integration with BME groups was highlighted. Board Members welcomed the Teeswide approach in terms of sharing information locally with a number of partner agencies, the benefits of which were discussed.

Decision

The Board endorsed the Teeswide Safeguarding Adults Board Annual Report 2015/16 and Strategic Business Plan 2016/17.

29. Health Protection Update (*Director of Public Health*)

The Director of Public Health introduced the report which provided background information to the statutory duties placed on Public Health England, NHS England and local authorities to protect the health of the population. The Board was referred to a plan, appended to the report, which provided details of the key activities that contributed to managing risk and responding to incidents.

Given the Board's decision to undertake a more in depth consideration of immunisation and screening, a representative from NHS England had been invited to the meeting to provide a presentation in relation to immunisation in Hartlepool.

The representative provided a detailed and comprehensive presentation which included latest statistics and trend analysis in relation to take up of immunisation. The key factors arising from the presentation were summarised as follows:-

- The two public health interventions with the greatest impact are the provision of clean water and immunisation
- No measures had saved more lives than immunisation
- Immunisation is a highly cost effective public health intervention
- Governance and assurance structure
- Details of childhood immunisations by type including statistics and trends in Hartlepool as a comparator with the North East and England
- Details of adult immunisations

Following the presentation, a number of examples were shared with the Board in relation to the side effects experienced by individuals following vaccinations, particularly the flu vaccination. In response to clarification sought on the side effects of vaccinations of this type, the NHS England representative advised that any side effects were reported to the Health Care Worker and monitored accordingly. Assurances were provided that whilst the flu jab could cause a localised reaction and some individuals may feel unwell, this would not give individuals the flu. The potential reasons for low take up of the flu jab were discussed and emphasis was placed upon the need to publicise the message that the flu jab would not result in illness.

With a view to increasing take up of immunisation, a query was raised as to whether any particular groups should be targeted. Board Members were advised that potentially BME groups should be targeted, given the low level of take up. The Chair reiterated the benefits of the flu jab and and expressed support in this regard.

A member of the public commented on a research paper on the alternatives to immunisation. It was suggested that this information be forwarded to the Director of Public Health following the meeting. Another member of the

public, who was also invited to speak, referred to a report on the links between the MMR immunisation and autism. Board Members responded to further issues raised in relation to the presentation.

Decision

(i) The Board noted the activities relating to protecting the health of the population as outlined in the plan.

(ii) The Board confirmed it had assured plans and arrangements in place to protect the health of the population in keeping with the requirements under the Health and Social Care Act 2012.

(iii) That the contents of the presentation and comments of Board Members be noted.

30. Health and Wellbeing Board – Terms of Reference Review (*Director of Public Health*)

The Scrutiny Manager presented a report which provided an opportunity for the Board, to review their Terms of Reference, sub-structure and non-statutory membership.

To assist the Board in the review of the sub-structure, a Development Day had been held on 17 October 2016 during which Members considered three key questions, a summary of which was outlined in appendices to the report. Based upon the outcome of the Development Session, it was suggested that the Board should, in the coming year, focus on the following:-

(a) Holding themed meetings to help the Board focus on two priority themes inviting relevant experts and involving the appropriate sub groups where not effective. Themed priorities discussed as options were:-

(i) Veterans Health
(ii) Offender Health
(iii) Refugee/Asylum Seeker Health

(b) Statutory/other business to be looked at during separate themed meetings, including:

(i) Implementation of the Hartlepool Matters Plan
(ii) Monitoring implementation of the Healthy Weight: Healthy Lives Strategy
(iii) Update and monitoring of the Health and Wellbeing Strategy to be monitored through sub groups, with issues escalated to the Health and Wellbeing Board, as and when necessary.
(iv) Completion of a GAP analysis
(v) Identification of an indicator to show progression

(vi) Achieving more quick wins and intermediate outcomes.

Other comments/suggestions identified at the Development Session were provided together with details of proposed sub-groups as set out in the report.

Members were referred to the revised Terms of Reference attached at Appendix A. With regard to the decision taken to remove the North Tees and Hartlepool Foundation Trust from membership of the Board, it was suggested that the South Tees NHS Foundation Trust be contacted again to encourage take up of a place on the Board.

The Scrutiny Manager made reference to a letter from the Home Office, a copy of which was tabled at the meeting, which highlighted the Home Office's support and important benefits that could be realised through closer collaboration between policing and health partners. The Scrutiny Manager was pleased to report that the Council had already taken on board a number of the recommendations suggested by the Home Office with strong collaborative working arrangements already in place with the police with representations on the Health and Wellbeing Board and regular attendance by the Police and Crime Commissioner. The Council had also signed up to the Care Concordat Triage arrangements.

In considering the revised Terms of Reference for the Board, issues were discussed regarding:

- The number of proposed Sub Groups under the Board - Given the potential for duplication, it was suggested that existing groups should be utilised where possible.

- The suggested themes for future meetings of the Board – Support was expressed for the principle of themed meetings to focus the activities of the Board. However, Members were unsure if the suggested themed priorities of veteran's health, offender health and refugee/asylum seeker health were the most appropriate. Whilst it was recognised that the suggested areas were important, it was considered that there should be more focus upon areas like obesity and groups disproportionately affected as this would result in a greater impact.

Decision

(i) The Board agreed that its future meeting programme would be planned to include separate themed and statutory / other business meetings. The basis of each being:

a) Themed meetings, to focus on two priority themes each year, inviting relevant experts and involving appropriate sub groups.

b) Statutory/other business meeting - to focus on issues including:-

(i) Implementation of the Hartlepool Matters Plan;
(ii) Monitoring implementation of the Healthy Weight: Healthy Lives Strategy;

c) Updating of the Health and Wellbeing Strategy.
d) Completion of a GAP analysis and identification of an indicator to show progression / performance.

(ii) The Board Agreed that from an operational perspective:

(a) A review be undertaken of the format of its minutes and layout of its reports to include reference to all sub groups and how the issue affects them.
(b) Information provided to include more relatable statistics / informatics (i.e. use of figures rather than statistics i.e. Hartlepool as a town info graphic in the Hartlepool Matters Plan).
(c) A Health and Wellbeing Board newsletter be introduced.

iii) That the revised Terms of Reference, attached at Appendix A, be agreed, with the following amendments / exceptions:-

Amendment

(a) That reference to the inclusion of an NHS Foundation Trust Representative to the 'Other Members' section of the Board membership (Page 5), be amended to read NHS (Acute) Foundation Trust (1).

Exception

(b) That approval of proposed amendments to Section 8.10 in relation to the creation of sub-groups and task and finish groups be deferred, in light of capacity and duplication concerns, and a further report outlining revised proposals brought to the Board.

(c) That approval of proposed amendments to Section 9.1, in relation to engaging with other bodies be deferred, pending further discussions with Stockton Borough Council as to the role, format and benefit of an annual joint meeting of Stockton and Harltepool's Health and Wellbeing Boards.

iv) The Board requested that the CCG approach the South Tees NHS Trust again to explore the potential of them filling the (acute) NHS Foundation Trust vacancy on the Board.

v) That a further report be presented to the Board to identify two topics / priorities, as alternatives to those identified in the report, to form the basis of the Board's future themed meetings.

31. Age Related Dual Sensory Loss (*Director of Child and Adult Services*)

A report presented by the Director of Child and Adult Services provided the Board with information regarding residents of Hartlepool who were living with age related dual sensory loss. The support of the Board was sought for a proposal to improve awareness and equip key organisations with the skills and training necessary to identify and support people with dual sensory loss.

It was reported that in Hartlepool it was estimated that there were at least 520 people living with age related dual sensory loss, of which 36 so far had been identified. The prevalence of co-occurring sight and hearing problems increased with age. In Good Hands (IGH) was a Big Lottery funded project managed by SCENE enterprises CIC and was working with all 12 local authorities and all care providers in the North East to deliver free training and advice to staff. Their ambition was to support key stakeholders to improve uptake of training and build their capacity to identify and support these older people in communities.

IGH would like to roll out the free training to all key stakeholders, including the NHS, emergency services and key voluntary organisations to ensure people had the right information advice and guidance necessary to support people with age related dual sensory loss.

Decision

That the proposal to support and encourage key organisations to sign up to dual sensory loss training be supported.

Meeting concluded at 11.45 am.

CHAIR

CHILDREN'S STRATEGIC PARTNERSHIP

MINUTES AND DECISION RECORD

27 SEPTEMBER 2016

The meeting commenced at 4.15 pm in the Civic Centre, Hartlepool.

Present:

Councillor Alan Clark (In the Chair)

Sally Robinson, Director of Child and Adult Services
Danielle Swainston, Assistant Director, Children's Services
Louise Wallace, Director of Public Health
Karen Hawkins, Hartlepool and Stockton-on-Tees Clinical Commissioning Group
Nicki Smith, CAMHS, Tees, Esk and Wear Valleys NHS Trust
Dave Wise, West View Project, (Voluntary and Community Sector Representative)
Kay Glew, Housing Hartlepool, Thirteen Group;
John Hardy, Head Teacher St John Vianney Primary School, (Hartlepool Primary Schools Representative)
Dave Pickard, Independent Chair, Hartlepool Safeguarding Children Board
Martin Todd, Changing Futures North East

Also present: Councillors Paul Beck, Lesley Hamilton and Brenda Harrison.

Young Peoples Representatives – Lauren Howells and Callum Reed

Officers: Helen White, Participation Manager
David Cosgrove, Democratic Services Team

9. Apologies for Absence

Mr Darren Hankey, Hartlepool College of Further Education.
Chris Davies, CAMHS, Tees, Esk and Wear Valleys NHS Trust.

10. Declarations of Interest

None.

11. Minutes of the meeting held on 28 June, 2016

Confirmed.

12. Better Childhood Programme - Governance (*Assistant Director, Children's Services*)

The Assistant Director, Children's Services gave a presentation to the Partnership outlining the current position the Better Childhood Programme in Hartlepool, the establishment of the Multi-Agency Children's Hub and the redesign of services. The Assistant Director referred to the previously reported and discussed vision and obsessions of the Better Childhood Programme that was to be delivered through –

- A workforce approach based on intervention based practice.
- A workforce that owns intervenes and takes action to meet the needs of children and families and assumes their responsibilities as agents of change.
- Building effective relationships with the families we work with to ensure they receive the help and support they need.
- Supporting families to develop their own plans making sure that all support networks available to them are used. This includes wider family networks and also workers from other organisations.

The presentation went on to highlight the following key points –

What was known -

- Domestic Violence, Substance Misuse and Bereavement and loss main issues identified for children becoming looked after.
- The main factors for children in families assessments – Domestic Violence, Parental Substance Misuse and parental mental health
- Issues were not being identified early enough and early help assessments were predominantly being undertaken by the Council (Children's Services)
- The workforce was often confused about our approach

What children and young people were telling us -

- More aspirations for us – what we can do.
- To be told the truth.
- Someone to help me plan.
- Act on what we have said and show us.
- See us and talk to us – do not only talk to our parents or carers about us.
- Come and check on us – come and find us in our bedroom and talk to us.
- Do not write stuff about us – create records about us with us.

What parents are telling us -

- There is no clear place to ask for help.
- Fear of being judged can be a barrier to engagement.
- Support needs to be immediately accessible when the problem arises.
- There should be regular contact with a single worker who can answer questions and provide direct interventions.

- Ongoing practical support should be available after case closure.

The implementation phase -

- Four locality teams – based on Children's centre reach area and school clusters.
- Two localities will be managed by health managers and two localities will be managed by social work managers.
- Initially health visitors, social workers, community nursery nurses, staff nurses, school nurses, family support workers and PCSOs.
- Office bases – Rossmere Children Centre, Ward Jackson Annex, Star Centre and Carnegie Building.

Governance -

- Children's Strategic Partnership to have overall oversight on progress and development.
- Operational board set up that includes all partners to oversee implementation and further development of the model.
- Workstreams to be developed depending on transition to the new model.
- Engagement with partners.
- Continuous Improvement and performance management.
- Models of effective intervention.
- Integrated processes.

The Assistant Director also circulated at the meeting an organisational chart showing the proposed integrated governance structure for the Better Childhood Programme in Hartlepool. There was some concern that the Partnership's role had been slightly diminished over recent months. The Assistant Director indicated that the Partnership's role was to lead the programme and to hold the various partners involved in the programme to account. The integrated processes were quite challenging when bringing all the various partners together into the new working arrangements. The Partnership's support for the processes and various work streams was therefore sought.

The Independent Chair of the Hartlepool Safeguarding Children Board supported the proposals though did comment that there was some duplication with the Safeguarding Children Board. The key element would be getting senior partners in the programme to attend the Partnership meetings to provide the necessary oversight. The Chair agreed and suggested that a letter be sent to those organisations whose representatives had not attended the past two meetings.

The Director of Public Health stated that the amount of work involved in bringing the Better Childhood Programme to this point could not be underestimated. The Director of Child and Adult Services and the Assistant Director, Children's Services had driven the programme forward to this point but in order for all agencies involved to continue to move away from their previous 'silos' to the child and family centred provision the

programme was based around would take commitment.

The Chair did feel that the work undertaken so far was bearing fruit and while it was normal for such large changes in working practices to take time to bed in, the way the multi agency children's hub, for example, had made such a key change in service delivery showed this was the right approach. What was key for the future was setting out what key performance measures should be monitored and how all partners, including the Council, would be held to account.

The Assistant Director indicated that a performance management framework was being developed. Similar frameworks were also being developed by the Hartlepool Safeguarding Children Board and Changing Futures. A draft of the framework would be brought to the next meeting for discussion.

There was concern raised that there had been some drift since the need for a Children's Plan had been removed though the programme did now fill some of that gap and should create its own momentum.

The Director of Child and Adult Services commented that the Strategic Partnership had two key functions, strategic oversight and governance of the Better Childhood Programme and the Multi Agency Looked After Partnership (MALAP), and finding the connectivity between the two while still moving both forward would be key. For this Partnership it was important to remember its position sitting under the Health and Wellbeing Board which allowed all partners to bring appropriate items to the agenda to drive forward the work of the Better Childhood Programme. It would, however, be important to build on the link to the Health and Wellbeing Board. The Director of Public Health added that the Health and Wellbeing Board would be holding a development day in the near future and it would be an appropriate issue to build into the agenda for that day.

The Chair welcomed the Directors' comments and added that it was as much a role for partners to ensure the local authority was being held to account and achieving what it said it would as much as the other way around.

Members commented in support of the governance proposals set out by the Assistant Director and the comments in relation to accountability. It was suggested that there would need to be a greater level of coordination between partner organisations in the future to ensure minimal overlap and replication. Members considered there was a need for the Partnership to move to being more proactive rather than just a meeting for the sake of holding a meeting and in many ways this may have been reflective in the sometimes disappointing attendance. The Chair added that he would make good on his commitment to move the future meetings out of the Civic Centre to aid that perception.

The Assistant Director indicated that there were also two other key

elements that needed to link into the Partnership; they were the CAMHS Transformation Plan from Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and the Education Commission for Hartlepool. Members agreed that it would send out a strong message if these were linked into the Better Childhood Programme. There would, however, need to be quite a lot of work done in terms on showing how this would work logistically but as individual strands they were all essentially pulling in the same direction. The Assistant Director commented that at the commencement of the Education Commission there had been a consistent message that it was designed to be a whole town approach across all schools and providers. The Primary Schools representative commented that the Commission had developed a brand of Hartlepool being a learning town with an aim that this would be 'exported' out of the Commission for 'buy-in' from other agencies, including the local authority. The Chair indicated that he would raise the issue for discussion with the other Policy Committee Chairs.

Decision

1. That the presentation and discussions be noted.
2. That the proposed governance structure submitted be approved.
3. That the remaining two scheduled meetings of the Partnership be held in venues away from the Civic Centre.

13. Better Childhood Programme – Development of Phase 2 (*Assistant Director, Children's Services*)

Following on from the debate on governance, the Assistant Director, Children's Services opened discussion on what the next phase of the Better Childhood Programme should look like. The redesign of the current approach to early help and social care to establish multi-professional (and ultimately multi-agency) teams of family partners had taken place. The design of these teams would reduce duplication for families and provide more focused support and intervention through a single key worker. The next steps from this now needed to be identified for the next phase of service integration in order to provide the future service efficiencies that all partners had to deliver.

The CCG representative indicated that the CCG had discussed what would be the next steps in this process and was to scope what the CCG's offer to children was and how future service integration through the Health and Wellbeing Board could be delivered. Those efficiencies were based around the workforce and how further integration with partners could drive forward services. The Chair of the Hartlepool Safeguarding Children Board commented that much work would need to be focussed around the previously discussed 'obsessions' and how these could be delivered. Commissioning integrated services around substance abuse, for example, would be difficult; these were complex issues but as had been shown in the previous presentation, these were key factors in family breakdown and children coming into care.

The Director of Child and Adult Services suggested that the December meeting of the Partnership could look to include a presentation from Changing Futures to hear how they were progressing. This would give another differing angle on the development of services. The development of key links within the localities was also an area that could be discussed. There wouldn't be a 'one size fits all' approach that could be rolled out across all four localities but there were key relationships that all would need to develop such as links with the local voluntary sector and school clusters for example. The locality teams brought together a wide range of local knowledge, including PCSOs. Building strength within families was at the core of the Better Childhood Programme and while there would be an overall town wide approach each of the localities would also look to what each community could provide.

The Primary Schools representative indicated that the work with school clusters would have to link with the existing cluster structure which had been developed over a number of years. What was of concern to him was the Academies agenda. Three of the academy chains operating in Hartlepool involved schools from outside the town so they had a different perspective not wholly focussed on the town. The Chair acknowledged that this was a difficult issue but the local authority had a responsibility to all children in Hartlepool regardless of their schools management. The Assistant Director commented that this was about partnership working and working with the pastoral leads in schools would be a way forward. Systems and localities would be different but it was still important to build those links and embed them.

The CAMHS representative indicated that it would be timely to bring an update to the next meeting on the Transformation Plan. CAMHS would be very receptive to working with the locality based services.

A young people's representative commented that the view that a school becoming an academy and/or joining an academy chain did not suddenly change the ethos of the school or its place in the community. There were still strong links with the local authority and the Education Commission; a school being an academy should not be seen as some kind of barrier to joint working. The Director of Child and Adult Services supported this view commenting that the local authority was always open to working with any school in the town and did work closely with academies now.

A young people's representative added that Hartlepool Youth Council were working on the production of an information leaflet for young people on mental health issues. There has been some confusion as to what services were available and how young people could access them. It was suggested that the leaflet could be discussed at the next meeting as while it currently had a young people's perspective, it would be valuable to have partners input to ensure it was fully inclusive. The Chair welcomed this proposal.

Decision

1. That the discussions be noted.
2. That the next meeting of the Partnership include specific input from Changing Futures North East, Tees, Esk and Wear Valleys NHS Trust in relation to the CAHMS Transformational Plan and Hartlepool Youth Council in relation to their Mental Health Services leaflet for young people.

14. Any Other Items which the Chairman Considers are Urgent

The Assistant Director, Children's Services advised the partnership that the local authority had been advised that an Ofsted local area SEND Inspection was to commence on Monday 3 October.

The meeting noted that the next meeting would be held on Tuesday 13 December 2016 at 4.15 pm.

In line with the discussion at the meeting, the Chair indicated that the next meeting would be held at an alternative venue away from the Civic Centre.

The meeting concluded at 5.10 pm.

CHAIR

HEALTH AND WELLBEING BOARD

16 January 2017

Report of: Chief Officer, HAST CCG

Subject: Urgent and Emergency Care Update

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1. PURPOSE OF REPORT

1.1 To provide the Health and Wellbeing Board with an update on initiatives that are being implemented to manage the demands on urgent and emergency care systems and how we are developing services in order to improve outcomes and experience for patients.

2. BACKGROUND

2.1 NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (the CCG) have a responsibility to commission high quality, effective, urgent and emergency care services for patients in line with national and local priorities.

2.2 Based on guidance available, the CCG has developed plans to address current challenges across the urgent and emergency landscape with one key scheme being the development and implementation of integrated urgent care services.

3. INTEGRATED URGENT CARE SERVICES

3.1 The CCG has engaged with the Health and Wellbeing Board throughout 2015 and 2016 to advise on plans for an Integrated Urgent Care Service (IUCS). The proposal for the service was in response to national guidance and best practice and also in response to local intelligence which outlined that service users are often confused about where and when to attend for urgent care needs and continued to present at accident and emergency services.

3.2 The new service will bring together a range of urgent care services including GP out of hours, minor injuries and walk in centre services to avoid service users making decisions and choices as to where the best place to attend will

be and will be delivered in two localities from 1 April 2017; University Hospital of Hartlepool and University Hospital of North Tees.

3.3 In November 2016, the procurement process concluded and the CCG Governing Body agreed the recommendation following a robust procurement process to award the new contract to North Tees and Hartlepool NHS Foundation Trust who will be working in partnership with North East Ambulance Services and Hartlepool and Stockton Health (GP Federation) to deliver the new Integrated Urgent Care Service (IUCS).

3.4 At the University Hospital of North Tees, the IUCS will be co-located at A&E and will ensure that service users are triaged and receive appropriate treatment in the most appropriate setting, to avoid unnecessary attendances at the A&E Department

4. MANAGING EMERGENCY CARE LOCALLY

4.1 The Accident & Emergency Delivery Board (A&EDB) replaces the Systems Resilience Group (SRG), a transformation that was mandated by NHS England in their correspondence to CCG Accountable Officers, dated July 26 2016.

4.2 The A&EDB will focus on the recovery of the 4 hour target but also A&E Delivery Boards and with Sustainable Transformation Plan (STP) groupings, will focus on the longer term delivery of the Urgent and Emergency Care Review. Additionally the Local A&E Delivery Board coordinates and oversees "Five Interventions" - developed by experts in the field of emergency care, with a focus on outcomes and processes, for which discharge to assess models is one key intervention.

4.3 The Hartlepool and Stockton-on-Tees A&E Delivery Board has allocated the SRG funding resource for 2016/17 to schemes identified through a process involving all then SRG members. The schemes are all developed with the vision to either address issues relating to hospital discharges (Delayed Transfers of Care), offer workforce resilience or to prevent avoidable/unplanned hospital admissions.

5. MANAGING PRESSURE - Operational Pressures Escalation Framework (OPEL)

5.1 System wide escalation plans have been developed and agreed in line with the new national framework with agreed local multi-agency triggers - including escalation and de-escalation. Both provider and commissioning organisations across the North East have plans in place which include triggers for both escalation and de-escalation built on a standardised framework (NEEP – North East Escalation Plans levels 1-6). These are monitored at a system level via the A&EDB

5.2 Delivery against the new A & E Improvement Plan is also reported upon at each A&E DB with monthly data collection responsibilities shared with providers.

6. RISK IMPLICATIONS

6.1 None for the Health & Wellbeing Board.

7. FINANCIAL CONSIDERATIONS

71 None for the Health & Wellbeing Board.

8. LEGAL CONSIDERATIONS

8.1 None identified.

9. CHILD AND FAMILY POVERTY CONSIDERATIONS

9.1 None identified.

10. EQUALITY AND DIVERSITY CONSIDERATIONS

10.1 None identified.

11. STAFF CONSIDERATIONS

11.1 No staff considerations identified.

12. ASSET MANAGEMENT CONSIDERATIONS

12.1 No asset management considerations identified.

13. RECOMMENDATION

13.1 It is recommended that the Health and Wellbeing Board notes the contents of the presentation.

14. REASONS FOR RECOMMENDATION

14.1 Multi agency Local A&E Delivery Boards are responsible for co-ordinating and overseeing these initiatives which aim to improve outcomes and experience for local people.

14. CONTACT OFFICER

Katie McLeod
Head of Strategy and Commissioning
HaST CCG

HEALTH AND WELLBEING BOARD

16th January 2017

Report of: HealthWatch Hartlepool

Subject: HealthWatch Hartlepool Dementia Diagnosis Consultation Report

1. PURPOSE OF REPORT

1.1 To inform the Health & Wellbeing Board of the outcomes of the recent consultation regarding patient experience of dementia diagnosis in Hartlepool.

2. BACKGROUND

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

2.2 The dementia diagnosis consultation was included in the 2016/17 work programme of Healthwatch Hartlepool as a result of concerns raised with us regarding access to and subsequent patient experience of dementia diagnostic processess.

3. PROPOSALS

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

- Obtain the views of the wider community about their needs for and experience of local health and social care services and make those

views known to those involved in the commissioning, provision and scrutiny of health and social care services.

- Promote and support the involvement of a diverse range of people in the monitoring, commissioning and provision of local health and social care services through membership of local residents and service users.
- Make reports and recommendations about how those services could or should be improved.
- Provide information to the public about accessing health and social care services together with choice in relation to aspects of those services.
- Represent the views of the whole community, patients and service users on the Health & Wellbeing Board and the Hartlepool Clinical Commissioning Group (locality) Board.
- Make the views and experiences of the broad range of people and communities known to Healthwatch England helping it to carry out its role as national champion.
- Make recommendations to Healthwatch England to advise the Care Quality Commission (CQC) to carry out special reviews or investigations into areas of concern (or, if the circumstances justify it, go direct to the CQC with recommendations, if for example urgent action were required by the CQC).
- This report will be made available to all partner organisations and will be available to the wider public through the Healthwatch Hartlepool web site.

4. EQUALITY & DIVERSITY CONSIDERATIONS

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

5. RECOMMENDATIONS

5.1 That the Health and Wellbeing Board note the contents the HealthWatch Hartlepool Dementia Diagnosis Report and consideration is given to recommendations contained within.

6. REASONS FOR RECOMMENDATIONS

6.1 The recommendations are based on findings from the consultation events and subsequent discussions.

7. BACKGROUND PAPERS

7.1 None

8. CONTACT OFFICER

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Healthwatch Hartlepool Investigation into Patient Experience of Dementia Diagnosis

Update Report

September 2016

MISSION STATEMENT

"Healthwatch Hartlepool has been established in a way that is inclusive and enables involvement from all areas of the local community. We wish to involve those who are seldom heard."

Contents of the Report

1. Background

1.1 Over recent years at both national and regional levels, there have been few issues and conditions that have attracted as much interest and coverage as dementia. It is estimated that around 850,000 people in the UK are living with dementia and that a further 700,000 are providing care and support to people with the condition.

1.2 Dementia is an umbrella term for a range of conditions which impact upon the functioning of the brain. The most common types are Alzheimer's disease and vascular dementia; less common forms include Lewy bodies and frontotemporal dementia.

1.3 Dementia is not a normal part of aging and will affect people differently. Symptoms can include problems with memory, thinking, concentration and language. One may become confused, have changes in mood, behaviour and emotion.

1.4 Recognition has also been given to the importance of achieving timely assessment for possible dementia. Diagnosing dementia, and the type of dementia someone has is important. It will ensure that people with dementia get the right support and treatment quickly and can plan for the future.

1.5 In most cases the person's G.P is the first person to be contacted and if dementia is suspected a referral will be made to a memory clinic or specialist. G.P's will also routinely ask certain patients who are at high risk of developing dementia whether they are concerned about their memory. This includes patients with Parkinson's disease, those who are over 60 and have diabetes or a heart condition and those with a learning disability.

1.6 However, making a diagnosis of dementia can be difficult, particularly at the early stages as there is no one simple test for the condition and symptoms can be very similar to many other common conditions.

1.7 There is also considerable evidence that despite the headway that has been in developing "dementia friendly" communities, there is still considerable fear of a diagnosis of dementia. This can have a profound effect on the willingness of individuals to acknowledge that there may be a problem and to seek help from their G.P.

1.8 As with many other conditions, early diagnosis of dementia can have a positive impact on how the progress of condition is managed and on the quality of life of the patient, their family and carers.

1.9 Recent government figures suggest that at both local and national levels there have been significant improvements in diagnosing dementia and in developing subsequent care pathways. This report looks at dementia diagnosis in Hartlepool from the perspective of both G.P practices and patients, their families and carers. A copy the NICE Dementia Pathway guidance is shown in Appendix 2.

2. Methodology

2.1 Healthwatch Hartlepool decided to look at the issue of dementia diagnosis as part of its ongoing interest in the provision of dementia care and treatment services.

2.2 Also, despite indications that diagnosis rates in the Hartlepool and Stockton Clinical Commissioning Group (HAST CCG) area were improving, concerns were identified that some patients were reluctant to acknowledge that they were experiencing memory problems due to stigma (perceived or otherwise) associated with the condition.

2.3 In November 2015 questionnaires were sent to all G.P surgeries in Hartlepool. The questionnaire asked about the process the individual practices followed with patients from a possible problem being identified through to diagnosis and ongoing treatment and support.

2.4 In total, eight practices returned the questionnaire, a copy of which, together with a summary of the responses received can be found at Appendix 1.

2.5 At the same time we also visited Caroline Ryder-Jones from TEWV who described the work which is undertaken through the Memory Clinic with patients who have been referred to them from G.P's and by other means.

2.6 Finally, a series of discussions took place with individuals and groups of patients and carers who have recent experience of dementia diagnosis. In total, we spoke to more than 30 patients and carers but encountered some difficulties finding people who were willing to talk openly about their experiences.

3. Findings

3.1 G.P Feedback

(i) Generally, we received a positive impression of the dementia diagnostic services provided by the eight practices who returned questionnaires. It must be said however, that overall, practices were slow to respond and despite several reminders only 50% of the practices in the town returned the questionnaire.

(ii) There was a clear indication that all surgeries undertake preliminary examinations and screening of patients if dementia is suspected. This includes blood and urine tests as well as basic memory tests (such as the 6 CIT test). Some Practices said that patient history and general mental health were also considered.

(iii) Several practices said that they had detailed discussions with patients/carers /family members at this stage and consent was gained to investigate further.

(iv) All practices indicated that a referral to the Memory Clinic would be made once initial tests had been concluded and results indicated that further investigation was needed.

(v) On receiving confirmation of a dementia diagnosis from the Memory Clinic, most practices indicated that the patient was added to their Dementia Register and would subsequently be called to an annual dementia review meeting. Most practices also said that they would be involved with other agencies in planning subsequent nursing and social care inputs.

(vi) Most practices said that dementia diagnosis had shown a slight increase in the previous two years. They also commented that patients were generally more aware of the condition and its symptoms and therefore more prepared to request screening at an earlier stage. Some also commented that greater awareness was also leading to relatives and carers being more likely to raise concerns.

(vii) In general, practices are promoting awareness and the importance of early diagnosis through surgery based information and discussions during consultations. It was also reported that national publicity is also helping to raise awareness levels.

(viii) Some practices said that patients were waiting slightly longer to access Memory Clinic appointments but overall, waiting times were not seen as excessive and all practices were of the opinion that diagnostic and treatment services have improved.

(ix) All practices that responded have provided staff training around dementia and in most cases this has included administrative and reception staff. Some reported using e-learning packages and others said that staff received annual dementia updates and that the issue was regularly discussed at team meetings.

(x) Some practices reported offering newly diagnosed patients care planning meetings which recognise the individual nature of each patient's dementia and seek to develop care packages which are right for that person. Patients are also encouraged to bring a relative or carer to review meetings whenever possible.

(xi) Most practices also reported that they have made attempts to make surgeries dementia friendly with examples being the use of easy read signage and introducing longer appointments.

(xii) Practices also reported that systems were in place to flag up patients who were at particularly high risk of dementia. In some practices patients with Learning Disabilities were offered dementia screening as part of their annual health check although some difficulties were reported in administering the 6 CIT test.

3.2 Patient/Carer/Family Feedback

(i) Around 30 patients, carers and family members with recent experience of the dementia diagnosis process have input into our investigation. This has been through one to one discussions and larger focus group events. We are extremely grateful to all those who have taken time to speak to us and their input is are extremely valuable.

(ii) Gathering information has proved to be quite difficult and on occasions people have been reluctant to talk about their experiences. We feel that this indicates that despite the enormous amount of excellent work that has happened over recent years aimed at raising awareness and understanding of dementia, it is still a condition which some patients are reluctant to talk about.

(iii) It is often said that each person with dementia will have their own individual experience of the condition. Our investigation indicates that this can also be said about the experiences individual patients have during the diagnostic process. The feedback we received from G.P's shows that broadly similar diagnostic processes are being followed and that pathways which leads to a referral to the Memory Clinic are fairly consistent. However, the point at which diagnosis occurs and the emotional, psychological and personal impacts on individuals vary greatly.

(iv) Some patients reported that they thought they had dementia before they spoke to their G.P –

"I know the signs and knew I had it even before I went to see my doctor"

For others it came as a complete surprise and in some cases was picked up as a result of other medical inputs.

"I went for an eye test and the optician said I should see my G.P"

(v) Some patients reported that a significant issue or event had caused them to consult their G.P -
"I was driving home from work after a training day. I got to a roundabout and could not remember what to do"
Others said that friends or relatives had noticed changes before they had themselves, and on occasions, a significant period of time could pass before they raised concerns with their G.P.

(vi) In all cases, both patients and family members reported that this was a particularly stressful time for all concerned and in most instances the referral to the Memory Clinic was triggered by the G.P although one patient said that their referral had happened via the hospital and two others said that they were referred following a stay in Sandwell Park.

(vii) Both patients and family members reported that generally once a referral to the Memory Clinic happened, the appointment came through quickly.

(viii) The diagnosis process is extremely stressful for patients and their families and carers. Concerns were raised by some patients about information and communication during the diagnosis process and in some instances poor communication had increased stress and anxiety –
"I felt that the way I was given my diagnosis was insensitive……I felt like there was no hope at all"
"I still don't know what type of dementia I have and what can be done"
"It was one of the most stressful times of my life"
However, some patients reported that communication had been good and they were kept well informed at all stages.
"My G.P was good, I was referred quickly and he kept me well informed".

(ix) Some patients reported that their individual diagnosis had taken several months to complete. This was most common among those patients who had experienced the onset of dementia in their 50's or early 60's. It was reported that in such cases G.P's had initially looked

to rule out other conditions before dementia was considered. In one instance a patient reported that their initial diagnosis had been for depression and that they had gone through a very traumatic period before their dementia was properly diagnosed.
"It took an age to get my diagnosis …….and I am still not sure what it all means"

(x) Patients and family members often reported that they had been given information verbally and in written form but had found it too much to take in and retain at the time and consequently were now unclear about their diagnosis and how the condition was likely to develop.

(xi) The impact on carers and family members can be immense both during diagnosis and subsequently. During the course of our investigation we heard many powerful accounts of the life changing impact the condition has on individuals, carers and family members.

(xii) Several patients and family members reported that their decision to see their G.P had been made following a visit to The Bridge where they were given information and advice about dementia and the importance of early diagnosis. Feedback regarding the Bridge and the work it does in supporting individuals with dementia and their families and carers, was extremely positive.

(xiii) Some patients commented that they had received very little post-diagnosis support from their G.P. Most surgeries who returned questionnaires indicated that patients with dementia will have an annual health check during which their condition is reviewed. They also reported that patients could also see their G.P at any time by appointment if needed.

4. Conclusions

4.1 Overall there was evidence that diagnosis and associated procedures have improved across the G.P practices that returned questionnaires. Awareness levels amongst all staff appear to have improved and staff training on dementia awareness now happens routinely in most Practices. This includes administrative and reception

staff as well as well as G.P's and nurses. However, service development in this area is still a "work in progress" and there is still scope for further improvement.

4.2 Diagnosis of dementia for an individual, their family and carers is still an extremely difficult and traumatic process. There was evidence that some patients and their families feel that there is still a stigma attached to the condition and this can impair their willingness to seek help and support at an early stage.

4.3 Much has been done to address some of the misconceptions and prejudice around the condition, but more is needed if the ambition of creating truly "dementia friendly communities" is to become a day to day reality.

4.4 Concerns were raised by some patients about the level of ongoing support they received once diagnosed. This suggests that improvements could be made to this aspect of ongoing care and consideration given as to how understanding can be checked at diagnosis.

4.5 Evidence was presented by those with dementia and family members and carers which showed that communication processes at all stages of diagnosis can be problematic. We acknowledge and accept that due to the nature of the condition and the stressful nature of diagnosis, communication can be difficult. However, it is not acceptable for patients to be unclear about any aspect of their diagnosis and its implications for the future. Every effort should be made to ensure that all parties are kept fully informed, and as far as is practicably possible have understood all aspects of diagnosis and ongoing implications.

4.6 Patients who had experienced the onset of dementia at an early age more frequently reported problems and delays in reaching a diagnosis of their condition, and in one instance the patient had been incorrectly treated for depression for a period of time. In some instances these patients also found it hard to accept and come to terms with the diagnosis as the condition was seen as "something that only happens to old people". We accept that our sample group is

relatively small but it does seem to indicate that some further work is needed in order to develop the support received by this age group during diagnosis and beyond.

4.7 Communication between G.P's and the Memory Clinic in most instances appear to be working reasonably well and as stated earlier the introduction of The Bridge Centre has been extremely helpful in providing additional information and support to patients and family members.

5. Recommendations

5.1 That the findings and conclusions above are noted and acted upon by all relevant parties and that Healthwatch Hartlepool continues to monitor the ongoing development of patient experience of service delivery in this area.

6. Acknowledgements

Healthwatch Hartlepool would like to thank all organisations and individuals who have provided our members with information and hospitality during the course of this investigation; their help has been invaluable.

Appendix 1

Healthwatch Hartlepool
Dementia Diagnosis and Pathways Questionnaire

1) When a patient comes for a consultation, and describes/displays symptoms which suggests dementia as a possible/probable prognosis how would you proceed?
*A template such as a G.P log is used to assess and depending on the results of this patient will be offered blood tests for dementia screening including calcium, vitamin B12 and folates. A referral to memory services would also be initiated depending on results.
*Look at patient history, duration of issues and mental state. If further examination needed, bloods and ECG.
*Do basic assessment as per Tees Dementia Screening.
Ask if patient has any concerns with memory. If yes ask patients consent to assess. Undertake GPCOG if consent given. Depending on score, bloods and urine taken and refer to Memory Clinic. Also discuss with family/carer.
*Discuss if the patient would like to proceed further. Gain consent to screen/investigate. Establish if the patient has capacity to make decision.
*GP takes a detailed patient history, particularly around symptoms associated with dementia. Clinician does CIT scoring test, if return score over 8 patient is referred to Memory Clinic.
*Check bloods/MMT screening and refer to Memory Clinic (2)
2) At what stage would a patient be referred to the Memory Clinic in order to access, diagnosis and support?
*As soon as concern is expressed or identified.
*If there is demonstrable cognitive impairment on MMT
*If score 8 or more on test will be referred.
*If the screening test showed referral appropriate and all tests have been completed.
*Once tests have been completed an assessment is done
*Following investigation and mental state examination a referral is made to Memory Clinic.
*If symptoms and or results of blood tests and GP log show

possibility of diagnosis patient is referred.
3) What ongoing involvement do you have with the patient regarding their condition once they have accessed the Memory service regarding their memory condition?
*Annual review as a minimum standard or earlier if needed. Blood test also done annually or sooner if needed.
*Depends on risk factors and patients circumstances, eg living independently, in a care home etc.
*Annual review, medication request.(2)
*Would deal with any medical problems as we normally do and await feedback from Memory Clinic. Arrange any nursing or social service interventions as appropriate.
*Provision of medication under shared care guidance. All patients with dementia diagnosis has it placed on their medical record. Other primary care services as normal.
*If a patient is diagnosed they will be added to our practice dementia register. They will be invited for yearly dementia reviews and the relevant GP will create a dementia care plan. As always patients have open access to GP's.
*Followed up in routine clinics after we receive results from the Memory Clinic. Added to practice dementia register.
4a) Over the last two years has the level of dementia diagnosis at your practice changed, if so please quantify?
*Increased due to improved screening and awareness. Also patients more forthcoming.
*Yes, increased.(2)
*Unable to say for certain.
*Yes 1% more.
*2014 80.9 (Q4), 2013 83.7, National average 62.06
*Patients have requested screening more as more aware so yes.
*This has increased due to our quality improvement scheme. Patients with certain chronic diseases such as stroke/PVD or diabetes over 60 or COPD, Downs Syndrome records flagged to carry out tests if any concerns.
4b) Are patients raising memory related concerns with you at an earlier stage, and if so why?
*Yes, the subject of dementia is more frequently mentioned and

patients are asked routinely whether they have any problems, which is highlighting issues at an earlier stage
*Yes, more concern around memory, can investigate more quickly and reach diagnosis.
*Yes possibly due to TV coverage.
*Have not seen any particular increase. Practice has increased screening/prompts to patients. We have flagged patient records who have learning disabilities and other high risk groups.
*Yes carers are also raising more concerns. More awareness of the issue generally.
*Often relatives of patients raise concerns. Patients are often concerned about raising memory problems for fear of what the diagnosis may be.
Yes – More awareness
4c) Has the time it takes for patients to access the Memory clinic changed, if so please quantify?
*Waiting time increased due to volume of referrals.
*Don't know 4
*Couldn't say for certain but since start of enhanced service and quality improvement schemes relating to dementia, the number of referrals has most likely increased leading to longer waiting times.
*Patients referred are seen fairly quickly.
5) In your opinion, over the last two years, have diagnostic and subsequent treatment services for patients with dementia – • **Improved Greatly □2** • **Improved a little □6** • **Stayed the Sane □** • **Have become a little worse? □** • **Have become a lot worse? □**
6a) What steps have been taken at your Practice to improve staff awareness and understanding of dementia and challenge associated stigma?
*Included in staff training programmes
*All patients considered to be more at risk of memory problems have alerts coded to their records. This prompts clinical staff to carry out 6CIT test. All relevant staff receive required training to help keep them up to date with patient needs.

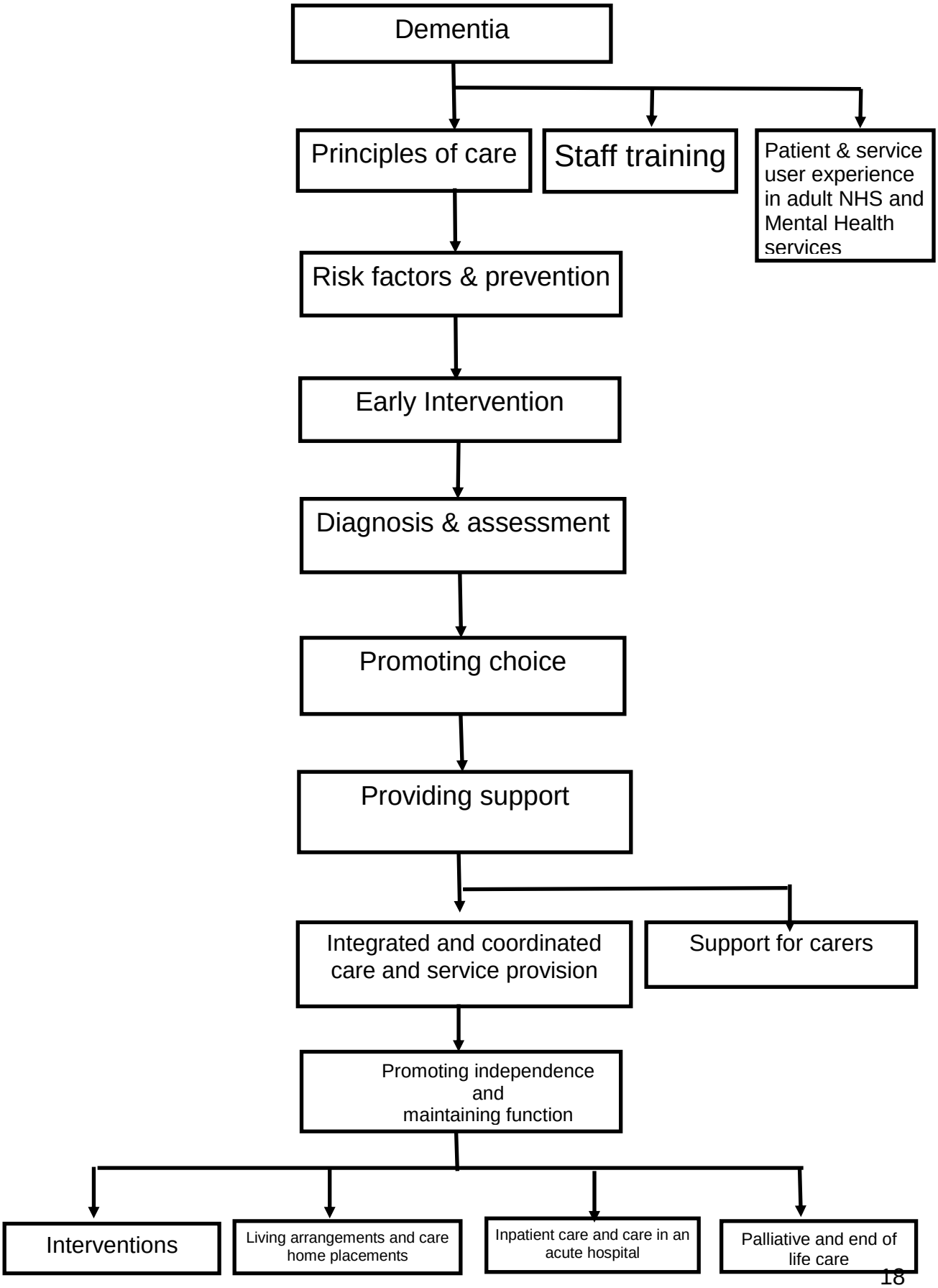
*Staff raise problems encountered. If changes in patient behaviour are noticed they are raised.
*Arranged training for reception and administrative staff in April 2016.
*Annual updates and regular discussion at Practice meetings.
*Using dementia e-learning package
We have recently signed up to have training for all staff to become Dementia Friends. This will run in 2016.
6b) Please give details of any mandatory training which clinical and administrative staff undertake around dementia ay your Practice?
*All practice staff undergo Adult safeguarding training. The G.P's also have training in mental health capacity each year. G.P's and Practice Nurses also attend time out sessions on dementia. (2)
*E-Learning training has been undertaken by few. Will ensure all staff (including admin) undertake dementia e-learning in coming months.
*Yearly dementia updates
*Access online training via Time Out. Attend town wide training session for GP's/Nurses
*G.P's attend regular updates as required. All nursing and admin staff have access to electronic training modules and time to complete training
*Time out sessions, lunch and learn and dementia with lewy bodies.
7) What steps have you taken to promote the importance and benefits of early diagnosis and care?
*G.P's carry out cognitive tests routinely
*Posters/leaflets are displayed.
*Undertook the 2014/15 Dementia DES. Flagged with wall charts in consultation rooms.
*Increased screening/prompts to patients and flagged patient records in high risk groups.
*Discuss any problem with patient and relatives.
*Early intervention – diagnosis – treatment – better care
*We signed upto a quality improvement scheme aimed at facilitating early diagnosis and support for dementia patient.

8) What steps do you take to ensure that patients and carers are included in all stages of diagnostic and subsequent treatment pathways?
*Care plans are developed and carers identified
*It's been Practice policy to include patients and their carers in all stages of diagnostic and subsequent treatment pathways for better outcomes. We believe in providing a holistic outcome.
*Regularly update them with dedicated clinics at surgery
*Patients newly diagnosed are offered care planning meeting. Carer/family is offered health check if our patient to assess their needs. All patients with dementia are offered annual dementia reviews.
*Active involvement encouraged as with all conditions. Patient centred and specific to the individual.
*As part of the dementia care plan a named relative is included on plan. Patients attending for dementia review are always advised to bring a relative or friend to their appointments.
*Patients with firm diagnosis are followed up by Memory Clinic offered support.
9) How is ongoing assessment and care planning agreed and co-ordinated with patients, carers, memory clinic and other agencies?
*Emergency healthcare plans in place in home environment.
*Diagnosed patients attend yearly reviews of their care plans with named G.P. Practice has encountered some issues with secondary care agencies, often long waiting time to receive care plans from care homes etc.
*Patients are seen annually at practice or at home to review care plan along with carer or family member were appropriate.

10) What steps have been taken within your Practice to ensure your surgery is "dementia friendly" in the following areas -
Physical Environment
*We are a small surgery on one level, we use easy read signage to access clinical rooms
*New premises.2
*L.D/Dementia friendly signage

*****Physical access to surgery is easy. Open access to G.P's means patients can be seen when needed.
Signage
*Easy read signage and leaflets are available.2
*We are working on it
*New purpose built premises2
*Posters in waiting room could be improved.
Appointment Systems
*Longer appointments if required with G.P. Also 30 minute health check with nurse for all dementia patients.
*Flexible timewise, and reminders sent.
*Extended appointments are available
*Fully triaged appointment system with phone/online access. Exceptions list for direct booking of patient appointments for those with other needs.
*Open access to G.P's
11) How do you ensure that patients with Learning Disabilities and sensory loss do not go undiagnosed and unsupported regarding the onset of dementia?
*Increased awareness, follow up complaints, clinical decisions
*Annual review for these patients with pro-active memory assessment if needed.
*G.P's have found it very difficult to conduct 6 CIT on patients with LD as they often don't understand the purpose of the test. Raising concern in next Practice meeting with LD team.
*Offered annual physical medical checks to patients with LD, opportunistic screening.
*Annual assessment3
*Patients over the age of 50 with LD have a flag on their records to show they are at risk of developing dementia. Clinicians raise this issue opportunistically and offer screening if appropriate.
12) Have you any comments or suggestions as to how diagnostic and treatment pathways could be improved in any way?
*Continue with awareness training for all.
*Early appointments at Memory Clinic.
*Improve communication and planning with other agencies, maybe get together every three months and discuss patients.

Appendix 2 (taken form NICE Dementia Pathway guidelines)



HEALTH AND WELLBEING BOARD

16 January 2017

Report of: Director of Child & Adult Services

Subject: Better Care Fund: 2016/17 Q2 Return

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1. PURPOSE OF REPORT

1.1 To present to the Health and Wellbeing Board the 2016/17 Q2 BCF return.

2. BACKGROUND

2.1 The Better Care Fund has six National Conditions that need to 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 national 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 are 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 are 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 is monitored nationally by NHS England.

3. BCF Q4 RETURN & PERFORMANCE DATA

3.1 BCF performance reports were submitted to NHS England on a quarterly basis throughout 2015/16 and the requirement for quarterly submissions has been maintained for 2016/17. The deadline for submission of the Q2 return (covering the period July – September 2016) was 25 November 2016.

3.2 The 2016/17 Q2 return is attached at **Appendix 1** and indicates that all national conditions are being achieved.

3.3 In relation to performance measures:

Permanent Admissions to Residential and Nursing Care Homes
The target for 2015/16 was achieved, with the number of admissions significantly reduced when compared to the previous twelve months. This reduction was partly attributable to the range of alternatives to residential care developed over recent years and which are now supported, or have been further enhanced, through the Better Care Fund. These services include low level support, telecare, reablement, extra care and housing related support, as well as support for carers to maintain their caring role.

It should be noted though, that the reduction achieved was also affected by an unusually high number of admissions to residential care in 2015/16 of people who fund their own care and do not receive support from the Council. This factor is very volatile and it is not possible to forecast with accuracy the proportion of admissions of this nature for future years.

On this basis the target set for 2016/17 is challenging, in that it represents a further reduction when compared to the 2015/16 target, but realistic in that no assumption has been made that the unusually high proportion of people who fund their own care will be replicated in 2016/17.

Q2 data for 2016/17 indicates that admissions continue to increase when compared to last year, so it should be noted that the 2016/17 target will not be achieved if this trend continues throughout the year.

This is a measure that is very closely monitored by the Council on a monthly basis, and any changes to trends are highlighted and examined.

Proportion of older people still at home 91 days after discharge from hospital into reablement / rehabilitation services
There was a slight reduction in the percentage of people still at home 91 days after discharge from hospital to reablement / rehabilitation services in 2015/16, compared with the previous year. It is recognised that, on reflection,

the target of 89.2% was very challenging and potentially unrealistic in the context of the complex needs of many people who are discharged from hospital into these services.

It should be noted that this measure of how effective reablement services are only considers a subset of all people who access reablement services, with many people accessing the service from the community as a preventative measure. Local measures indicate that 583 reablement packages were started in 2015/16 with 78.4% of people having no ongoing social care needs following provision of a completed reablement package and 91.5% of reablement goals achieved at the end of a period of reablement.

The target set for 2016/17 demonstrates ambition to improve on performance in 2015/16, while also being realistic about what is achievable for this client group. Data for Q1 of 2016/17 recorded performance of 70% against a target for the year of 83.1% (13.1% below target). Q2 performance is 76.1%, which is an improvement when compared to Q1 but still 7% below target. Further analysis is being undertaken to understand the reasons for this decrease, and to track outcomes for people who are not still at home after 91 days (which may be due to readmission to hospital, admission to a care home or death). This work will also review whether the data is appropriately capturing those people with reablement potential on discharge from hospital.

<u>Delayed transfers of care (DToC) from hospital per 100,000 population (days delayed)</u>
The planned target for Q2 of 342.4 days delayed was not achieved and actual performance was 1892.5. Compared to the same period in 2015/16, this is a +233% increase.

In terms of provider level split for the year to date, 92% of delays are from North Tees and Hartlepool Foundation Trust. The total delay from this Trust (April-September) is 2,050 days and of these delays, 58% are due to nursing bed availability and 25% due to family/patient choice.

Multi-agency work is underway to specifically look at delayed transfers of care and the development of an Integrated Discharge to Assess Pathway.

<u>Total non-elective admissions into hospital per 100,000 population</u>
The planned target for Q2 of 2,873 non-elective admissions was not achieved and actual performance was 3,161. Compared to the same period in 2015/16, there has been an increase in admissions of 11.7%.

The greatest increase is in Ambulatory Care, accounting for almost 50% of the increase and the increase is across all age bands, although the lowest growth is in people aged over 65. 0-19 year olds shows a 26.7% increase, 19-64 year olds a 20.3% increase and over 65 year olds a 9.0% increase.

As a percentage of total admissions, the ‘65 & over’ category contributes to 39% of admissions, which is an improvement from 40% in Q1 and 42% for the same period in 2015/16.

Further detailed analysis is to be carried out to understand the impact of the increase in activity.

Estimated diagnosis rate for people with dementia
The target for 2016/17 is 76.13%. September 2016 performance is 76.88% which is over target by 0.75% and an improvement from Q1.

3.4 Local performance indicators are also used to evidence impact of the BCF.

3.4.1 Use of Assistive Technology
Investment in assistive technology in Hartlepool has enabled the number of people receiving support to grow on an annual basis for the last five years with over 2,100 people using assistive technology at the end of September 2015. Investment in different forms of technology has enabled the service to support a wide range of people including adults with learning and physical disabilities and people with dementia, as well as being available to all over 75s and a feature of extra care schemes. Feedback from people accessing the service is positive, and the service is an essential part of the wider strategy to support people to stay independent in their own homes for as long as possible. BCF funding has been identified to sustain and further expand the service, which will include exploring how telehealth can be better utilised. The table below demonstrates the uptake in assistive technology by Hartlepool residents.

Time Period	**Number of clients accessing assistive technology**
2012/13	1,102
2013/14	1,615
2014/15	1,970
2015/16	2,173
2016/17Q1	2,346

3.4.2 Support for Carers
It is recognised that carer breakdown can be a factor in hospital admissions and care home admissions, and evidence suggests that providing carers with support enables them to continue in their caring role for longer, preventing the need for more intensive and costly health and social care interventions. BCF funding is used to fund carers support services, including Direct Payments that provide carers with a break from their caring role. The table below identifies the proportion of carers who have received support.

Time Period	**Proportion of carers receiving assessment / information & advice / carers services**
2012/13	40.1%
2013/14	65.1%
2014/15	64.3%
2015/16	85.4%

The table below identifies the proportion of carers being supported by a Direct Payment (this indicator was introduced in the Adult Social Care Outcomes Framework in 2014/15 so data is not available prior to that date).

Time Period	Proportion of carers receiving a Direct Payment
2014/15	65.3%
2015/16	68.6%
2016/17 Q1	81.4%

3.4.3 Effectiveness of Reablement Services

Regional measures have been developed to measure the effectiveness of reablement services, including a measure of the proportion of reablement goals achieved at the end of a period of reablement.

Time Period	Proportion of reablement goals achieved at the end of a period of reablement
2014/15	87%
2015/16	91.5%
2016/17 Q1	92.5%

3.4.4 Overall satisfaction of people who use services with their care and support

The recent annual national survey of people who use adult social care services demonstrates that overall satisfaction of people using adult social care in Hartlepool has increased.

Time Period	Overall satisfaction of people who use service with their care and support
2014/15	64.6%
2015/16	67.9%

4. BCF PLANS FOR 2016/17

4.1 Plans for 2016/17 aim to build on achievements in 2015/16, with a particular focus on admission prevention and closer working with primary care.

4.2 Work has been undertaken to review services that are currently funded by the BCF to clarify their impact. The outcome of the review will be reported to the BCF Pooled Budget Partnership Board in February 2017.

5. RISK IMPLICATIONS

5.1 A risk register was completed as part of the original BCF plan with mitigating actions identified and this was updated for the 2016/17 plan.

6. FINANCIAL CONSIDERATIONS

6.1 The BCF Pooled Budget is hosted by Hartlepool Borough Council and governed through the Pooled Budget Partnership Board.

6.2 The BCF Pooled Budget was fully committed in 2015/16 with slippage used to support one off pressures in adult social care and Disabled Facilities Grants.

6.3 Plans have been agreed that fully commit the budget for 2016/17 and the budget will continue to be monitored throughout the year by the Pooled Budget Partnership Board.

7. LEGAL CONSIDERATIONS

7.1 The legal framework for the pooled budget is a Section 75 Partnership Agreement.

7.2 A Section 75 Partnership Agreement was in place for 2015/16 and a new agreement was signed for 2016/17, in line with the national requirement to have this in place by 30 June 2016.

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. RECOMMENDATION

12.1 It is recommended that the Health and Wellbeing Board notes the 2016/17 Q2 return, which was submitted on behalf of the Health and Wellbeing Board using delegated authority as agreed previously.

13. REASONS FOR RECOMMENDATION

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

14. CONTACT OFFICER

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Cover

Q2 2016/17

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)

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	36
4. I&E	15
5. Supporting Metrics	13
6. Additional Measures	67
7. 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 had not been previously stated that the funds had been pooled can you confirm that they have now?	
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 a previous quarterly collection returned 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 have been met, 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 an explanation as to why the condition was not met within this quarter (in-line with signed off plan) and how this is being addressed?

Condition (please refer to the detailed definition below)	Q1 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)	If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:
1) Plans to be jointly agreed	Yes	Yes		
2) Maintain provision of social care services	Yes	Yes		
3) In respect of 7 Day Services - please confirm:				
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	Yes		
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	Yes	Yes		
4) In respect of Data Sharing - please confirm:				
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes	Yes		
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes		
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes	Yes		
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	Yes	Yes		
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes		
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes		
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes		

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight 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 Review, 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, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. 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. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also 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) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

- To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
- To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number

The appropriate and lawful 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 consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:
- confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
- confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
- ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
- ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

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 named care coordinator, 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 care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.

This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

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 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	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	£2,537,906	£1,674,842	£1,674,842	£1,674,842	£7,562,432	£7,562,432
	Forecast	£2,537,906	£1,674,842	£1,674,842	£1,674,842	£7,562,432	
	Actual*	£2,537,906					

Q2 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	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	£2,537,906	£1,674,842	£1,674,842	£1,674,842	£7,562,432	£7,562,432
	Forecast	£2,537,906	£1,674,842	£1,674,842	£1,674,842	£7,562,432	
	Actual*	£2,537,906	£1,674,842				

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q2 actual differs from the Q2 plan and / or Q2 forecast	

Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	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	£1,890,608	£1,890,608	£1,890,608	£1,890,608	£7,562,432	£7,562,432
	Forecast	£1,890,608	£1,890,608	£1,890,608	£1,890,608	£7,562,432	
	Actual*	£1,767,000					

Q2 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	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	£1,890,608	£1,890,608	£1,890,608	£1,890,608	£7,562,432	£7,562,432
	Forecast	£1,767,000	£1,694,000	£2,050,716	£2,050,716	£7,562,432	
	Actual*	£1,767,000	£1,694,000				

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q2 actual differs from the Q2 plan and / or Q2 forecast	The forecast phasing of expenditure has been amended to reflect the later start date of a couple of schemes and the Disabled Facility Grant capital expenditure which was forecast to spend equally across the year. The grant is fully committed however owing to timing issues and the nature of capital expenditure the phasing will be for expenditure to be incurred later in the year than originally forecast.

Commentary on progress against financial plan:	The BCF allocation is fully committed in 2016/17 and will be fully spent by the end of the financial year.

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. Pre-populated Plan, Forecast and Q1 Actual figures are sourced from the Q1 16/17 return previously submitted by the HWB.

National and locally defined metrics

Selected Health and Well Being Board:	Hartlepool

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	There has been a continuous increase in Non-Elective admissions. When comparing YTD positions for 15/16 and 16/17 there has been a 16.6% increase. The increase is across all age bands but the lowest increase is in the over 65's (9%) (0-19 age group is 26.7%, 20-64 age group is 20.3%). The highest increase is in Ambulatory Care showing a 37% increase when comparing the six month period with

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	There is a significant issue with availability of nursing home beds in Hartlepool and patients are being requested to look at suitable alternatives in out of borough homes. There are a small number of patients refusing to leave hospital for an out of area placement who are accounting for a high number of days delayed including full months in some cases.

Local performance metric as described in your approved BCF plan	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:	On track to meet target

Local defined patient experience metric as described in your approved BCF plan	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:	Annual measure so reviewed on an annual basis.

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Latest available data indicates that this target is unlikely to be acheived in 2016/17. Further work is being undertaken to understand the reasons for the recent increase in admissions.

Additional Measures

Selected Health and Well Being Board: Hartlepool

Improving Data Sharing: (Measures 1-3)

1. Proposed Measure: 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 Measure: 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	Live	In development	In development	In development	In development	In development
Projected 'go-live' date (dd/mm/yy)		01/04/17	01/04/17	01/04/17	01/04/17	01/04/17

3. Proposed Measure: 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

Other Measures: Measures (4-5)

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

Total number of PHBs in place at the end of the quarter	53
Rate per 100,000 population	57.1

Number of new PHBs put in place during the quarter	7
Number of existing PHBs stopped during the quarter	2
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	55%

Population (Mid 2016)	92,899

5. Proposed Measure: 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?	Yes - in some parts of Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures were updated to the mid-year 2016 estimates as we moved into the new calendar year.

Narrative

Selected Health and Well Being Board: Hartlepool

Remaining Characters	30,819

Please provide a brief narrative on overall progress, reflecting on performance in Q2 16/17. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

• Daily Discharge Planning Meetings continue with representatives from health and social care working closely to support coordinated discharge of patients and ensure reduced likelihood of bottle-necks within the system.
• HBC altered staff working patterns to make Saturday and bank holiday cover a permanent arrangement to help facilitate discharges from hospital. DLT pilot has now been completed and consultation undertaken with staff. DLT recommenced 6 day working from end of August.
• Additional posts recruited within social care to facilitate the handover of rapid response cases into social care within 5-7 days (as per enhanced EIS model). New cases handed over after 1 September to be transferred within 5-7 days with RRN team identifying priority cases via DDPMs.
• Proposal for education and training for care homes was considered by the PBPB in September and funding was agreed for a one year pilot.
• 2016/17 BCF plan was submitted and approved.
• Service reviews undertaken for all services funded from BCF pooled budget in 2015/16 to demonstrate impact.
• Community based model to support risk stratification and care coordination around GP practices is being progressed.
• Work ongoing with COPD services focused on admission avoidance.
• HBC falls prevention service linked with early intervention model based at UHH.
• Home from hospital proposal was considered by the PBPB in September and funding agreed for a two year pilot.
• Initial meeting held to look at integrated SPA options across Stockton-on-Tees and Hartlepool and regular meetings proposed going forward.
• HBC has commissioned a befriending network (initially as a 12 month pilot), outside of BCF, to support the aim of reducing social isolation.
• Feedback from iMPOWER work supports the proposed SPA integration and indicates that preventative services are generally effective, with some opportunities to reshape and better target the prevention offer.