HEALTH AND WELLBEING BOARD

AGENDA

HARTLEPOOL BOROUGH COUNCIL

23 September 2019

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 Buchan, Thomas, Moore and Ward.
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group – Dr Timlin and Nicola Bailey
Director of Public Health, Hartlepool Borough Council – Dr Pat Riordan
Director of Children's and Joint Commissioning Services, Hartlepool Borough Council – Sally Robinson
Director of Adult and Community Based Services, Hartlepool Borough Council, Jill Harrison
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 – Denise McGuckin
Assistant Director of Joint Commissioning, Hartlepool Borough Council – Danielle Swainston
Representative of the NHS England – Dr Tim Butler
Representative of Hartlepool Voluntary and Community Sector – Tracy Woodall
Representative of Tees, Esk and Wear Valley NHS Trust – Dominic Gardner
Representative of North Tees and Hartlepool NHS Trust – Deepak Dwarakanath / Julie Gillon
Representative of Cleveland Police, Lisa Orchard
Representative of GP Federation – Fiona Adamson
Representative of Headteachers - Julie Thomas

Observer – Statutory Scrutiny Representative, Hartlepool Borough Council

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 1 July 2019

4. **ITEMS FOR CONSIDERATION**

4.1 Improving Outcomes for Children and Young People (Integrated Working) – *Hartlepool and Stockton-on-Tees Clinical Commissioning Group*

4.2 Children and Young People's Mental Health – Local Transformation Plan – *Hartlepool and Stockton-on-Tees Clinical Commissioning Group and Director of Children's and Joint Commissioning Services*

4.3 All Age Carers Strategy – *Director of Children's and Joint Commissioning Services and Director of Adults and Community Based Services*

4.4 Clinical Commissioning Group Annual Report 2018/19 – *Director of Commissioning, Strategy and Delivery (Locality Commissioning Director – Hartlepool and Stockton-on-Tees CCG and Darlington CCG)*

4.5 SEND (Special Educational Needs and Disabilities) Improvement Plan Progress – *Director of Childrens and Joint Commissioning Services and Stockton-on-Tees Clinical Commissioning Group*

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

Date of next meeting – 2 December 2019 at 10.00 a.m. at the Civic Centre, Hartlepool.

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

1 July 2019

The meeting commenced at 10 a.m. in the Civic Centre, Hartlepool

Present:

Councillor Moore, Leader of Council (In the Chair)

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors Buchan, C Richardson (as substitute for Councillor Thomas) and Ward
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group – Dr Nick Timlin and Nicola Bailey
Director of Children's and Joint Commissioning Services, Hartlepool Borough Council – Sally Robinson
Director of Adult and Community Based Services, Hartlepool Borough Council, Jill Harrison
Representatives of Healthwatch - Margaret Wrenn
Other Members:
Assistant Director of Joint Commissioning, Hartlepool Borough Council – Danielle Swainston
Representative of Cleveland Police – Steven Graham
Representative of Tees, Esk and Wear Valley NHS Trust – Dominic Gardner
Representative of North Tees and Hartlepool NHS Trust – Julie Parkes (as substitute for Dr Dwarakanath)
Representative of GP Federation – Fiona Adamson
Representative of Headteachers – Julie Thomas
Observer – Statutory Scrutiny Representative, Hartlepool Borough Council - Councillor Hall

Also in attendance:-
Councillor Harrison, Hartlepool Borough Council
Cath Hitchen, SEND Professional Adviser, Department for Education

Hartlepool Borough Council Officers:
Craig Blundred, Deputy Director of Public Health
Joan Stevens, Statutory Scrutiny Manager
Amanda Whitaker, Democratic Services Team

1. Apologies for Absence

Elected Member, Councillor Thomas

Director of Public Health, Hartlepool Borough Council – Dr Pat Riordan
Denise McGuckin, Director of Regeneration & Neighbourhoods
Representatives of Healthwatch - Ruby Marshall
Representative of the NHS England – Dr Tim Butler
Representative of Hartlepool Voluntary and Community Sector – Tracy Woodall

2. Declarations of interest by Members

Councillor Ward declared a personal interest as a Director of a Wellbeing Company

3. Minutes

The minutes of the meeting held on 4 March 2019 were confirmed.

4. Review of the Role and Purpose of the Health and Wellbeing Board (*Director of Public Health*)

The report set out proposals with regard to the strategic approach to improving Health and Wellbeing outcomes. The Board was requested to review the following proposals:

- There is a need to identify the top five issues that have the most significant impact on the health and wellbeing of the population of Hartlepool.
- That we determine the key health and wellbeing outcomes which we seek to achieve in relation to these issues.
- We jointly agree to the development of five multi-agency workstreams to deliver the high impact outcomes which we seek.
- The five workstreams are co-owned and therefore delivered in partnership. In order to do this the Health and Wellbeing Board needs to develop a sense of common purpose and commitment to the five workstreams.
- A strategic delivery plan supporting these workstreams is agreed by the Health and Wellbeing Board.
- The delivery plan identifies the measures of success for the workstreams including key outcomes; KPIs and ownership of the deliverables. This should be reported to the Health and Wellbeing Board on a quarterly basis to monitor progress.
- The Health and Wellbeing Board more effectively engages with the public in Hartlepool in determining what the important issues are and also in monitoring success in delivering the outcomes.

Agreement was sought to a workshop being scheduled to address the specific issues. The Chair encouraged all Board Members to attend the workshop.

Decision

The Board approved:

- The proposed review of the role and purpose of the Board.
- That a workshop take place in September in order to agree the way forward.

5. Face The Public Event - Feedback (*Director of Public Health*)

Board Members were advised that the Health and Wellbeing Board's Face the Public Event for 2019 had been held on the 11th March 2019 and had focused on 'starting well' as a priority outcome identified within the Director of Public Health's Annual report and Joint Health and Wellbeing Strategy (2018 – 2025). The event had been attended by 29 representatives from a variety of partner organisations and residents, with a number of questions explored as detailed in the report. A summary of comments made at the event was appended to the report.

Decision

(i) The Board noted feedback from the Face the Public Event.
(ii) It was agreed that the outcomes of the Face the Public Event be utilised to inform the review of priorities going forward as part of the refresh of the Joint Health and Wellbeing Strategy and Healthy Weight Strategy.

6. Update on the Healthy Weight Strategy and Proposal to Develop a Whole Systems Approach to Obesity Prevention (*Director of Public Health*)

The Board was reminded that in August 2014, the Board had selected child obesity as a priority and had requested that work start on developing a Childhood Obesity Strategy. A town wide obesity conference was held in February 2015 and following this, the Healthy Weight Strategy had been developed which had been approved by the Board in September 2015. Key successes to date were set out in the report.

It was recognised that Partners needed to work differently to ensure that the prevalence of obesity in the town was reduced. It was proposed:-

- That the priorities in the Healthy Weight Strategy are refreshed.
- That adopting the Whole Systems approach to obesity prevention is fundamental to our aim to decrease the number of overweight and obese people in the town
- That the leadership of the Healthy Weight Strategy reflects the requirements of the Whole Systems approach and recognises the strong leadership provided through the local authority.

Board Members were advised that the next steps would be a second workshop in July to consider mapping the provision of services in the Borough, setting up a system network to coordinate the work and the development of a social movement to support the aims of the project.

Following presentation of the report, the Director of Children's and Joint Commissioning Services highlighted links to the Child Measurement Programme and concerns which she had received relating to the way the Programme is implemented. The Deputy Director of Public Health acknowledged issues associated with the wording of the letters sent to parents.

Decision

(i) The Board approved the Whole Systems Approach to obesity prevention.
(ii) The Board approved bringing the Healthy Weight Strategy in line with the Whole Systems Obesity proposals.

7. Developmental Of Neurodevelopmental Pathway

(*Director of Children's and Joint Commissioning Services and Hartlepool and Stockton-on-Tees Clinical Commissioning Group*)

The report shared with Board Members the development of a neurodevelopmental pathway which would replace the existing ASD pathway. Board Members were presented with background information including estimated prevalence of ASD, referral numbers and waiting times for diagnosis. An expert reference group had been established which had reviewed parental consultation and best practice in other areas to draft a new model. The Hartlepool and Stockton model had been developed and was appended to the report. A task and finish group had been established in Hartlepool to develop and trial the pathway. The work to date was set out in the report. It was noted that the Group would continue to develop the pathway and trial the different elements of the pathway and report to the Board in 6 months on progress.

Board Members discussed issues arising from the report and Partners spoke in positive terms in relation to the pathway. An Elected Member highlighted that the report referred to five times as many boys being diagnosed as girls. The Tees, Esk and Wear Valley NHS Trust representative undertook to verify with clinicians and report back to the Board. The Chair agreed to circulate a copy of the response.

Decision

(i) The development of a neurodevelopmental pathway was noted.
(ii) It was agreed that a progress report is presented to the Health and Wellbeing Board in six months.

8. SEND (SPECIAL EDUCATIONAL NEEDS AND DISABILITIES) INSPECTION REVISIT AND SEND IMPROVEMENT PLAN

(*Director of Children's and Joint Commissioning Services*)

The Board was advised that the joint local area SEND Inspection had identified serious weaknesses and the local area had been required to produce a written statement of action. A SEND revisit had been undertaken in January 2019 to review progress against the serious weaknesses (the letter from Ofsted and CQC was appended to the report and outlined the findings from the revisit). Inspectors had been sufficiently assured in the following two areas that sufficient progress had been made:

a) Weaknesses in providing the clear and timely information, advice and support that families need.
b) Weaknesses in the monitoring of the effectiveness of services in improving outcomes for children and young people who have special educational needs and/or disabilities.

However inspectors were not assured in the remaining two areas:

c) Inconsistencies in the timeliness and effectiveness of the local area's arrangements for identifying and assessing children and young people's special educational needs and/or disabilities.
d) Weaknesses in the strategic joint commissioning of services for children and young people who have special educational needs and/or disabilities.

The local area had been required to submit an Improvement Plan in response to the revisit findings to the DfE (appended to the report). During the re-visit, inspectors had raised concerns that the governance arrangements were not robust and leaders were not holding each other to account to ensure swift and timely progress on the areas of weaknesses. A review of the governance arrangements had been undertaken with a review of the terms of reference for the Strategic SEND Board (appended to the report) and the Operational SEND group (appended to the report).

It was highlighted that due to the cross cutting nature of SEND it was important that the Board hold all organisations to account for the implementation of the SEND Code of Practice and delivery of the Improvement Plan. It was therefore proposed that the Board is the governing board for the implementation of the SEND strategy.

Following presentation of the report, the Assistant Director of Joint Commissioning responded to the Chair in terms of plans to address quality assurance issues and assured Board Members that reports would be submitted to the Board. The role of the Board was reiterated and the Chair encouraged all Board Members to fulfil their responsibilities.

Decision

(i) The Board noted the SEND revisit findings and the SEND improvement plan.

(ii) That Board approved the revised SEND governance arrangements with the Health and Wellbeing Board being the overarching governing body holding all partners to account. This includes terms of reference for Operational and Strategic SEND groups.

9. BETTER CARE FUND 2018/19: Q4 PERFORMANCE UPDATE (*Director of Adult & Community Based Services*)

The report provided the background to the Better Care Fund reporting arrangements and summarised the National Conditions and performance measures. Performance reports were submitted to NHS England on a quarterly basis. The Q4 return covering the period January – March 2019 had been submitted in April 2019 and had confirmed that all national conditions continued to be achieved. An analysis of performance data had also been provided which was summarised in the report.

Decision

The Board retrospectively approved the Hartlepool Better Care Fund Quarter 4 return and noted the current positive position in relation to performance, with three of the four key indicators, and a dramatic improvement in delayed transfers of care, achieved.

10. Verbal Update/Presentations (*Hartlepool and Stockton-on-Tees Clinical Commissioning Group)*

The Board received updates from the Chief Officer, Hartlepool and Stockton-on-Tees Clinical Commissioning Group(CCG) in relation to the following:-

(i) Whorlton Hall – Board Members were informed verbally of the background to the current complex police investigation arising from the BBC Panorama's undercover filming which appeared to show abuse at Whorlton Hall. The Chief Officer explained the role of the CCG and referred to the co-ordination of commissioning of alternative accommodation for the residents of Whorlton Hall. The support received from the Tees, Esk and Wear Valley Trust was acknowledged and individuals were continuing to be supported in their new placements. It was highlighted that the situation was very complex and difficult for all concerned. An update report would be submitted to a future meeting of the Board.

Board Members discussed issues arising from the update. It was highlighted that Cygnet Health Care, who owned Whorlton Hall, also owned a care home in Hartlepool. Following clarification sought from Board Members, assurances were provided regarding safeguarding and review arrangements in that Home. The Director of Adult and Community Based Services advised Members that she would include

updates in regular reports to the Council's Adult and Community Based Services Committee which could also address also a question raised regarding Dignity and Care Champions.

(ii) North East Integrated Care System – A presentation detailed background information, purpose and key challenges relating to an Integrated Care System (ICS) for the North East and North Cumbria. Features and key principles of established ICS Partnership Assemblies were outlined together with the key benefits to local people.

Merger Application - Proposals for new Clinical Commissioning Groups for Tees Valley and Durham CCGs – A presentation updated the Board on the current CCGs arrangements covering Teesside, Darlington and Durham. The presentation outlined the role of CCGs and the additional benefits which it was considered a merger could provide. Options were detailed to the Board as follows:-

- Single CCG across the ICS i.e. Cumbria and the North East
- Single CCG across the 5-CCG collaborative: merger of Darlington CCG, Durham Dales, Easington & Sedgefield CCG; Hartlepool & Stockton-on-Tees CCG; North Durham CCG and South Tees CCG.
- Single CCG across each Integrated Care Partnership: i.e. the southern ICP (South Tees CCG, Hartlepool and Stockton on Tees CCG and Darlington CCG) and the central ICP (Durham Dales, Easington and Sedgefield CCG, North Durham CCG, South Tyneside CCG and Sunderland CCG)
- Two CCGs with a shared management structure i.e. a single Tees Valley CCG and a single Durham CCG whilst retaining a shared management structure.

Based on principles and expected benefits, option 4 was considered by the CCG to work best as it would retain a local focus whilst making greater savings, it would support pathway transformation and greater equality in clinical outcomes across our populations and would strengthen work with the Local Authorities. It was considered also that it would help to use clinical leadership effectively across a broader population base, it would support financial sustainability and was considered to be likely to be supported by partners, stakeholders and NHS England.

The Clinical Commissioning Group was working with local Healthwatch organisations to engage with patients and the public to get their views on plans. Views were being sought also from Partners, Health and Wellbeing Boards, Councils and stakeholders to get their views also. These would inform the decisions the CCG Governing Bodies would make at the end of August. Following clarification regarding timescales, the Chair requested Board Members to submit their comments on proposals, by 19th July, in order that a response on behalf of the Board could be submitted.

11. Any Other Items which the Chairman Considers are Urgent

The Chairman ruled that a request by a member of the public, in attendance at the meeting, that items of business should be considered by the Committee as a matter of urgency in accordance with the provisions of Section 100(B) (4)(b) of the Local Government Act 1972 in order that the matters could be dealt with without delay

A member of the public expressed concerns regarding infection control associated with the alleged manipulation of water quality results. Concerns were expressed also regarding incidents of listeria linked to patient deaths linked to an alleged listeria outbreak.

The Chair advised that he was not aware of background to the concerns expressed and informed the member of the public that he was happy to discuss the issues with the member of the public following the meeting. The Chief Officer of the Clinical Commissioning Group added assurance that the listeria issue was being addressed.

Meeting concluded at 11.40 a.m.

CHAIR

HEALTH AND WELLBEING BOARD

23rd September 2019

Report of: Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Subject: IMPROVING OUTCOMES FOR CHILDREN AND YOUNG PEOPLE (INTEGRATED WORKING)

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1. PURPOSE OF REPORT

1.1 To update the board on work that has taken place across health, local authority and voluntary, community and social enterprise (VCSE) sector in relation to integrated ways of working for children and young people.

1.2 To present a compact agreement that has been jointly developed as a result of the integrated work.

1.3 To ask the board to endorse the agreement set out within the compact and support the principles as the way of working for all children and young peoples development/commissioning when there is more than one strategic partner involved.

1.4 The board are also asked to provide oversight/governance to the priority group and act as a point of escalation/resolution where required.

2. BACKGROUND

2.1 In January 2019 an event was hosted by the CCG, and facilitated by the Advisory Board to explore both the potential and appetite for working systematically across the children and young people's agenda.

2.2 The event was attended by partners from health (North Tees and Hartlepool Foundation Trust and TEWV), both Local authorities (commissioning, education, social care and public health) and the VCSE (Catalyst represented as a strategic partner for the sector).

2.3 There was consideration given to inviting children/young people and families, however at this stage it was determined that the work required related to the system working differently together.

2.4 During the event the facilitator presented a number of examples of working as an integrated system and the steps that needed to be taken in order to embed the ways of working, which ensured the systems holds one another to account.

2.5 The event also allowed for exploration of current challenges and frustrations which were being felt across the system by all partners. This provided the platform for identifying some initial areas of work that could be explored further and tested for a new integrated way of working.

2.6 The areas that were identified for initial further exploration were emotional health and wellbeing and SEND.

2.7 A steering group that was representative of all partners working within the children and young people's system was established following this event in order to take the work forward.

3. ACTIONS TAKEN TO DATE

3.1 The membership, name and responsibility of the group was reviewed and finalised with a terms of reference developed.

3.2. There was collective agreement that to ensure organisations could hold one another to account an agreement needed to be developed and endorsed/signed up to by each organisation.

3.3 A compact (which is attached) was jointly developed which outlines the strategic goals, principles, behaviours, commitments, risks and sustainability which the group will work too when working as an integrated system.

3.4 The compact has been reviewed by each organisation separately and supported as a way of working for the children and young peoples' agenda.

3.5 The two priority areas that were identified at the initial event were reviewed in more detail, a decision was made to take forward emotional health and wellbeing as the area for testing integrated ways of working.

3.6 The group worked with a facilitator to develop and refine a series of workshops that would be attended by practitioners from organisations across the whole system. The aim of workshops was to review the current pathway, identify gaps, identify areas of priority and suggest areas of development.

3.7 The series of workshops concluded with outputs being presented to the integrated group for review and agreement around actions to be taken forward.

3.8 These recommendations are presented to board today in a separate paper requiring a decision.

3.9 A collective agreement was made that to ensure the system is held to account for working within the compact principles, and has a place to escalate too. The HWBB would be presented the work and asked to act in a governance capacity as all partners are represented and provides an obvious place for escalation and resolution if required.

4. NEXT STEPS

4.1 To continue to oversee and implement the work from workshops for emotional health and wellbeing.

4.2 To review the second priority area and agree what work needs to be taken forward as a system, in order to improve outcomes for children and young people.

4.3 To develop and implement the approach identified for implementing this work.

4.4 To explore other priority area's that will form part of the workplan for integrated group.

5. RISK IMPLICATIONS

5.1 There is a risk that if services do not work together we will continue to see an increase in children and young people presenting with mental health issues. It is important that organisations work together to implement a joint approach to early intervention and understand how the system can work together.

6. FINANCIAL CONSIDERATIONS

6.1 There are no specific financial considerations within this report.

7. LEGAL CONSIDERATIONS

7.1 There are no legal or regulatory implications, the compact is not a legally binding document.

8. EQUALITY AND DIVERSITY CONSIDERATIONS (IMPACT ASSESSMENT FORM TO BE COMPLETED AS APPROPRIATE.)

8.1 Any work undertaken and supported by the integrated priorities group will be done so with the express aim of improving services for children, young people and families. The ethos of the compact is to look for solutions as a system, in order to eradicate/minimise any negative impacts for children, young people and their families.

9. STAFF CONSIDERATIONS

9.1 There are no staff considerations within this report.

10. ASSET MANAGEMENT CONSIDERATIONS

10.1 There are no asset management considerations within this report.

11. RECOMMENDATIONS

11.1 For the Health and Wellbeing Board to endorse the agreement set out within the compact and support the principles as the way of working for all children and young people's development/commissioning when there is more than one strategic partner involved.

11.2 For the Health and Wellbeing Board are to provide oversight/governance to the priority group and act as a point of escalation/resolution where required.

12. REASONS FOR RECOMMENDATIONS

12.1 To ensure that the system is working effectively together to implement improvements for our children and young people.

13. BACKGROUND PAPERS

None

14. CONTACT OFFICER

Jo Heaney, Head of Commissioning and Strategy, NHS Hartlepool and Stockton-on-Tees CCG, Billingham Health Centre, Queensway, Billingham. TS23 2LA, 01642 745958 jheaney@nhs.net

NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group

Integrating

Health and Social Care

in Hartlepool and Stockton

Compact Agreement

"Developing a shared set of principles to improve the outcomes and lives of children and young people across Hartlepool and Stockton-on-Tees"

Good Health Everybody's business

2019 - 2021

Introduction

The Compact provides the framework for organisations from health, local authority and the voluntary and community sector to work together across Hartlepool and Stockton to improve outcomes for children and young people.

All partners have been involved in the development of this compact and have therefore expressed an intention to work effectively together in the same spirit as the agreement was developed. It is noted that the agreement is not legally binding.

The aim is for organisations to come together, bringing their individual knowledge, resources and expertise to explore and overcome collective issues relating to improving services and outcomes for children & young people.

The success of this local compact will be measured by:

- Having measurable performance data in the programme of work
- Integrating the views of children and young people in everything we do
- Integrating the view of parent carers in everything we do

All organisations who are party to this Compact agreement have agreed to adhere to the stipulations provided within this agreement. Each organisation has its own governance structure which must be adhered to as part of the decision making process.

A children's priorities integrated working group will oversee the programme of work and ensure that the principles outlined in the Compact are adhered to.

Work on the Compact will not replace existing work streams and will, where possible, enhance ongoing pieces of work.

Areas of work

This Compact will provide the framework for work across all areas of services for children and young people where there is more than one strategic partner involved in the commissioning or delivery of a service.

The Children's Priorities Integrated Working Group has identified two initial key areas of work where the remit spans all organisation who have signed up to the Compact:

1) Special Educational Needs (SEND)
2) Mental health & wellbeing

These areas have been identified as priorities because these are key strategic areas where children and young people hit a different part of the system.

Strategic goals

Although priority areas of work have been identified, the Children's Priorities Integrated Working Group have agreed that there is a set of overarching strategic goals which will be applied to these and future areas of work.

- Children and young people can access support to meet their needs at the earliest opportunity
- CYP know how to access support
- Parent Carers have a responsibility to access support for their children
- Services are commissioned to meet needs and provide value for money
- Quality services are commissioned and are effectively managed

Developing the Compact

"Effective partnerships are built on trust, transparency, integrity and honesty"

Bringing organisations together to improve services for children and young people is complex. All organisations have their own cultures and agendas. To work effectively together, we have to, in essence, leave those complexities behind and agree a set of principles to work too.

Principles

- Collectively, the Children's Priorities Integrated Working Group have agreed the following set of principles:
- Measurable Differences – being able to demonstrate that what we are working on is making a difference
- Value for Money – efficient & effective use of a collective resource
- Children & Young People focused – putting the child, young person and their family at the centre of our work programme, above the needs of the individual organisation
- Equality between Partners – recognising both the successes and challenges of each organisation
- Learn from success and failure – building on what works well and not being afraid to stop a service that cannot demonstrate it is effective
- Effective and high quality communication between partners with shared accountability

Behaviours

- Respect confidentiality of any information shared
- Be committed to attending meetings, and to have a named deputy where attendance is not possible to allow for consistency
- Recognising that the public sector and VCSE are accountable in different ways
- Look for evidence-based solutions, not being afraid to be open minded and 'think out of the box'
- Understand each other's constraints and recognise conflicting priorities
- Be mutually supportive but constructively challenge where and when appropriate

Commitments

"Collective responsibility – let's make this happen by having the best approach not the easiest approach"

All partners to this Compact seek to adhere to the following commitments:

- Accountability – all partners will hold each other to account for non-delivery, recognising individual challenges
- Effectiveness – a programme of review will be put in place
- Outcomes & Evidence – a commitment to developing outcome focused, evidence based sustainable services
- Grappling with difficult issues – to work to seek solutions despite the challenges
- Honest approach to finances – transparency around changes or challenges to funding
- Systematic/co-ordinated change – a recognition that for a significant impact to be felt, there needed to be whole system changes
- Impact assessments – developed as a partnership before reallocating funds, reshaping services and funding decisions being made
- Dispute resolution – with hard decisions come disagreements, however, all disputes will be resolved in partnership
- Resources – all organisations are responsible for exploring all funding opportunities to expand the financial pot which is available. Where the VCSE can access funding not available to statutory organisations, support will be provided to maximise chances of success to enable innovation

Recognising risk

It has to be acknowledged that achieving the level of change which is required to transform local services for children and young people, comes with a degree of risk. The Compact acknowledges these risks:

- Reducing resources across the system
- Not understanding the ‘demand’ picture
- The political landscape
- Being reactive instead of proactive
- Lack of connectivity across some partners; schools due to academisation etc.

Ensuring the Compact is sustainable

The partnership will agree:

- Dispute resolution
- Escalating points and criteria
- Timescales for review
- Each organisation will have its own complaints process and governing body should the matter need to be referred

HEALTH AND WELLBEING BOARD

23rd September 2019

Report of: Hartlepool and Stockton-on-Tees Clinical Commissioning Group and Director of Children's and Joint Commissioning Services

Subject: CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH – LOCAL TRANSFORMATION PLAN

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1. PURPOSE OF REPORT

1.1 To share with members an update on the progress of the children and young people's mental health local transformation plan.

1.2 The Board is requested to approve the overarching proposals for the available funding and to agree for the associated work to be taken forward as set out in section 4.

2. BACKGROUND

2.1 In February 2019, the Health & Wellbeing Board was provided with an updated Future in Mind Local Transformation Plan for Children's & Young People's Mental Health provision. The paper highlighted a change of direction in the implementation of the plan, shifting from a focus on testing small scale projects to improve outcomes for specific groups of children and young people towards whole system transformation. This work was due to commence with a series of multi-agency workshops to map the current system and to develop a collective vision for future delivery which all partners could support.

2.2 The principles and high level outcomes for the Local Transformation Plan remained the same. A focus on early intervention, prevention, making specialist services accessible, implementing the principle of the Trailblazer/Green Paper and continuing the work for the transformation of the neurodevelopmental pathway were highlighted.

2.3 This paper provides the Board with an update on the outcome of these workshops, and also includes details of other developments which are

happening concurrently within the Children and Young People's Mental Health agenda.

3. FUTURE IN MIND

3.1 In 2014 the government produced '*Future in Mind – Promoting, protecting and improving our children and young people's mental health and wellbeing.* A requirement of *Future in Mind* was for areas to develop a local transformation plan focused on improving access to help and support when needed and improve how children and young people's mental health services are organised, commissioned and provided. There was a further requirement to update this plan annually.

3.2 The local transformation plan provides a framework to improve the emotional wellbeing and mental health of all Children and Young people across Hartlepool and Stockton-on-Tees. The aim of the plan is to make it easier for children, young people, parents and carers to access help and support when needed and to improve mental health services for children and young people.

3.3 Across Hartlepool and Stockton on Tees CCG footprint, Future in Mind resources have been utilised to invest in CAMHS specialist services; enabling the Crisis Service to be available 24/7, supporting the development of a Tees-wide Eating Disorder Service and the funding of Primary Mental Health Support Workers (PMHW) and Early Intervention Psychosis.

3.4 Within the Hartlepool locality, the focus has been building the capacity of the children and young people's workforce to identify and respond to those who need emotional health and wellbeing support. The primary focus of this work has been to upskill education professionals to increase their understanding of mental health issues and to enable them to deliver low level interventions to children and young people. Work has also been carried out to establish a baseline view of how children & young people throughout primary and secondary schools view their own emotional health and wellbeing.

3.5 The CCG and Hartlepool Borough Council have worked together to mobilise an ASD waiting list initiative and transformational work to move to a needs led pathway. This is proving successful and enabling the waiting times for a multi agency autism assessment to be reduced. Although there is work to still do, the picture is greatly improving for children and families.

4. OUTPUTS FROM MENTAL HEALTH WORKSHOPS

4.1 As planned, a series of three workshops were held during June and July 2019 with a group of staff from across a number of agencies in Hartlepool and Stockton on Tees including: TEWV, HBC, Harrogate District Foundation Trust, VCSE organisations, North Tees & Hartlepool Foundation Trust, schools and the CCG.

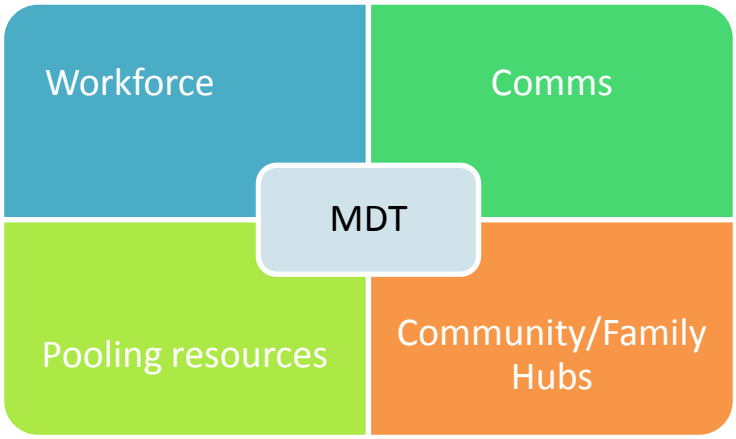
4.2 The workshops were externally facilitated and enabled practitioners from across the organisations to have informed discussions to highlight the current issues within the system and devise appropriate and relevant solutions.

4.3 Whilst mapping the current system, a range of issues were identified including:

- Children and young people move around the system with too many hand offs
- Specialist services are not operating effectively due to high case loads
- Referrals are often received at crisis point
- High level of inappropriate referral into specialist services
- Some provision is under-utilised/misunderstood
- Existing services competing for the same resource
- Services lack co-ordination
- Wider infrastructure for CYP are not linked in – scouts etc
- General lack of awareness from families – crisis reactions
- Limited preventative service offer
- No overarching governance across the whole system
- Need for an overarching accepted model of working e.g. thrive

4.4 The workshops also helped to identify strengths within the current system including the highly trained workforce within specialist CAMHS services and the value of this group of professionals providing consultation and support to those working across the children and young people's system. It was also acknowledged that schools play a vital role in early identification, intervention and ongoing support and there are examples of good practice locally. The benefits of integrated teams and their ability to achieve better outcomes were also highlighted.

4.5 The outputs from the workshops have identified 5 main areas of work which need further defining and exploration through task & finish groups. The 5 areas are interconnected and are as follows:



Key areas to be explored in each area:

4.5.1 Workforce – to determine where service providers are providing the same or similar services and determine if these can be amalgamated, delivered collectively etc. Develop a training directory to enable all available training to be accessible to all staff. Look at the feasibility of Specialist Mental Health services acting in a 'consultation' capacity to support and provide guidance to services supporting CYP below specialist level i.e. Schools/ Early Help/ 0-19.

4.5.2 Communication – no resources have previously been deployed into communication. This will be developed following a multi-agency workshop to understand how TEWV determine which referrals can be supported by them, where the referrals go who are not appropriate and therefore how do we work systematically to reduce the number of inappropriate referrals. The Local Offer, TEWV and NTHFT websites need reviewing. The views of children and young people will be central to the development of a communication plan.

4.5.3 Pooling Resources – this will be explored in terms of staffing working in a more integrated way, working strategically with VCSE to collectively bid for funding, moving forward with joint commissioning and pooled budgets.

4.5.4 Community/Family Hubs – linking workforce and pooling resources together to determine how organisations can work more effectively together utilising existing resources such as the Community and/or Family Hubs.

4.5.5 MDT (Multi-Disciplinary Team) – the thread throughout the workshops was collaborative working and this has been highlighted in the above groups. The MDT approach will take learning from the newly piloted 'triage' process aligned to the Neurodevelopmental work. An MDT approach takes waste out of the system and allows for collective and early discussions around a child's referral.

4.6 It is proposed that Task & Finish groups are established within each identified area and plans further developed.

5. FUNDING OF LOCAL TRANSFORMATION PLAN OBJECTIVES

5.1 Although high level priorities were set as part of the Local Transformation plan which the Board previously agreed to, we would like the Board to agree that the available funding of £329,000 available for the financial year 19/20 is utilised in the following way:

- £150,000 is made available to facilitate and take forward work which comes out of the task & finish group as highlighted above;
- The remaining £180,000 be utilised to fund a further 4 months ASD waiting list initiative. This request is being made to enable the 'needs' led element of the pathway to be more embedded, allow for the school based training to be completed and for more time to embed the multi-agency triage process and to enable more children to be seen thus making the transition to a fully operational neurodevelopmental service more efficient.

6. DEVELOPMENTS

To support the Children & Young People's mental health agenda, there have been a number of development's which will support and work alongside the proposals outlined above. Since the last paper to the Board in February 2019, there have been a number of developments which are worthy of note:

6.1.1 Kooth

Through NHS England Waiting List initiative money, Hartlepool & Stockton CCG have worked with Tees, Esk & Wear Valley (TEWV) to purchase the online digital platform, Kooth. Kooth provides on line advice and counselling from trained psychologists to young people aged 11-19. The site contains blogs, self-help tools, advice and guidance for parents as well as 1:1 counselling. Within quarter 1 of this year, 34 children and young people living in Hartlepool accessed the online service. 80% of those accessing were female and 60% of those accessing this provision did so outside of standard service opening times – therefore on evenings and weekends.

An additional module has been purchased which enables teachers and school staff to access on line support for their mental health &wellbeing, in an acknowledgement that they are working and supporting some of our most vulnerable young people on a daily basis and that they too need to have some external support at times to sustain their wellbeing.

6.1.2 Trailblazer

Hartlepool and Stockton on Tees localities successfully bid to be part of NHSE and Department for Education's wave 2 Trailblazer pilot. This will see Mental Health Support Teams being present in 20 schools in the South and Central 2 school cluster from September 2020. As part of this national pilot a new role of Education Mental Health Practitioner (EMHP) has been created

to work into schools. These workers will be able to work with children and young people who are displaying low to moderate level needs – predominantly around anxiety and low mood. Work will be undertaken on a 1:1 basis and in group setting. Additionally the workers will be able to lead outcome based interventions with parents and work with the school's mental health lead to develop a mental health friendly culture within school.

The Mental Health Support Teams will be delivered by Alliance Psychological Services with additional input from TEWV. Alongside the EMHP, there will be additional support for parents which we acknowledge is an essential element which has to occur concurrently with any work done with children & young people.

Although the full complement of the team will not be in schools until September 2020, there is a planned roll out from September 2019, which will include working with schools to understand their current mental health & pastoral offer and developing relationships with schools to ensure that once the EMHP are fully trained they will already have those relationships with the schools to make their implementation a smoother process.

It is essential that these new teams build on what already exists and does not replace any current provision.

As only five teams were awarded across the North East and Cumbria (and Hartlepool and Stockton received two of them) we feel that this is an excellent opportunity to work with schools to implement transformational work.

6.1.3 Joint Commissioning with schools

Work is being taken forward on the SEND joint commissioning agenda with schools. The CCG and local authority have jointly presented to head teacher forums on the subject of joint commissioning and how, by working together, we can achieve better outcomes for children and help to change the direction of travel of the mental health system.

To date approx six schools have taken part in 1:1 interviews with CCG staff to enable an in depth understanding of what they currently commission in terms of mental health provision, the outcomes this achieves and costings. This allow for action plans to be developed to improve any issues.

Meetings with schools will continue into the autumn terms. Following this a working group will be developed to plan, implement and evaluate a joint commissioning project.

6.1.4 Anna Freud School Link Programme

The Anna Freud School Link Programme is being rolled out nationally following a pilot period, and Hartlepool is included in the roll out. The remit of the programme is to improve relationships between schools and specialist

mental health services. It allows for open and frank discussions from both sides as to frustrations and blockages to better working relationships and for an understanding to be developed as to the role of each organisation with a view to developing outcomes around new ways of working and positive relationship building.

6.1.5 Neuro developmental pathway

The development of the new pathway is included within the Local Transformation Plan. An update on this work was provided to the Health and Wellbeing Board 1st July 2019

https://www.hartlepool.gov.uk/meetings/meeting/3999/health_and_wellbeing_board

7. RISK IMPLICATIONS

7.1 There is a risk that if services do not work together we will continue to see an increase in children and young people presenting with mental health issues. It is important that organisations work together to implement a joint approach to early intervention and understand how the system can work together.

8. FINANCIAL CONSIDERATIONS

8.1 There are no specific financial considerations within this report.

9. LEGAL CONSIDERATIONS

9.1 There are no specific legal considerations within this report, however all partners must ensure they are meeting their duties within the Children and Families Act 2014 and Code of Practice (SEND)

10. EQUALITY AND DIVERSITY CONSIDERATIONS (IMPACT ASSESSMENT FORM TO BE COMPLETED AS APPROPRIATE.)

10.1 The services discussed in this report support children with additional needs.

11. STAFF CONSIDERATIONS

11.1 There are no staff considerations within this report.

12. ASSET MANAGEMENT CONSIDERATIONS

12.1 There are no asset management considerations within this report.

13. RECOMMENDATIONS

13.1 For members to the progress of the children and young people's mental health local transformation plan.

13.2 The Board to approve the overarching proposals for the available funding and to agree for the associated work to be taken forward as set out in section 4.

14. REASONS FOR RECOMMENDATIONS

14.1 To ensure that the system is working effectively together to implement improvements for our children and young people.

15. BACKGROUND PAPERS

Future In Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Local Transformation Plan
https://www.hartlepoolandstocktonccg.nhs.uk/wp-content/uploads/2019/04/Hartlepool-and-Stockton-on-Tees-Local-Children-and-Young-Peoples-mental-health-Transformation-Plan.pdf

16. CONTACT OFFICER

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HEALTH AND WELLBEING BOARD

23 September 2019

Report of: Director of Children's and Joint Commissioning Services and Director of Adults and Community Based Services

Subject: ALL AGE CARERS STRATEGY

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1. PURPOSE OF REPORT

1.1 For members of the Health and Wellbeing Board to approve the Carers Strategy.

1.2 For members of the Health and Wellbeing Board to commit to supporting the development of an action plan in order to implement the strategy.

2. BACKGROUND AND CONSULTATION

2.1 A report was presented to Health and Wellbeing Board on 4th March 2019 setting out the development of a Carers Strategy. The priorities had been developed through consultation with young carers and carers. Feedback from this meeting on the 4th March 2019 have been incorporated into the final strategy which is attached as **Appendix A**.

2.2 Further consultation has taken place with Children's Services Committee and Adults and Community Based Services Committee. This is set out below:

2.2.1 Feedback from Children's Services Committee held on 9th July 2019:

- A Member raised whether there could be a young carer's register. The Assistant Director, Joint Commissioning explained that there were a number of carers that did not define themselves as carers and a register would therefore not be appropriate. However, young carers had asked for a young carers card to be developed.
- Emphasis was placed upon the importance of supporting young carers during the transition from primary to secondary education in terms of sharing information going forward to ensure there was an awareness of individual needs.

- Concerns were also raised that health agencies such as GP's were not adequately aware of the needs of young carers and how they should be treated when attending appointments with parents etc. The benefits of health partners working with schools and other agencies to identify any health related problems carers may be experiencing was highlighted as well as the importance of developing young carer cards.
- Whilst Members emphasised the importance of supporting young carers, the Committee was pleased to note that a number of young carers managed their caring responsibilities admirably, were doing very well at school and were assured that support was available should they need it.

2.2.2 Feedback from Adults and Community Based Services Committee 18th July 2019

- Members discussed the true number of carers in the town as they were concerned that this was much greater than that set out in the strategy document. The Assistant Director acknowledged the issue. The 2011 census had identified 1 in 10 as carers, Carers UK thought the figure was nearer 1 in 8. The Assistant Director considered that it was unlikely the true number would ever be known but advised that the focus had to be on how to support carers rather than focusing energy on quantifying numbers.
- Members considered that carers had to be shown a great debt of gratitude for the service they provided, which some consider to be essentially a second NHS.
- Members also spoke in tribute to the excellent service provided by Hartlepool Carers.
- Members requested that the issue of respite (or short breaks) be incorporated in the strategy, building on information shared with this Committee previously.

2.3 All feedback from these committees have been incorporated into the final strategy (**Appendix A**).

3. RISK IMPLICATIONS

3.1 It is important that Hartlepool's strategy addresses the priorities identified by young carers and carers. There is a risk that if we don't effectively support carers at the earliest possible opportunity they will be unable to support those they care for placing further pressure on the community and services.

4. FINANCIAL CONSIDERATIONS

4.1 There are no financial considerations.

5. LEGAL CONSIDERATIONS

5.1 There are no legal considerations.

6. EQUALITY AND DIVERSITY CONSIDERATIONS (IMPACT ASSESSMENT FORM TO BE COMPLETED AS APPROPRIATE.)

6.1 The strategy covers all carers and it will ensure that all cohorts of carers are supported as required.

7. STAFF CONSIDERATIONS

7.1 There are no staff considerations

8. ASSET MANAGEMENT CONSIDERATIONS

8.1 There are no asset management considerations.

9. RECOMMENDATIONS

9.1 For members of the Health and Wellbeing Board to approve the Carers Strategy.

9.2 For members of the Health and Wellbeing Board to commit to supporting the development of an action plan in order to implement the strategy.

10. REASONS FOR RECOMMENDATIONS

10.1 To ensure that carers are supported to prevent an escalation of needs and to ensure that those needing to be cared for are cared for appropriately.

11. BACKGROUND PAPERS

Joint Committee (Children and Adults) Meeting 5th February 2019
https://www.hartlepool.gov.uk/meetings/committee/155/joint_childrens_services_and_adult_services_committee

Health and Wellbeing Board Meeting 4th March
https://www.hartlepool.gov.uk/meetings/meeting/3778/health_and_wellbeing_board

Children's Services Committee 9th July 2019
https://www.hartlepool.gov.uk/meetings/meeting/3926/childrens_services_committee

Adults and Community Based Services Committee 18th July 2019
https://www.hartlepool.gov.uk/meetings/meeting/3978/adult_and_community_based_services_committee

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HARTLEPOOL BOROUGH COUNCIL

NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group

Carers Strategy

2019-2024

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CHAIR OF THE BOARD

Signature & Name

SCOPE AND PURPOSE

This document sets out Hartlepool's Strategy for promoting carers' Health and Wellbeing 2019 -2022. It has been produced by the Health and Wellbeing Board for Hartlepool. **This strategy covers both young carers and adult carers. When we refer to carers we define this as:**

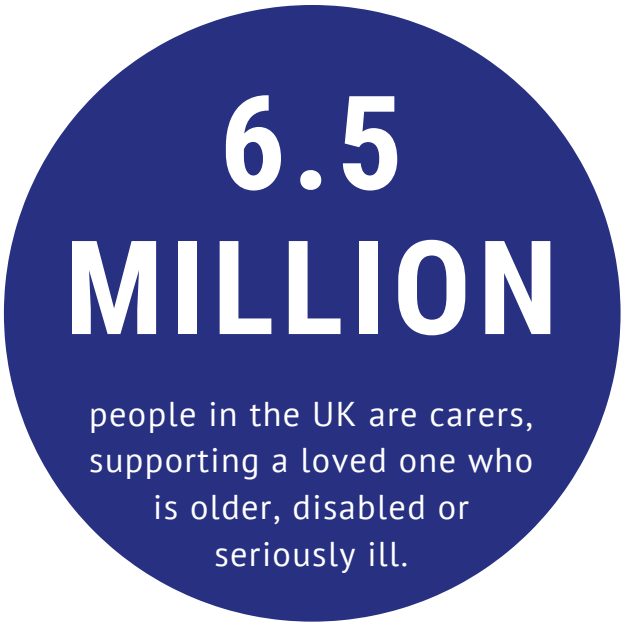
"Anyone who spends time looking after or helping a friend, family member or neighbour who, because of their health and care needs, would find it difficult to cope without this help regardless of age or whether they identify as a carer."

INTRODUCTION

Across the UK today 6.5 million people are carers, supporting a loved one who is older, disabled or seriously ill. **That's 1 in 8 adults who care, unpaid, for family and friends.** According to the Children's Society, there are an estimated **700,00 young carers** in the UK – kids or teens who are the primary carer for a sick, incapacitated or addicted parent.

That means two young carers in every classroom, each typically spending 20-50 hours a week on their caring duties. And the number is rising.

We know there are a large proportion of "carers" who do not define themselves as a carer as they are first and foremost a husband, wife, mum, dad, daughter, son, friend and neighbour.



- Almost three quarters (72%) of carers in the UK suffer from mental ill health due to their caring role (Carers Trust 2018)

- Over half (61%) of carers said their physical health had worsened as a result of caring. (Carers Trust 2018)

- There are now nearly 10,000 young carers under the age of eight in England and Wales who carry out unpaid care, with the most recent Census in 2011 finding an 83% increase in the number of young carers aged 5-7 since 2001.

- 46% of young carers are getting up in the night to care for loved ones, missing out on their own sleep (Snap shot national survey (Carers Trust)

- More than 80% of young carers are carrying out caring duties every day or most days of the week (Snap shot national survey (Carers Trust)

- More than 1.8 million unpaid carers over the age of 60 in England with more than 87,000 over the age of 85.

CASE STUDY 1

Leon is a Young Adult Carer for several members of his family who all live in Hartlepool. Leon's sister has had epilepsy for many years and he is always on hand to ensure her safety and create a calm environment within which her episode could pass with as little distress as possible.

Leon as a young carer supported family members to take their medication, attending appointments and supporting with rehabilitation. Leon registered with Hartlepool Young Carers project many years ago and has maintained his contact with the charity and has now transitioned into the Adult Carers Project.

Leon studied for his GCSEs alongside his caring role, being predicted all A-C grades. Leon was unable to complete the exams due to a severe injury, but this did not stop this determined young man.

Since September 2018 Leon has been at Sunderland University, having gained an unconditional offer after being identified as an outstanding candidate.

Previously, with an ambition to become a paramedic, Leon worked for four years as an Ambulance Care Assistant to gain the relevant experience alongside his caring role.

However, Leon discovered that many of the patients he was taking to hospital to be 'fixed' were returning home to environments which were the underlying cause for many of their medical problems, inherently poverty and social deprivation being the catalyst to problems with drugs and alcohol misuse and mental health issues.

With this in mind Leon took the decision to study towards a BSc in Sociology degree and is loving every minute of it, with a view to forging a career in research into how backgrounds affect opportunities and lives, and working in the field of bridging the gaps in social inequality.

Leon has volunteered in Hartlepool for many community organisations, he has his own family, continues to care for his family members and plans on volunteering with Young Carers Project to ensure other young carers reach their goals and aspirations.

OUR VISION

Our vision is that Hartlepool will develop a culture and environment that promotes and supports health and well-being for all.

Our ambition is to improve the health and well being of all the residents of Hartlepool and reduce health inequalities. (Hartlepool's Health and Well being Strategy).

For carers this means we will work together to support them to live long and healthy lives and be able to care for as long as they would want to and to support carers when they are no longer fulfilling their carer role.

OUR PRIORITIES

In order to achieve the vision our plan will focus on six priorities:

1. Identify carers at an early age, recognising their contribution and involving local care in planning individual care packages.

2. Carers having a family and community life alongside caring personalised support for carers and providing good quality information, advice and support

3. Support carers to stay healthy – mentally and physically

4. Carers realising and releasing their potential in education and employment

5. Providing opportunities to help ex-carers sustain and fulfill healthy lives

6. Widen participation of carers to influence decision making at a local level

NATIONAL CONTEXT

On a national level there has been significant attention paid to the role of carers. The government has re-stated their commitment to the priorities set out in the National Carers Strategy **"Carers at the heart of 21st century families and communities"** 2008 and developed an action plan 2018 – 2020.

NATIONAL CARERS STRATEGY:

Carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role;

Carers will be able to have a life of their own alongside their caring role;

Carers will be supported so that they are not forced into financial hardship by their caring role;

Carers will be supported to stay mentally and physically well and treated with dignity;

Children and young people will be protected from inappropriate caring and have the support they need to learn, develop and thrive, to enjoy positive childhoods.

Since the publication of the National Carers Strategy a number of national strategies and plans have been introduced which show the importance of carers in our society.

THE CARE ACT 2014

New rights have been introduced for carers and new duties are in place for local authorities

Carers have the same rights to an assessment and support as those who they care for

There is a national eligibility criteria for carers and those who they care for which identifies whether they are entitled to support from the Local Authority with meeting their care and support needs

Following assessment a support plan should be generated with the carer that sets out how their eligible needs will be met. This may include services funded by the Local Authority and other ways of meeting their outcomes, including from their own resources and support from the local community

NATIONAL CONTEXT: NHS 10 YEAR PLAN

We will improve how we identify unpaid carers, and strengthen support for them to address their individual health needs.

We will do this through introducing best-practice Quality Markers for primary care that highlight best practice in carer identification and support.

We will continue to identify and support carers, particularly those from vulnerable communities. Carers are twice as likely to suffer from poor health compared to the general population, primarily due to a lack of information and support, finance concerns, stress and social isolation. Quality marks for carer-friendly GP practices, developed with the Care Quality Commission (CQC), will help carers identify GP services that can accommodate their needs. We will encourage the national adoption of carer's passport

Carers should not have to deal with emergencies on their own. We will ensure that more carers understand the out-of-hours options that are available to them and have appropriate back-up support in place for when they need it.

Young carers feel say they feel invisible and often in distress, with up to 40% reporting mental health problems arising from their experience of caring.

Young Carers should not feel they are struggling to cope on their own. The NHS will roll out ‘top tips’ for general practice which have been developed by Young Carers, which include access to preventive health and social prescribing, and timely referral to local support services.

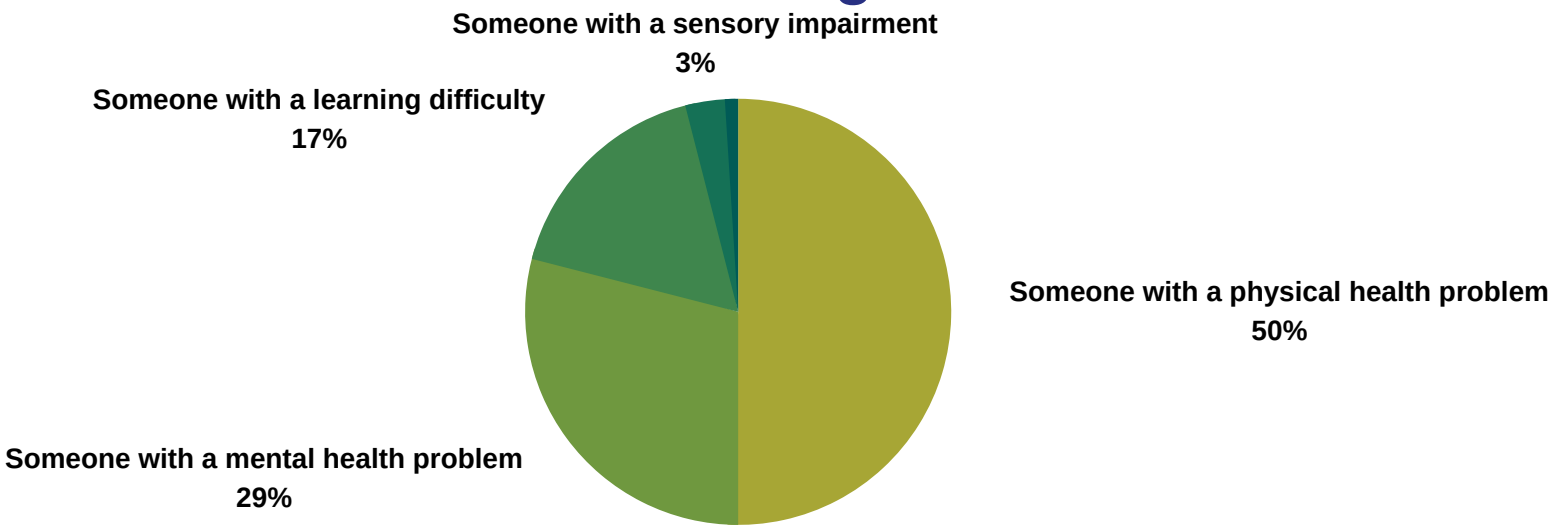
Up to 20,000 Young Carers will benefit from this more proactive approach by 23/24.

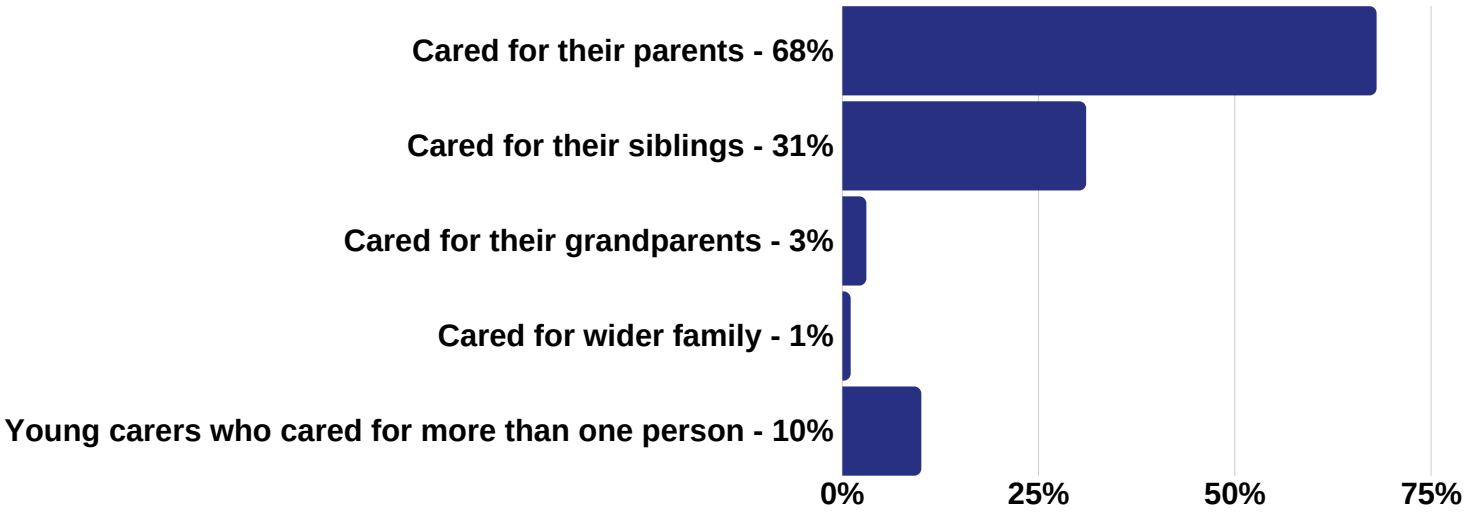
Patients, clinicians and the carers working with them will have technology designed to help them. They will have a digital service for managing their interactions with the NHS, a view of their record, care plan, expectations, appointments and medications, to enable care to be designed and delivered in the place that is most appropriate for them.

Create straightforward digital access to NHS services, and help patients and their carers manage their health.

NATIONAL CONTEXT: YOUNG CARERS

Recent survey of young carers shows they are caring for:





TYPE OF CARE THEY PROVIDE:

- Help at home
- Emotional support
- Shopping
- Order & administrator medication
- Help with bills
- Supporting siblings
- Interpret/ communicate/ advocate
- Personal care
- Support with hospital/ health appointments

YOUNG CARERS ARE MORE LIKELY TO:

- Have a disability, long term illness or special education needs
- Miss school to care for a parent or sibling
- Lower levels at GCSE (than peers)
- 43% young carers school work "adversely affected" by caring
- To be NEET aged 16-19
- Earn less in their early 20s and lave less skilled jobs

CASE STUDY 2

Simon registered with Hartlepool Carers in 2017, when he left his job in London to return back to the town to care for his dad.

His dad was diagnosed with dementia in 2014, Simon came back to Hartlepool to visit for 3 weeks and saw the impact the caring role was having on his mum. Simon decided he needed to come back to Hartlepool to care for his dad full time.

Although this was life changing to say the least, Simon felt his only option was to support his father the way in which his father supported him over the years. Throughout this time Simon has extended his caring role and cares for several family members with their own health conditions. Simon provides practical and emotional support, personal care tasks and around the clock support for his father.

Leaving employment and taking up his caring role had a significant impact on his own health and well-being, as well as financial implications.
Even though Simon is a full-time carer he has still found the time to re-educate himself and completed English, Maths, British Sign Language and several holistic qualifications.

Simon feels the support he has received from the local authority for his father, has helped him have a break away from his caring role. Through his statutory carers assessment, he now has the ability to manage and support his own mental health needs that has resulted from the impact of his caring role. He now attends the gym and swimming whilst his father is in respite/day care which has a real positive impact on his own well being.

Simon said “Without the support of the local authority and Hartlepool Carers I don’t think I would have been able to manage my caring role as well as I have, knowing that they are people out there that understand makes you feel less alone and would urge all carers to come forward”
Simon has recently gained employment as a 111-call advisor and was inspired from his role at Hartlepool Carers as Vice Chairman, after seeing that there is a need for support in every form.

Simon is also a mentor supporting newly identified carers in Hartlepool. He is passionate in raising the profile of caring and the positive outcomes that can be achieved alongside your caring role.

LOCAL CONTEXT: HARTLEPOOL CARERS

Hartlepool Carers works to improve the quality of lives of Carers throughout Hartlepool and the surrounding villages. They do this by providing advice, information and support services. Carers can be of any age and come from any social, ethnic or cultural background and will be treated with respect and dignity at all times.

A carer spends a significant proportion of their life providing unpaid support to family, friends or neighbours. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.

A young carer is someone under 18 who helps look after someone in their family, or a friend, who is ill, disabled or misuses drugs or alcohol.
Hartlepool Carers can offer support and information on issues connected with your caring role:
• Emotional support, one to one with a support worker or counsellor
• Information and guidance on local helping agencies in the Third Sector, Health and Social Care Services
• Group social and peer support activities
• Advocacy service

There have been some recent changes in the leadership at Hartlepool Carers and a change in the focus of the support they offer to carers. Hartlepool Carers acknowledge that there are numerous community organisations offering high quality support to carers and it is important that carers get the right support at the right time. This means that as well as supporting carers with specific activities and advice and guidance Hartlepool carers are also acting as a link to other community based support helping as many carers as possible are receiving the support they need.

Information collected over the last year shows:

• Over half of the Adult Carers supported by Hartlepool Carers are between 31 and 65 (66%). The majority of the remainder are aged 65+.

• The most common Primary Caring Need is physical disability, with 253 (41.7%) of carers referred to Hartlepool Carers providing support to someone with this need. Mental Health is also high, at 21.5% of the total Hartlepool Carers cohort.

• The most common Primary Caring Need is physical disability, with 253 (41.7%) of carers referred to Hartlepool Carers providing support to someone with this need. Mental Health is also high, at 21.5% of the total Hartlepool Carers cohort.

LOCAL CONTEXT

People who provide unpaid care by age

	People aged 0-15 who provide unpaid care		People aged 16-24 who provide unpaid care		People aged 25-34 who provide unpaid care		People aged 35-49 who provide unpaid care		People aged 50-64 who provide unpaid care		People aged 65+ who provide unpaid care	
Area Name	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Hartlepool	17,800	19	10,976	12	10,655	12	19,103	21	17,896	19	15,598	17
Brus	1,547	23	887	13	848	13	1,338	20	1,189	18	970	14
Burn Valley	1,117	20	855	15	751	13	1,233	22	987	17	745	13
Dyke House	1,086	22	708	14	591	12	982	20	895	18	690	14
Elwick	351	17	182	9	153	7	485	24	480	23	410	20
Fens	752	15	485	10	360	7	942	19	1,098	23	1,234	25
Foggy Furze	822	18	540	12	561	12	894	20	987	22	693	15
Grange	1,045	20	735	14	738	14	1,054	20	949	18	701	13
Greatham	313	15	195	9	168	8	426	20	543	25	487	23
Hart	1,353	20	670	10	904	13	1,628	24	1,257	18	1,101	16
Owton	1,359	24	802	14	777	14	1,099	19	942	17	712	13
Park	933	16	593	10	373	6	1,289	22	1,474	25	1,272	21
Rift House	1,240	20	724	12	681	11	1,192	19	1,120	18	1,328	21
Rossmere	1,211	19	673	11	785	12	1,228	19	1,325	21	1,131	18
Seaton	1,181	17	686	10	661	10	1,497	22	1,459	21	1,381	20
St Hilda	1,083	19	686	12	735	13	1,131	20	1,078	19	995	17
Stranton	1,190	19	898	15	916	15	1,233	20	1,041	17	827	14
Throston	1,217	20	657	11	653	11	1,452	24	1,072	18	921	15

Source: Census 2011

Provision of unpaid care by hours per week

		Provides 1-19 hours unpaid care a week		Provides 20-49 hours unpaid care a week		Provides 50+ hours unpaid care a week		Total Number of Carers
Area Name	Population	Number	%	Number	%	Number	%	Number
Hartlepool	92,028	5,325	5.8	1,555	1.7	3,044	3.3	9,924
Brus	6,779	262	3.9	125	1.8	265	3.9	652
Burn Valley	5,688	331	5.8	81	1.4	130	2.3	542
Dyke House	4,952	240	4.8	94	1.9	193	3.9	527
Elwick	2,061	152	7.4	32	1.6	52	2.5	236
Fens	4,871	377	7.7	105	2.2	186	3.8	668
Foggy Furze	4,497	244	5.4	66	1.5	133	3.0	443
Grange	5,222	295	5.6	82	1.6	138	2.6	515
Greatham	2,132	168	7.9	33	1.5	68	3.2	269
Hart	6,913	468	6.8	99	1.4	180	2.6	747
Owton	5,691	212	3.7	101	1.8	200	3.5	513
Park	5,934	517	8.7	114	1.9	150	2.5	781
Rift House	6,285	344	5.5	122	1.9	267	4.2	733
Rossmere	6,353	350	5.5	121	1.9	241	3.8	712
Seaton	6,865	511	7.4	84	1.2	222	3.2	817
St Hilda	5,708	245	4.3	102	1.8	226	4.0	573
Stranton	6,105	259	4.2	97	1.6	206	3.4	562
Throston	5,972	350	5.9	97	1.6	187	3.1	634

Source: Census 2011

LOCAL CONTEXT: COMMUNITY LED SUPPORT (CLS)

Hartlepool Borough Council has recently embarked on a transformational programme that develops a new way of delivery of community support. This is called Community Led Support. It is based on a set of principles for how social care support should be delivered. These are implemented in ways that are determined by people directly delivering services along with local partners and members of the community they are serving. It builds on what is already working, joining up good practice and strengthening common sense, empowerment and trust.

THE OVERARCHING, LONG TERM, CORE COMPONENTS OF THE VISION THAT THE CLS PROGRAMME AIMS TO SUPPORT INCLUDE:

- That local people receive support that is responsive, community based and focused on resilience and keeping them in control of their lives;

- That communities are actively involved in shaping and delivering local support and develop local solutions to respond to need;

- That social care practitioners feel supported and trusted, experience increased morale and ability to determine local working practices, develop skills to have strengths based conversations with people, are skilled in identifying local solutions and have a positive approach to risk;

- That voluntary sector partners and other statutory agencies are involved in the delivery of information, advice and support at a local level and deliver support in a joined up, holistic way; and

- That statutory services are of a high quality, are efficient and responsive and 'fit for purpose' in their ability to respond to increased demand on services within restricted budgets.

CASE STUDY 3

Christine and Gavin are both carers for her two sons, James who is 11 years old and Harry who is 7 years old.

In 2007, their first son was born in Hull Hospital, whilst they were living away from their home town due to Gavin's employment.

After a long and difficult birth, James was born unresponsive and required additional support to get him breathing on his own. Within 24 hours they were told that doctors thought he had Marfan syndrome and would require genetic testing to diagnose.

They eventually returned home on maternity/paternity leave, to be met with appointments for physiotherapy, genetic testing at Newcastle, paediatrician appointments and specialist appointments at Leeds General Infirmary.

Christine and Gavin returned to Hartlepool and over a period of three years, they had over 20 professionals from Health and Social Care involved in their lives. As well as working full time they both travelled the country in search of a diagnosis for their son, who was not reaching his milestones.

After 3 years of specialists searching for a diagnosis they received the news that they had found the cause of James delays. In 2010 James was diagnosed with a rare genetic neurological degenerative disease known as MASA Syndrome. At that time doctors were not aware of any other children living with this condition and could not tell the family exactly what to expect. Their caring role was increasing with the need for daily therapies and interventions to keep James well.

In 2011, Christine found that she carried the rare genetic condition and at risk of passing this on to any other children. Within this time they also found out they were expecting their second child. They were offered a termination and testing to check if their unborn child was affected. After many appointments and meetings, both decided to turn down all testing.

Harry was born in 2011 and with Christine and Gavin's knowledge of the condition from travelling to America to meet other families, they knew immediately that Harry was also affected with the rare syndrome. Their caring role significantly increased and Christine left her full time position to care full time.

Christine said "We do not necessarily see ourselves as carers, we are James and Harry mam and dad, who do everything in our power to ensure they live happy, healthy lives. Without the support from Children's Services and Health professionals involved in our boys care, I am not sure how we would actually function as a family. Although our boys need 24 hour care, we have an amazing team around our whole family. Social Care has significantly helped us creating a flexible package of support to meet our needs as a whole family."

With the flexible package of support and now both boys accessing multimedia specialist educational provision, Christine has returned back to employment at Hartlepool Carers, supporting other carers to receive the right support at the right time.

OUR PRIORITIES

In order to achieve the vision our plan will focus on six priorities:

1. **Identify carers at an early age, recognising their contribution and involving local care in planning individual care packages.**

2. **Carers having a family and community life alongside caring personalised support for carers and providing good quality information, advice and support**

3. **Support carers to stay healthy – mentally and physically**

4. **Carers realising and releasing their potential in education and employment**

5. **Providing opportunities to help ex-carers sustain and fulfill healthy lives**

1. IDENTIFY CARERS AT AN EARLY AGE, RECOGNISING THEIR CONTRIBUTION AND INVOLVING LOCAL CARE IN PLANNING INDIVIDUAL CARE PACKAGES

WHAT DO YOUNG CARERS WANT?

- Emotional support – safe place to talk
- Help and support with bullying at school
- Need information about parental/ sibling illness
- One to one opportunity to talk to staff they know
- Help with homework and study
- Help to let people know such as their schools to understand their caring role
- Respected when taking our family members to appointments

WHAT DO CARERS WANT?

- I am listened to
- My peers understand the challenges I face
- I get help to stay fit and well
- Inclusive communities where families don't have to cope
- I am proud of my caring role and get help with it

WHAT WILL WE DO?

1. Development of effective partnership between GP practices and Hartlepool Carers.

2. Development of a young carers card that allows young carers to share with services so they understand carers needs.

3. Work with Schools, GPs, hospitals and other professionals to understand what young carer means and how to support us.

4. Support Hartlepool Carers to develop more peer to peer support for young carers because talking to other young carers really helps.

5. More activity opportunities for young carers – we love the break from our caring roles.

6. Work with primary care to ensure carers are identified and supported.

7. Work with Hartlepool Carers for them to undertake carers assessments and allocate resources as appropriate.

8. Increase awareness and understanding of what it means to be a carer across the workforce.

WHAT DO YOUNG CARERS AND CARERS WANT?

- I am supported to access regular activities
- I am encouraged to socialise
- I am able to access information and services where I live
- I am provided with advice
- I am able to request and access transport

WHAT WILL WE DO?

1. Work with Hartlepool Carers, recognising they are best placed given their lived experiences, for them to support carers to access informal and formal support.

2. Develop a Community Hub offer that carers can access.

3. Develop & publicise a Hartlepool Local Offer to Carers.

4. Implement Community Led Support

5.Development of effective relationships between Hartlepool Carers and HAST CCG to enable carers to navigate the system and complexities of health funding.

6. Consult with carers about
their needs for short break respite care and review provision in light of
consultation findings.

WHAT DO YOUNG CARERS AND CARERS WANT?

- I do not feel alone
- I have people to support me
- I can take part in leisure activities or hobbies that I want to
- Getting involved in fundraising
- I can take a break from being a carer
- I know where to go for help
- I get information to help me to take care of myself
- I can live a healthy life as a carer
- My GP knows I'm a carer
- My GP knows what is available for me
- I have someone who understands me and my needs

WHAT WILL WE DO?

1. Young Carers to be supported to access activities that meet their needs; e.g Hartlepool

2. Carers, Youth Service, universal activities within communities.Create opportunities in Community Hubs for carers to:
- Development connections with other carers that will support their Mental Health.
- Access activities that supports their physical health.

3. Development of effective relationships between Hartlepool Carers and GPs.

4. Identify best practice examples within primary care than support carers to stay healthy and share this with the system.

5. Work with health providers e.g. TEWV and NTHFT for them to understand carers needs and support them as needed

4. CARERS ABLE TO RELEASE AND REALISE THEIR POTENTIAL IN EDUCATION AND EMPLOYMENT

WHAT DO YOUNG CARERS AND CARERS WANT?

- I have somewhere to go where I can learn new skills
- I can attend training or can go to college or university
- I feel supported to create a CV/apply for jobs and go for interviews
- I am supported/ encouraged to try new things
- My employer understand my caring role
- I can volunteer and use my skills

WHAT WILL WE DO?

1. Work with school for them to understand the needs of Young Carers and how they can support them to achieve their education.

2. Develop opportunities in Community Hubs so that carers can access activities that will support their pathway to employment.

3. Work with adult education/ volunteering program to enable carers to access opportunities that support them.

4. Develop partnerships with FE providers to promote identification of young carers and establish appropriate support.

5. Work with local employers to create a supportive working environment for carers in the workplace.

WHAT DO CARERS WANT?

- I would like to meet other ex-carers and attend social activities
- I would like to feel included once my caring role ends
- I would like assistance back into employment, volunteering and training
- I would like my experiences as an ex carer to be used to benefit others
- I would like to help other carers new to the role
- I would like to be supported to ensure I have the belongings of my loved ones when they have been in care home

WHAT WILL WE DO?

1. Community Hubs – marketing of activities available across the town for carers and ex carers.

2. Hartlepool Carers to work with ex carers to support them to access support and activities.

3. Develop opportunities in Community Hubs so that carers can access activities that support a pathway to employment.

4. Work with adults education/ volunteering programmes to enable ex carers to access these opportunities.

5. Hartlepool Carers to further develop ex carers volunteers.

6. WIDEN PARTICIPATION OF CARERS TO INFLUENCE DECISION MAKING AT A LOCAL LEVEL

WHAT DO YOUNG CARERS AND CARERS WANT?

- I am able to voice my opinion on important matters
- I do not feel discriminated against
- I can see that my opinions are taken seriously
- Information on the development of services is shared with me
- I know where I can get information and support
- I am involved in the planning and delivery of services

WHAT WILL WE DO?

1. Work with Hartlepool Carers to reinstate Carers Strategy group so they support the implementation, monitoring and review of this strategy.

2. Young Carers (need to add group??)

3. Work with H'Pool Carers for them to empower carers to enable them to shape their own support.

HOW WILL WE KNOW IF WE HAVE BEEN SUCCESSFUL?

- Progress on the action plan which will be reported to the Health and Wellbeing Board annually.
- Number of carers being supported by Hartlepool Carers increases.
- Number of carers being offered advice and guidance by.
- Young Carers report that services are aware of their caring role and adapt their service as required.
- Number of carers accessing Community Hubs increases.
- Carers report that services are more aware of their needs as carers and respond to them effectively.
- Number of GP practices actively working with Hartlepool Carers increase.
- Increased number of services recognise young carers card

HEALTH AND WELLBEING BOARD

23 September 2019

Report of: Director of Commissioning, Strategy and Delivery (Locality Commissioning Director - Hartlepool and Stockton-on-Tees CCG & Darlington CCG)

Subject: CLINICAL COMMISSIONING GROUP ANNUAL REPORT 2018/19

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1. PURPOSE OF REPORT

1.1 To provide the Health and Wellbeing Board with an overview of the 2018/19 Annual Report for Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG).

2. BACKGROUND

2.1 The Hartlepool and Stockton-on-Tees Clinical Commissioning Group's Annual Report provides an overview of the CCG's purpose and main activities during the year. It sets out the challenges experienced during the year along with the organisation's achievements.

3. REPORT HIGHLIGHTS

3.1 The CCG was rated as 'outstanding' by NHS England as part of its annual assessment of CCGs which demonstrated the CCG's commitment to continual improvement during a challenging year, progressing from a rating of 'good' in the previous year. A number of key areas of strength were identified through the assessment such as quality of life for carers, cancer patient experience and dementia diagnosis and the support received from partners is acknowledged in the report. Areas of ongoing challenge for the CCG included one year survival from all cancers, choices in maternity services and maternal smoking rates at time of delivery.

3.2 The report also details the collaborative working approach implemented during 2018/19 with the appointment of a single Accountable Officer for the five CCGs in Durham and the Tees Valley. The report goes on to share some examples of collaborative projects which include talking with local people to improve the commissioning and provision of rheumatology services; audiology services; and mental health talking therapies (IAPT).

3.3 The CCG's financial position was maintained during the year reflecting the strong financial management within the organisation; however, the report highlights the challenging NHS financial climate and that CCGs are facing significant financial pressures.

3.4 With regards to performance against national targets, the CCG generally performed well in relation to time from referral to receiving treatment; waiting times for A&E services; and the CCG met seven of the nine national cancer targets. New national ambulance targets were introduced in year and remain a challenge, with the local ambulance service providers meeting three of the six response time targets; this remains a challenge nationally. Other areas for improvement include the need to reduce Healthcare Acquired Infections, improve cancer targets to achieve the 62 day wait from urgent GP referral to treatment and to improve waiting time for diagnostic tests. The CCG continues to work with its providers to understand the challenges faced and identify ways to improve compliance against these important targets to benefit the local people we serve.

3.5 With regards to primary care, following a comprehensive bidding and evaluation process, the CCG selected the local GP Federation Hartlepool & Stockton Health (H&SH) as the preferred provider of GP Extended Access services. The service is aimed at providing additional clinical capacity in general practice at times when there is considerable pressure on healthcare services as a result of rising patient demand and includes early evenings, weekends and public holidays.

3.6 Specifically in relation to our work in Hartlepool, the report featured:

- The review and implementation of recommendations from the Special Educational Needs and Disabilities (SEND) inspection.
- The Care Home Pharmacy Scheme review which included self-assessment audits conducted across all homes and safeguarding matters addressed with care home staff who have been supported to implement improved areas of good and safe practice. In addition, all care homes have participated in the Medicines Optimisation training programme and self-assessment audits have been undertaken to assess and improve the quality of medication administration processes.
- The development of a fit for purpose Mental Health strategy that meets the requirements of all relevant guidance, working in partnership with Public Health and other local authority colleagues. Hartlepool's 'Beautiful Minds Partnership' project which comprises of a range of organisations working across the town dedicated to promoting good mental health is also highlighted.

4. RECOMMENDATIONS

4.1 The Health and Wellbeing Board is asked to note the content of the Annual Report.

5. REASONS FOR RECOMMENDATIONS

5.1 To ensure Board members are aware of the Annual Report for Hartlepool and Stockton-on-Tees Clinical Commissioning Group.

6. BACKGROUND PAPERS

2018/19 Annual Report for Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG) published on the CCG's website.

7. CONTACT OFFICER

Michael Houghton, Director of Commissioning, Strategy and Delivery (Locality Commissioning Director Hartlepool and Stockton - on -Tees CCG & Darlington CCG)

NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group

Annual report and accounts

2018/19

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Statement from the Accountable Officer and Chair

Welcome to the NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCGs) 2018/19 Annual Report.

This report details our performance throughout 2018/19 including our financial performance, our approach to good governance and how we work with our partner organisations across the health and social care sector to achieve our aims.

The performance report describes our objectives and strategies as a commissioning organisation and our challenges and successes. It outlines the projects we have led on and how they have improved delivery of healthcare in our communities.

We were delighted to be rated as 'outstanding' in the annual assessment carried out by NHS England this year. The assessment recognises the significant improvements and progress made over the last year and continued strong delivery which has seen the CCG rating improve from 'good' in 2017/18.

All clinical commissioning groups in England are subject to a comprehensive annual assessment framework which is led by NHS England. This examines 51 indicators across a series of policy areas covering performance, delivery, outcomes, finance and leadership.

The assessment considers the strengths, challenges and areas for improvement before applying a headline rating of outstanding, good, requires improvement or inadequate.

The assessment highlighted a proactive approach to quality and continued delivery of the majority of constitutional standards as well as the creation of a learning disability commissioning hub and joint cancer workplan.

A number of key areas of strength were highlighted in the assessment, placing NHS Hartlepool and Stockton-on-Tees in the top quartile of CCGs nationally in a series of indicators including, quality of life for carers, cancer patient experience and dementia diagnosis amongst others.

The assessment identified a number of areas that remain challenging. These related to obesity, one year survival from all cancers, maternal smoking at delivery and choices in maternity services.

We are absolutely delighted with the outcome of the assessment and would like to take this opportunity to thank our member practices, providers and partners across health and social care and the voluntary sector for their help in achieving this rating and driving improvements across health and social care in our local communities. We will continue to work on our areas of challenge.

We describe within the report how we are linking our work with a key transformation programme called the Integrated Care System. An Integrated Care System is not a statutory body or organisation, although they need clear leadership, decision-making and governance structures, they are essentially about individual organisations joining together to improve health and care. Integrated care means working together, focused on the same outcomes for patients. The work involves NHS organisations, councils and the voluntary or charity sector

working together, in particular when providing care closer to home and tackling the causes of ill health. We also highlight in the report those areas where our performance can be further improved.

The financial section of this report shows how we have managed our difficult financial position this year which has been closely monitored and assured by NHS England. The CCG cannot deliver its vision whilst spending more than we receive in funding, effectively spending tomorrow's healthcare budget today. The scale of the financial challenge facing both the CCG and local health and social care economy is significant.

We hope that you find this Annual Report informative and interesting. If you would like to find out more about us or get involved in the work we do, further information about NHS Hartlepool and Stockton-on-Tees CCG is available on our website www.hartlepoolandstocktonccg.nhs.uk

Dr Neil O'Brien
Chief Clinical Officer

Dr Boleslaw Posmyk
Chair

PERFORMANCE REPORT

Dr Neil O’Brien
Accountable Officer
28 May 2019

About NHS Hartlepool and Stockton-on-Tees CCG – Overview

NHS Hartlepool and Stockton on Tees Clinical Commissioning Group (the CCG) has an annual duty to review national planning guidance and agree a range of priorities for the financial year that form the basis of their annual operating plans. These plans, for 2018-19, set out priorities that took into account:

- Requirements as set out in the NHS Long Term Plan, Five Year Forward View, Mental Health Five Year Forward View and GP Five Year Forward View
- Sustainability and Transformation (STP) Partnership requirements
- Integrated Care System (ICS) requirements
- Current financial constraints of the CCG
- The nine national 'must do's' as set out in national planning guidance. They include primary care, urgent care, cancer and mental health care

The purpose of the following overview section is to enable you to understand the CCG, our purpose, our objectives and any associated risks to the achievement of those objectives. It also tells you how the CCG has performed during the year and should enable readers to have an overview of the organisation and the year without the need to look further into the Annual Report.

About Us

NHS Hartlepool and Stockton-on-Tees CCG was established as a statutory body in April 2013 as a result of the Health and Social Care Act 2012. We are responsible for planning and purchasing a range of local healthcare services on behalf of patients across the Hartlepool and Stockton-on-Tees areas.

We are based at Billingham Health Centre, Queensway, Billingham and we represent all 33 GP practices across the two boroughs and our population of 297,299. We are a clinically-led membership organisation made up of the GP practices we represent. In 2018/19, we had a total annual budget of £475.4million which we received from NHS England.

We are committed to creating an accessible health service that provides safe, high quality care in the best place for our patients and we are dedicated to developing effective working relationships with partners, stakeholders and the public to deliver more joined up healthcare that will benefit everyone.

We are responsible for commissioning the following services;

- Mothers and new-born children
- Mental health
- Learning disabilities
- Emergency and urgent care
- Routine operations
- Long term conditions
- End of Life
- Continuing healthcare

- GP services.

We work with a broad range of stakeholders including healthcare service providers, neighbouring CCGs, Healthwatch organisations, Hartlepool Borough Council and Stockton Borough Council, as well as community and voluntary organisations to ensure a joined up approach to the provision and resourcing of healthcare in our community. We know that by working closely with partner organisations who have similar priorities and challenges we can achieve so much more.

We chaired the North of Tees Partnership Board until September 2018. The board was established to set common goals to work closely together to develop services in Hartlepool and Stockton-on-Tees that will help people live longer, healthier lives with a view of ensuring health and social care services are commissioned to meet the needs of individuals. The group comprises the CCG and the Local Authorities and includes other stakeholders including the local NHS Foundation Trust and Mental Health Trust. It is through a shared approach to transforming services across our localities we will remove the barriers organisational boundaries traditionally create.

Our vision and aims

Our vision:

Our vision as NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG) is ‘to develop outstanding, innovative and equitable health and social care services, ensuring excellence and value in delivery of person centred care working across both health and social care’.

This means:

- Health services which are safe and of the highest quality
- Best possible health outcomes
- Joined up services which benefit patients and the public and give best value for money

To deliver our vision we focus on these key aims:

- Work with our patients to promote and support healthy living and self-care
- Involve service users, carers, staff, providers, partners and the public to develop services and reduce health inequalities
- Work in partnership to transform services and ensure transparency through inclusion of all stakeholders to meet patient needs
- Make use of and contribute to the evidence base that drives service transformation, embracing opportunities to innovate
- Commission sustainable services as close to the patient’s home as possible
- Ensure services are safe, high quality and cost effective

- Plan and respond to the identified needs at a locality level for the residents of Hartlepool and Stockton on-Tees

Sustainability and Transformation Partnership/Integrated Care System

Clinical Strategy for Hospital Services

During 2018/19 the South Integrated Care Partnership has been taking forward and building upon the work of the Better Health Programme, and other programmes over recent years to develop proposals for sustainable hospital services in this area.

The Better Health Programme was established in 2015 to develop models of care that could remain clinically sustainable whilst meeting the likely workforce pressures of the future. Learning from the Better Health Programme's public engagement work on what people value from their hospitals and other NHS services has gone on to form the basis of the next phase of work.

This next phase is the development of the Clinical Strategy for Hospital Services for the South of the North East and North Cumbria region.

The Clinical Strategy for Hospital Services is a programme of service model development where clinical leaders are developing better ways and new ideas to organise health and care services to help solve some of these challenges, by joining up processes to 'do once' and deliver more with the same resources.

They are also taking into account clinical priorities set out by clinical networks across Northern England such as the Northern Trauma Network, the North East Urgent and Emergency Care Network and the Northern England Neonatal Network, and the work of Local Maternity Systems (LMS).

The first phase the of clinical strategy is looking at the future delivery of a number of key hospital services which are a priority for change - Urgent and Emergency Care, Women's and Children's services (Maternity services , Obstetrics, Gynaecology, Neonatal intensive care and Paediatric services), Frailty and Stroke services, and elective (non-urgent, planned) care for spinal, breast and urology services.

While the Better Health Programme was initially driven by potential changes to hospital services at Darlington, Middlesbrough and Stockton, specifically for the smaller number of patients deemed to be high risk or requiring specialist emergency care, it was also influenced by an ambition to transform care so more people could stay safely independent at home rather than needing hospital-based care.

The NHS Five Year Forward View encouraged the NHS to look at new ways of providing services which are much more joined up across local organisations which would better meet the needs of local communities.

More care outside hospital is now in place with more planned. This aims to manage more patients out of hospital either by not admitting them in the first place, or if they are admitted, making the right support available so that they can be discharged from hospital at an earlier stage. As such, these new arrangements mean the provision of care can be reshaped in local areas and that the GP practices and other local services involved have greater responsibility and accountability for a defined (registered) patient population.

NHS Long Term Plan

The NHS Long Term Plan is a new plan for the NHS to improve the quality of patient care and health outcomes. It sets out how the £20.5 billion budget settlement for the NHS, announced by the Prime Minister in summer 2018, will be spent over the next 5 years.

The plan focuses on building an NHS fit for the future by:

- enabling everyone to get the best start in life
- helping communities to live well
- helping people to age well

The plan has been developed in partnership with frontline health and care staff, patients and their families. It will improve outcomes for major diseases, including cancer, heart disease, stroke, respiratory disease and dementia.

The plan also includes measures to:

- improve out-of-hospital care, supporting primary medical and community health services
- ensure all children get the best start in life by continuing to improve maternity safety including halving the number of stillbirths, maternal and neonatal deaths and serious brain injury by 2025
- support older people through more personalised care and stronger community and primary care services
- make digital health services a mainstream part of the NHS, so that in 5 years, patients in England will be able to access a digital GP offer

NHS Hartlepool and Stockton-on-Tees CCG's Operational Plan

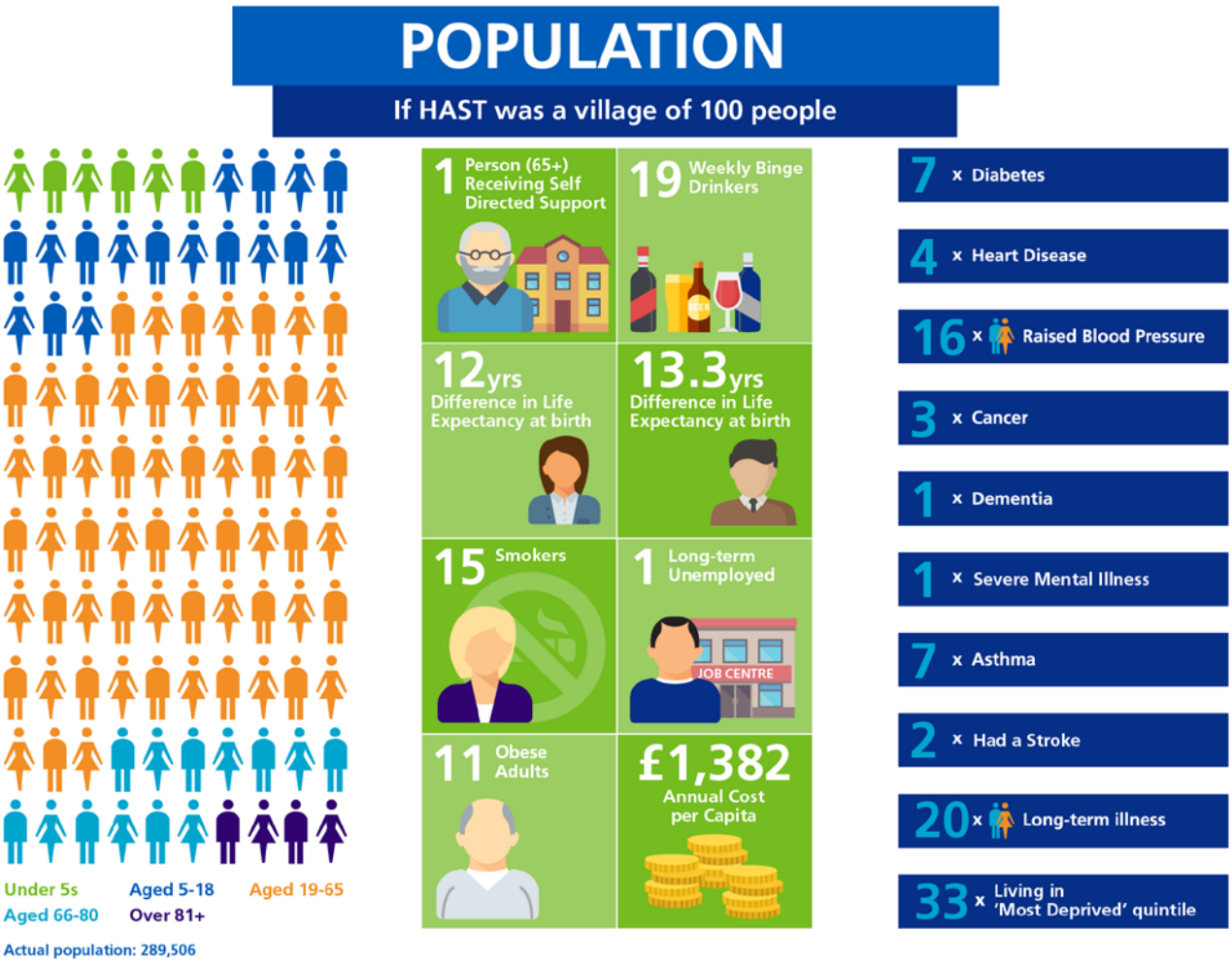
In April 2017 the CCG developed a two year operational plan which articulated how we will deliver transformation at scale and pace in order to deliver the requirements of the 'Five Year Forward View'. The plan built on the progress already made during 2017/18 focusing on the following areas;

• Further strengthening of our partnership working with all providers and other CCGs across our STP footprint in order to understand the shared opportunities and wider impact of our respective plans

• Continuing to build on our history of working in partnership to drive improvements in the health and wellbeing of our local population

• Detailing the quarter on quarter benefits of the transformation programmes we plan to deliver and the expected outcomes. The plan highlighted the demographics of patients living across Hartlepool and Stockton-on-Tees and the areas which pose significant challenges to the CCG in terms of prevalence of disease, quality and financial constraints.

The graphics below represent the local population health statistics. HAST is Hartlepool and Stockton on Tees.

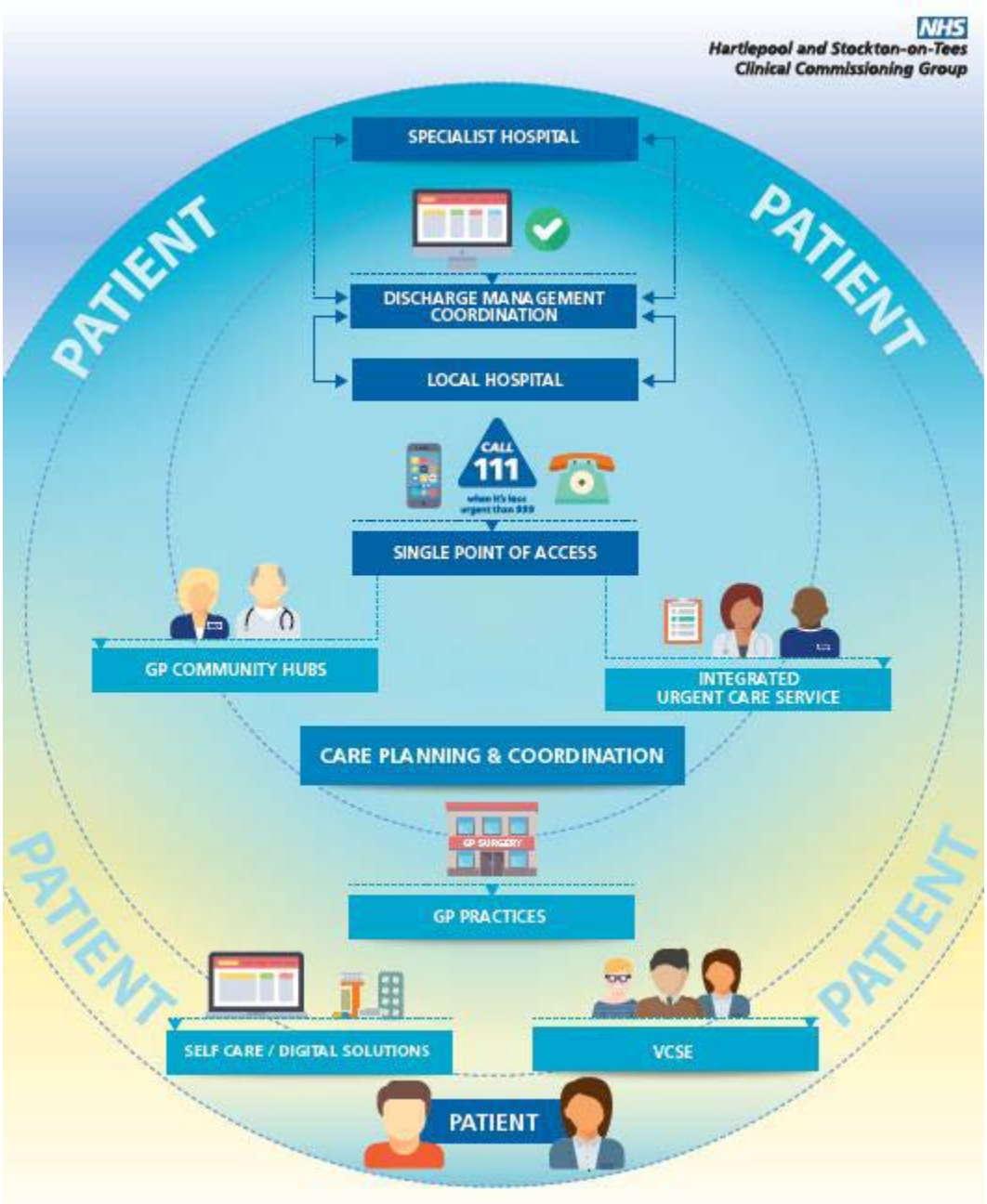


The Operational Plan incorporates the CCG plans for new models of care (NMoC). NMOC are based on both personalised coordination of care and on system coordination of care. Greater involvement of people in their own treatment and care should lead to improved personalised coordination of care. This requires hub based health and social care teams to form to allow partnership working on multiple levels and joint care planning.

We are making progress towards realising those improvements to meet our vision of how we want services to look in 2020 with patients at the centre. The operational plan is available on the CCG website www.hartlepoolandstocktonccg.nhs.uk

NHS Hartlepool and Stockton-on-Tees CCG Care Blueprint

The Blueprint below outlines how local services are organised around the patient.



Our Achievements 2018/19

Throughout the financial year the CCG closely monitors performance against agreed operational plans and performance frameworks linked to the detailed plans in place. A robust governance structure is set up to support this process (described in the Governance statement) and regular assurance checks are undertaken by NHS England to ensure plans are in progress.

The following section sets out our achievements against the ambitions set out in our detailed operational plan.

CCG 2018-19 Ambitions

The following 4 areas are high level ambitions linked to the delivery of our detailed operational plan for 2018-19. They outline what the CCG deliver in 2018-19 and the actual achievement against each.

Ambition 1	**Reduce unwarranted variation across a range of services to ensure patients receive equitable access to high quality services in the right place at the right time**
Ambition 2	**Design and implement plans to transform a range of services in line with national, regional and local initiatives to improve access, sustainability and achieve the best possible outcomes**
Ambition 3	**Strengthen care outside of hospital to ensure that individuals and their carers are able to take more control of their health and maintain independence for longer through early intervention and prevention, whilst preventing or delaying the need for more services in an acute setting and avoiding unnecessary complications and acute crisis**
Ambition 4	**Implement plans to deliver a sustainable primary care offer fit for the 21st century, delivering access to high quality, cost effective, patient centred care through a motivated, diverse and appropriately skilled workforce**

AMBITION 1

URGENT CARE	
We Said	**We Did**
We would support the review and development of regional plans regarding urgent care:	• Implemented a revised NHS 111 service and a Clinical Assessment Service within NHS 111, ambulance dispatch and GP out of hours services supporting increased access to clinical advice

RESPIRATORY	
We would ensure development of a revised Respiratory service, increasing care closer and avoiding unplanned admissions to hospital.	• Support 'Hospital at Home' model of care. Work with discharge teams to enable early supported discharge, to support patients to remain at home or return home sooner if clinically appropriate. More GP and nurses education sessions on managing respiratory conditions. • Hospital admissions for COPD have remained stable over the last 3 years since the inception of Hospital at Home. Reduction in length of stay and readmissions associated with respiratory conditions.
ORTHOPAEDIC SERVICES	
We would undertake a comprehensive review of Orthopaedic Services to support care closer to home and reduce inappropriate planned attendances in hospital	• Community MSK service treats patients in the community service through the single point of access. reducing the need for hospital attendance and reducing unnecessary outpatient appointments and day cases • The MSK service now works with non-medical prescribers to allow for medication reviews and discussions with patients, saving an additional GP appointment being needed.
GASTRO INTESTINAL (GI)	
We would undertake a comprehensive GI review and agree and implement changes to address unwarranted variation.	• Reduction in wait time for access to gall stone related surgery
ATRIAL FIBRILLATION (AF)	
We would improve detection and ongoing management of patients with Atrial Fibrillation (AF).	• We have established an AF detection programme in, GP practice, Pharmacies, Outpatient clinics, Podiatry resulting in an overall potential stroke reduction rate of 8%
BONE HEALTH	
We would undertake a programme of work to review unwarranted variation in relation to bone health and fractures.	• Established a programme of work in GP practice to prevent and identify individuals at risk / who have osteoporosis, ensuring they are medically optimised / educated to prevent worsening disease processes and subsequent fractures.
CLINICAL ASSESSMENT AND PEER REVIEW PROGRAMME	
Evaluate the Clinical Assessment and Peer Review (CASPeR) programme to assess effectiveness of the service and develop recommendations for the future	• Increased access to support for GP Practices • Assessed and triaged almost 12,000 referrals (August 2017 – December 2018 data available)

	• Offered alternative management options for on average, 6% of referrals received, supporting access to care closer to home • Contributed to a reduction in outpatient first appointment activity compared to 17/18 levels
SEPSIS	
We would support the development and implementation of a community sepsis pathway, working in conjunction with North Tees and Hartlepool NHS Foundation Trust	• Worked with Trust and GPs to pilot a new digital decision support tool that assists community matrons to accurately assess the risk of patients becoming septic.
AUTISM SPECTRUM DISORDER (ASD) DIAGNOSIS	
We would review pathways and implement changes to reduce wait times for Autism Spectrum Disorder (ASD) diagnosis	• Work with Parent Carer Forums in Hartlepool & Stockton to review and improve letters sent to parents of children on waiting lists. The letters are now more 'parent friendly' and less 'clinical'. Signposting information was also provided. • Agreed additional resources to fund a waiting list initiative enabling an additional 500 Children and Young People to be assessed over a 12 month period. Parent Carer engagement has been integral to the changes being made. • 76 children and young people have received a MAAT assessment between November and the end of February 19. Children who received their assessment in February have seen an impact of an average of a 9 month improvement on their original MAAT date.
VISION SCREENING	
We would undertake a Vision Screening Review	• Commissioned Primary Eyecare Services to deliver a community children's optometry service that will support the management and treatment of children who fail school vision screening. The service will go live in March 2019.
PAEDIATRIC CONTINENCE	
We would develop and implement an integrated Tier 2 Paediatric Continence Pathway	• Engaged with local groups to get a better understanding of gaps and needs of local families and as result, developed a Tier 2 specification for integrated paediatric continence service for 0-19's that includes the assessment, reassessment and management of continence products aligned to the NICE Paediatric Continence Commissioning Guidance • Commissioned North Tees and Hartlepool NHS Foundation Trust to deliver an integrated 0-19 paediatric continence service. The full service will

	go live in April 2019.
PAEDIATRIC CARE	
We would review current non elective (NEL) paediatric activity with a view to revising pathways to reduce inappropriate activity/admissions and streamline overall patient flow	• Implemented 'Consultant Connect' to allow referrers to discuss patients with senior consultant to support decision making • Implemented hot clinics to manage the most common conditions that are referred and discharged within 4 hours.
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT)	
We would undertake review of current Psychological Therapies (IAPT) services	• IAPT services have been reviewed and a consultation exercise undertaken. The results and outcomes will be used to procure services in 2019. In Hartlepool and Stockton, all targets for access and recovery are being met at 100% or exceeded where targets are set as a percentage.
MENTAL HEALTH	
We would review provision of services for people with Persistent Physical Symptoms and implement any necessary improvements.	• Working with NHS England on a programme supporting practices in identifying potential PPS patients. Pilot sites are in place at Kingsway Medical Practice, Billingham and Denmark St, Darlington. Findings from the pilot will be published in 2019
We would improve health equality for people with Learning Disabilities including improved rates of Annual Health Checks, Flu Vaccination and Cancer Screening.	• As part of the implementation of NHS England's programme for Enhanced Services the CCG requires that GPs undertake a programme of Annual Health Checks, cancer screening and flu vaccination for people with additional needs. • Service is designed to encourage practices to identify all patients aged 14 and over with learning disabilities; to maintain a learning disabilities register; and to offer people an annual health check, which includes producing a health action plan together with subsequent health screening and vaccination.
We would develop processes to complete Anti-psychotic medication reviews and take any remedial action required.	• Alongside the LeDeR programme, CCGs have worked on the STOMP (Stopping over medication of people with a learning disability, autism or both) pledge, a national project helping to stop the over use of psychotropic medicines. • Resources provided to GPs, psychiatrists, psychologists, pharmacists, nurses and social care providers in addition to local support groups, individuals, families, carers and

	community teams • Funding received to pilot collaborative working between specialist services, GPs, carers and patients to review prescribing. This is to be completed by an Independent Prescriber specialising in Learning Disabilities who has the knowledge and expertise to review medications safely and appropriately.
We would review treatment provision out of area and implement activities to ensure people receive care close to home.	• Reported that fewer people were admitted to a hospital that is not the one they would expect to be admitted to - known as out of area placements. Work continues on reviewing these placements.
We would review the current Autism service and make improvements	• Adult Autism Service has been reviewed and the results included in the Autism Self-Assessment Framework (SAF) 2018, enabling local strategy groups to review progress and support future planning with strategic partners, people with Autism and their families. • TEWV implemented Autism Awareness Training and mandatory Equality and Diversity training as part of staff induction.

AMBITION 2

CANCER	
We Said	**We Did**
We would work closely with the Northern Cancer Alliance and Trusts to implement new cancer navigator roles, regionally defined Community Cancer Awareness Development Worker posts and work with Cancer Alliance and CRUK to provide non clinical 'signs and symptoms' training to GP practice staff	• Recruited new Cancer Community development worker to work with community groups and employers to raise awareness of the signs and symptoms of cancer and accessing screening services. Positive contribution to the reduction of health inequalities and improvement in the early diagnosis of cancer. • Provided training to non-clinical staff in general practice re: signs and symptoms, early diagnosis and screening. • Implemented a cancer navigator post in endoscopy to ensure compliance with 2 week wait referrals.
We would work closely with the Northern Cancer Alliance and continue to implement 'Living with and Beyond Cancer (LWBC)' transformation plans	• Funded a Cancer Care Coordinator to develop, implement Treatment Summaries, Holistic Needs Assessments and cancer care reviews in GP practice • Funded Voluntary Community and Social Enterprise (VCESE) organisation Catalyst to work with the Trust and the voluntary sector to develop understanding within the VCSE community in relation to Cancer, includes holding health and

	well-being events • The Cancer Care coordinator has worked cancer nurse specialists improving communication with GPs, so that practices can see what has happened to patients and what actions the GP now needs to take forward post diagnosis/treatment.
We would, with the Northern Cancer Alliance to develop plans to implement follow up pathways for breast and urology cancers.	• Implemented new stratified pathways for breast and urology cancer so that patients who are identified as low risk by their consultants and cancer nurse specialist will be placed on a pathway where they do not have to return to an outpatient appointment but can be monitored and supported over the phone. Knowing that if any issues arise they can return to a more traditional pathway if needed. This reduces unnecessary attendance to a hospital setting
NHS DIABETES PREVENTION PROGRAMME	
We would implement the NHS Diabetes Prevention Programme (wave 3)	• The NHS Diabetes Prevention Programme has been implemented and went live from the beginning of April 2018. The programme enables access to an education programme which encourages increased physical activity and support via behavioural therapy. • Up to the end of December 2018, there have been 2,744 referrals made into the NHS Diabetes Prevention Programme. Of these referrals, 1,244 people have attended an initial assessment which equates to an uptake rate of 45%. To date, there have been 1,057 participants who have started on the Programme. The average weight loss measured at the 6 month point was -3.4kg
CHILDREN AND YOUNG PEOPLE	
We would review screening of Children and Young People (C&YP) to ensure early identification of any additional needs.	• Developed Special Educational Needs and Disability (SEND) Top Tips for multi-agency distribution about the requirements of the SEND Code of Practice • Designated clinical Officer (DCO) recruited • Identified and planned strategic joint commissioning opportunities which will be taken forward as a tangible project in 19/20
We would design and implement a 'needs led' Neurodevelopmental Pathway	• Consultation with schools to further explore their approach to supporting a child who they have identified as having possible ASD. • Joint commissioning with Stockton Borough Council has been undertaken to commission a Sensory Training Service and a Family Support Service. Work ongoing to develop a training package to ensure all schools have access to

	training.
We would review and implement the recommendations from the Special Educational Needs and Disabilities (SEND) inspection within Hartlepool	A SEND re-inspection took place in January 2019. Progress was reported against a wide range of areas including (but not limited to): • Improvements to availability and delivery of physio • Improved access to information, increased parent/carer involvement and increased feedback from families • Embedded co-ordinated Support Plans • Improved consistency in allocating resources to support children and young people • Improved IT systems to enable them to track progress against outcomes • Children, young people and families have had their EHC Plan completed within 20 weeks, from a more responsive SEND Service, verbal feedback from parents has shown confidence in the service has increased. Families receive a questionnaire asking for feedback about their experience throughout the statutory assessment process. • Young people have had their needs identified and responded to more quickly; this has ensured they have access to services and interventions which meet their assessed needs. • Four young people who would have needed to access specialist provision out of town are now able to be in Hartlepool for their education. • Children have access to enhanced and improved facilities at the new build at Springwell School which is one of the first modular builds for a special school in the country. • Following consultation 12 young people are now accessing an employment programme
We would, in partnership with Public Health, review the recommendations from the obesity strategy and re-design the childhood obesity pathway and identify any gaps in provision which require procurement	• Work will progress during 2019/20 to ensure that any gaps in provision of weight management services for local children and young people are addressed where necessary.
We would review Core CAHMs service delivery and implement recommendations to improve the core service	• A list of recommendations have been agreed to improve service delivery. • Awarded additional resources from NHSE to help reduce waiting times. This resource is

	being used to purchase Kooth – an online interactive resource for CYP to access low level support as and when they need it.
We would continue to support Future in Mind – CYP Mental Health transformation	• Implementation of a one stop shop pilot which is GP lead and involves a partnership between Eaglescliffe medical practice, TEWV and SBC's Youth Directions. Operating from October 2018. In the first quarter 76 CYP had accessed the service. Further roll out into schools of wellbeing and resilience training
HARTLEPOOL CARE HOME PHARMACY SCHEME	
We will undertake a review of the Hartlepool Care Home Pharmacy Scheme .	• The Pharmacy scheme has been reviewed and is shown to have delivered the expected outcomes in that self-assessment audits have been implemented across all homes and safeguarding concerns have been addressed with care home staff supported to implement improved areas of good and safe practice • All Care Homes in Hartlepool have participated in the Medicines Optimisation training programme and self-assessment audits have been undertaken to assess and improve the quality of the medication administration processes
MENTAL HEALTH	
We would support the development of a Mental Health, Learning Disabilities and Autism partnership across Durham and Tees.	• In 2018, the Tees Valley and County Durham CCGs formed a partnership with Tees, Esk and Wear Valleys NHS Trust as lead partner provider. The vision is that the Durham, Darlington, Teesside Mental Health and Learning Disability Partnership will work together as one responsive system to plan, buy and deliver high quality, best value health services for those living with learning disability or mental health needs.
We would develop a Mental Health strategy to ensure it is fit for purpose and meets the requirements of all relevant guidance in partnership with Public Health and the Local Authorities.	• The CCGs Mental Health Strategy committed the CCG to implementing Parity of Esteem. • The Joint Strategic Needs Assessments (JSNAs) for all four Tees-wide local authorities are currently being refreshed and re-appraised by Public Health. • Hartlepool's "Beautiful Minds Partnership" project comprises of a range of organisations working across Hartlepool that deliver mental health services. The project is dedicated to promoting good mental health. Within this programme, a directory of services exists to promote and support good mental health • Stockton's current Health and Wellbeing Strategy runs from 2012-2018. The strategy aimed to reduce health inequalities and improve health and wellbeing for all, building on the Local Strategic Partnership (LSP) aspiration of "Promoting

	Achievement and Tackling Disadvantage". • Community Teams are in place across the CCG and all service providers are reported as meeting access and recovery targets. • The IAPT treatment programme waiting times England average is continuing to improve and across Hartlepool and Stockton, targets are being achieved.
We would review and revise the current Learning Disabilities and Autism strategy to ensure it is fit for purpose and meets the requirements of all relevant guidance in partnership with Public Health and the Local Authorities.	• The CCG is a member of the North Cumbria and North East Transformation Board that oversees the delivery of the Transforming Care and Building the Right Support Programmes. • Local Delivery and implementation Groups, formed with Local Authority partners, have developed community models to increase the availability of local support, and housing for people with a learning disability and/or autism. • Reducing the reliance on inpatient settings and preventing avoidable admissions is critical to achieving better outcomes for people and their families/carers • The Community Model is being strengthened to ensure that we have a range of housing and support options to enable people to remain in their own community. • Tees Esk & Wear Valley NHS Foundation Trust (TEWV) provide community and inpatient specialist assessment and treatment services to people with learning disabilities and mental health problems, autism, epilepsy and behaviour that may be challenging. • Reduced inpatient bed capacity and ring-fenced investment to move services and skilled teams to the community. • Reviews into over 60 adult learning disability NHS-funded placements have been carried out leading to actions to improve people's lives • Appointed three strategic learning disability workforce development managers aligned to a collaborative commissioning hub, plus recruitment of 31 Practice Leaders from 29 provider organisations onto the programmes starting in September 2018, with over 700 staff participating
We would review treatment provision out of area and implement activities to ensure people receive care close to home.	• An application process for high cost packages of care has been developed together with a risk sharing agreement ensuring that a robust process for the monitoring and repatriation for out of area patients is in place.
We would review current commissioned screening and physical health intervention pathways for patients with a severe mental illness with a view to improving pathways where required.	• Launched a three year health improvement plan "A Weight Off Your Mind" • Researched the "Mental Health Physical Health Review Template". It is a short assessment template for healthcare professionals responsible for carrying out annual health checks for patients with serious mental illness.

	• Uptake across Hartlepool and Stockton CCG, although still below the expected NHSE target, performance has increased when comparing Q2 to Q3.
We would carry out a Crisis Referral & Intensive Home Treatment Team service review to ensure compliance with mental health access and waiting time standards.	• NHS England targets (set at 95%) regarding the percentage of persons who have been seen by the crisis team within 4 hours of their referral and admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission are both being exceeded.
We would increase the use of Personal Health Budgets to enable people to have more choice and control over their lives and the services they purchase.	• All CCGs have submitted trajectories to deliver their share of 50,000 PHBs by March 2019 putting us on track to deliver the top end of the Mandate ambition, 50,000 – 100,000 PHBs by March 2021 (100 – 200 PHB per 100,000-registered population). For the North, this equates to achieving 18,260 by Q4 18/19. • PHBs have been available for some people in Hartlepool and Stockton since 2009, giving people greater choice and control over the healthcare and support they receive • The CCG is part of the North East Personal Health Budgets Regional Network, working to expand the offer and availability of PHBs, creating the environment for people to explore whether a PHB would be right for them and the financial environment for them to operate so that anyone eligible will be offered a PHB through 2019-2020.
We would undertake an evaluation of the Tees Advocacy Hub and implement any required changes.	• On Tees, since 2014, advocacy services have been provided through a hub model Managed by Middlesbrough Citizen's Advice Bureau. To support the framework, Hartlepool and Stockton CCG and South Tees CCG have contributed funding in addition to funding for the advocacy services themselves • The service has been refreshed and is operating successfully meeting all performance targets

AMBITION 3

We Said	We Did
CANCER	
We would review the current Cancer Information Service Model to support development of plans to implement a sustainable model of service delivery for future years	• The role and function of the service has been reviewed and we have secured funding Macmillan for the service for the next two years.
VOLUNTARY SECTOR HEALTH INITIATIVES	
We would continue to support the voluntary sector via the 'health initiatives' CCG scheme, which aims to support objectives set against CCG priorities via grant funding arrangements.	• The CCG has a long history of supporting the VCSE sector and has in recent years Grant Funded our local infrastructure organisation to commission services from local Third sector organisations. These arrangements aim to support organisations to develop to self-support activities. • The majority of services have reached their target access requirements as agreed and all have gathered case study information to demonstrate the positive impact they have had.
END OF LIFE	
We would undertake a comprehensive review of the End of Life/Palliative Care pathway to reduce the number of emergency admissions that take place in the last 12 months of a person's life and increasing access to care in their preferred place.	• Implemented a system that allows GPs to be more aware of the need to review their patients palliative care plans and as a result take a more proactive approach to support patients.
We will work in partnership with the Local Authority (LA), local Acute Trust and other stakeholders to develop a model of community integrated intermediate care to offer appropriate and timely care to people in the community avoiding the need for an acute stay.	• Engaged community Health ambassadors, GPs, intermediate care staff, patients and managers • Collection of intelligence/evidence over 10 different health and social care services re: how a new model could work in order to meet NICE guidance. New model is due to be presented for final approval in March/April 2019 and will then be implemented throughout 2019/20
We will review Rosedale rehab and assessment beds to maximise capacity utilisation in relation to delivering effective patient flow priorities.	• Work has been undertaken to improve the flow of patient from an acute bed, into an appropriate rehabilitation bed
We will review Westview Lodge rehab and assessment beds to maximise capacity utilisation in relation to delivering effective	• The longer term vision for community based rehabilitation beds will be considered as part of the

patient flow priorities	final intermediate care model.
We will monitor the performance of the Community Matron service into the Rosedale Centre and extend the pilot should it continue to be demonstrating a positive impact.	• Community Matron role was made a dedicated role • Trusted assessor model was introduced to support hospital discharge • Review of policy and procedure continues which empowers staff at Rosedale to manage patients Those readmitted to hospital less than 7 days following admission to Rosedale rehab beds shows a 53% reduction since 16/17 and 4% reduction as a % of overall admissions into the unit. The readmissions into hospital following a LOS of >7-42 days in the rehab beds demonstrates a significant decline of 79% from 16/17 to 18/19 and a 20% reduction as a % of overall admissions into the unit, which suggests that the community matron is supporting patient flow effectively Since the introduction of the community matron trusted assessment model in Rosedale in September 2018, the readmissions for rehab beds has been 3 in number, compared to 16 in the same period (Sept-Dec) in 17/18 and 22 in 16/17, a reduction of 86%
We shall monitor the performance of the Clinical Triage service and extend the pilot should it continue to be demonstrating a positive impact.	• Overall in 2018, non-elective admissions, length of stay and A&E attendances for people in a care home have reduced, whilst costs of admissions have increased, demonstrating that people in care homes are receiving appropriate and timely support to manage their health needs in the community
We will work with partners to ensure the delivery of high quality dementia service and develop a vision and business case to support the development of an integrated model for dementia service.	• Dementia diagnosis rates remain high for the CCG, who are one of the best performers in this area across the Region.
We will work in partnership with the Training and Education Alliance to monitor the care home education and training scheme	• Care Home staff report staff report feeling much more empowered and knowledgeable in the care of their residents • Staff report they are more confident in making informed referrals to clinical staff and the use of the NEWS digital monitoring in patient care • Care home reporting processes shows a general

	downward trend on the expected levels of admissions for this year compared to the previous year based on the predicted admissions. • In Hartlepool in September 2017 emergency admissions were 60 and down to 49 in September 2018 • In Stockton emergency admissions in August 2017 were 133 reducing to 93 in August 2018 and in September 2017 admissions were 95 reducing to 85 in September 2018. Comparative costs over this two month period over 2017 and 2018 showed a saving of £150,275.00.
We shall implement the high impact change model across: • Early discharge planning • Systems to monitor patient flow • Multi-disciplinary/Multi-agency discharge teams (inc. voluntary and community sector) • Home First Discharge to Assess • Seven-day service • Trusted Assessors • Focus on choice • Enhancing health in care homes	• Implemented the Trusted Assessor process Hartlepool and Stockton • Implemented the Capacity Tracker System across all of the homes in Hartlepool and Stockton to improve timely access to care homes • Commissioned Rapid Response Nurses who work focus on patients identified as Frail to try and prevent/ facilitate early discharge from hospital. • Development of an Integrated Discharge Team (IDT) to improve unnecessary delays for people leaving hospital once their acute care is complete and to support them to return and remain safely at home. • Implemented the Trusted Assessor process Hartlepool and Stockton • Implemented the Capacity Tracker System across all of the homes in Hartlepool and Stockton to improve timely access to care homes • Commissioned Rapid Response Nurses who work focus on patients identified as Frail to try and prevent/ facilitate early discharge from hospital • Development of an Integrated Discharge Team (IDT) to improve unnecessary delays for people leaving hospital once their acute care is complete and to support them to return and remain safely at home. In Hartlepool in September 2017 emergency admissions were 60 and down to 49 in September 2018. This equates to a reduction of 18% when comparing the 2 periods. Comparative costs over this two month period over 2017 and 2018 showed a saving of £9.5k. In Stockton in quarter 2 (July to September 2018) emergency admissions reduced to 272 from the July to September 2017 figure of 330. In Stockton, emergency admissions to hospital from a care home have reduced by 18% when compared to

	the same period last year. The costs of these admissions has also reduced by 7%. The costs associated with A&E Attendances for care home residents also decreased by 12%. The length of stay (length of time that people stay in hospital for once admitted) has reduced by 14% when compared to the same period last year Delayed Transfers of Care • In Hartlepool delayed transfers of care achieved the quarter 3 showing 776 delayed days against a target of 810. • In Stockton delayed transfers of care achieved the quarter 3 showing 455 delayed days against a target of 828. • The Integrated Discharge Team won an award for Best Innovation Project at the North East, Cumbria, Yorkshire and Humber Commissioning Awards in 2017.
MENTAL HEALTH	
We would support the crisis care concordat and engage with the different strands of work.	Hartlepool and Stockton CCG is a fully contributing member of the Crisis Care and Prevention Concordat Board. <u>Mental Health Conveyance</u> • Following an initial pilot, all Durham and Tees area CCGs agreed to formally procure a two-year mental health ambulance conveyance service to improve waiting times. <u>Suicide Prevention</u> • A Suicide Prevention Group has been established for Tees. A funded post of a Suicide Prevention Coordinator is in place and a review of data completed to inform the JSNA. <u>Crisis and Home Treatment Team Services Reviews</u> • In Tees and Durham the respective Crisis Care Concordat groups are overseeing wider partner requirements. This includes Street Triage programmes, Police Force Control Room Mental Health support, Crisis Houses and Safe Havens. • Mental Health Conveyance waiting times have reduced, the 1 hour target is now being met. • Re-commissioned Street Triage process – worked in partnership with Police to ensure continuation of service to ensure appropriate

	contact referrals/signposting • Action on frequent attenders, this involves Each identified patient now has a multi-agency response plan in order to prevent further re-attendance
We would carry out gap analysis of Mental Health Liaison Services against 'core 24' standards and propose an action plan to ensure service meets all required standards and changes are implemented	• Current performance demonstrates that Liaison Teams across Hartlepool and Stockton-on-Tees are exceeding the 90% targets in relation to the percentage of assessments in A&E that are undertaken within 1 hour of referral and the percentage of assessments undertaken on wards within 24 hours of referral.

Greater collaborative working across five CCG partners

A major development in the year is the further joint working with NHS Darlington CCG, NHS North Durham CCG, NHS Durham Dales, Easington and Sedgefield CCG and NHS South Tees CCG and with the appointment of a new Accountable Officer.

Dr Neil O'Brien was chosen to head a joint leadership and management team of the five CCGs who have been moving towards working more collaboratively since early 2018, with the aim of combining skills and resources to improve delivery. The appointment of Dr O'Brien is the next step to achieve this.

Dr O'Brien will continue to work with hospital trust and local authority partners to develop arrangements for the planning and provision of primary and community care, and health and social care integration.

Dr O'Brien, a GP in Chester-le-Street for 16 years was the Chief Clinical Officer at North Durham CCG.

The CCGs will very much remain as separate organisations but by working together, we will be able to share expertise and deliver the best outcome for patients locally and regionally across Durham and Tees Valley.

Review of Rheumatology Services

We worked with partners across County Durham, Darlington and Tees to improve Rheumatology services by engaging with patients who used the services.

Rheumatology deals with the investigation, diagnosis and management of patients with arthritis and other musculoskeletal conditions. This is a range of disorders affecting joints, bones, muscles and soft tissues. This this includes inflammatory arthritis, autoimmune disorders, vasculitis, soft tissue conditions and metabolic bone diseases.

The aim of the project was to offer a more consistent service to patients no matter where they live across the County Durham, Darlington and Tees area, and ensure patients are seen in the right place, by the right clinician, first time.

Patient feedback was key to improving this service and those accessing services were able to have their say on their experiences, positive aspects and areas where they think the services could be improved.

The engagement process provided opportunities for information to be exchanged between patients and clinicians to help inform clinical workshops we asked Rheumatology patients for their comments and suggestions based on their experience of services. We worked with all the providers of local Rheumatology services to help reach those individuals attending appointments, allowing them the opportunity to contribute.

As part of our engagement work, local and regional voluntary and community support groups helped reach other patients to complete a short survey. This helped us understand the experiences of living with these conditions and the services that currently support patients. The feedback was used to provide insights and direct improvements services could make in the future that could be more responsive to patients needs and provide consistency across the Durham, Darlington, Tees and North Yorkshire areas.

Improving access to Adult Hearing Services

The five CCGs across Durham and Teesside worked together to put in place Direct Access to Adult Hearing Services for Age Related Hearing Loss – Audiology Services.

The impact of hearing loss in adults can be immense both at a personal and a societal level leading to social isolation, depression, loss of independence and employment challenges.

One in six people in the UK has some form of hearing loss. Most are elderly people who are gradually losing their hearing as part of the ageing process, with more than 70% of over 70 year-olds and 40% of over 50 year-olds having some form of hearing loss.

The aim of the service is to provide a comprehensive, patient-centred, direct access adult hearing service for age-related hearing loss in line with national guidance and local requirements.

A period of 8 weeks public engagement took place between Monday 14th May 2018 and Friday 6th July 2018. We gathered the views of service users and local stakeholders about their experience of the current service and sought suggestions on how to improve a future service.

Following this period of engagement and review, in October 2018, a process to identify a service provider to deliver the Direct Access Adult Hearing Service began. The process has been extended to allow for further work to be undertaken and we expect the new service to be in place from 1st September 2019.

Mental health services

The five CCGs in Durham and Tees worked together to deliver an enhanced Improving Access to Psychological Therapy (IAPT) talking therapy service that it is consistent across the region with a single point of access.

In 2017 the five collaborating health commissioners reviewed current services which included engaging with members of the public, service users, GP's, stakeholders and providers to capture their views about what the issues were, if any, and how we could improve IAPT services to meet national requirements set out in the Five Year Forward View.

There were a number of themes from conversations with the public undertaken across the five Clinical Commissioning Groups including suggested improvements to referral processes and timely access, flexibility and choice around support and treatment options, reduced waiting times, improved communication to support attendance at appointments and more responsive step up and step down processes between primary and secondary care, to flexibly manage complex needs.

This feedback has been used to help develop a proposed expanded IAPT model which people will be able to influence further by participating in local focus groups.

During April 2018, we talked to service users and local stakeholders again to gather views about the draft model for the new service.

An online survey was also open for past and present services users, stakeholders and members of the public to have their say and provide their feedback and views on the proposed model. A summary report has been produced which highlights the feedback we received during this engagement period. A copy of this report is available on the CCG website.

This will mean changing the way that the service is delivered. We carried out engagement to gain views on the proposed model from past and current services users. The expanded service will be in place by Spring 2019.

GP Extended Access services

Following a comprehensive bidding and evaluation process, Hartlepool and Stockton-on-Tees CCG have selected the local GP Federation Hartlepool & Stockton Health (H&SH) as the preferred provider of GP Extended Access services.

GP Extended Access is aimed at providing additional clinical capacity in general practice, at a time when there is considerable pressure on healthcare services as a result of rising patient demand, to enable:

- Patients to receive high quality, responsive and convenient care in a location closer to home
- Patients to have an increased choice of access
- An increase in capacity in primary care during early evening, weekends and public holidays
- Support towards the reduction in the number of contacts at acute secondary care and in urgent care services

This approach is in line with our vision of developing a sustainable primary care fit for the 21st century, delivering appropriate access to high quality, cost-effective, patient-centred care, through a motivated, diverse and appropriately skilled workforce

Online consultations for GP appointments

A number of GP practices across Hartlepool and Stockton-on-Tees are now offering online consultations to patients as part of a national £45 million investment by the NHS into new consultation types.

Patients are being encouraged to escape the wait and simply visit their practice website to start an online consultation.

It allows patients to access safe and efficient advice for their health conditions, as well as being able to submit a query to their GP from the convenience of their own home and receive a response by the end of the next working day.

There is a wealth of information available, including, a symptom checker (self-help guides and videos about common conditions), pharmacy advice, link to NHS 111 and help to request a prescription.

Recent years have seen the rapid development in the number of online consultation systems helping patients to connect with their practice in a new way. It's not for everyone but it offers increased choice and accessibility. For many patients online consultations offer a quick and convenient way to access health advice without having to take time away from work or home to see a GP face to face. Some people also feel more comfortable talking about their problems online rather than face to face and we believe this now offers patients a new way to access advice and treatment.

Online consultations also free up time for GPs and other health professionals, allowing them to spend more time managing patients with complex needs.

Successful NHS 111 service will continue to improve under new contract

The successful NHS 111 telephone helpline in the region will continue to improve with a new contract agreed.

Current providers the North East Ambulance Service NHS Foundation Trust will operate the new service under a five-year contract which started in October 2018.

The service operates 24 hours a day, seven days a week, helping patients who need medical help fast but do not need to call 999 – as well as anyone who is unsure which service to use.

NHS 111 is a vital part of the urgent and emergency care system in the North East, and helps over 800,000 patients every year to get the care they need.

The new service builds on this success, including a clinical assessment service meaning patients can conclude their call with advice, a prescription or an appointment for further assessment or treatment.

The new service is designed to ensure that most patients' problems are dealt with on their first call, including a consultation with a clinician where that is needed. Staff will have access to a range of real-time information, including a summary of GP-held patient records, and details of local services such as GP extended hours schemes and community pharmacies.

Staff will also be able to book appointments with local GPs, send prescriptions directly to a convenient pharmacy or dispatch an ambulance where that is necessary.

Clinicians supporting the service – such as dental nurses, mental health nurses and palliative care nurses – will also be available to help professional colleagues working with patients in the community.

Last year NEAS handled 858,224 calls to NHS 111, including 95,142 in December alone. NEAS currently handles an average of 64,000 calls every month, and is leading the way nationally in providing directly bookable appointments with local GPs.

Learning disability respite services

Following a formal public consultation in February 2018, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group working in partnership with NHS South Tees CCG agreed to make changes to learning disability respite services, to ensure an enhanced model of services offering choice, whilst continuing to maintain a bed base at Bankfields Court in Middlesbrough and Aysgarth in Stockton.

Since this decision was made, the CCGs have been working closely with Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) to support the development of a new model of respite services. To ensure equity and as consulted upon this includes refining the allocations process and weighting tool. It is really important to the CCGs that this element is developed with input from patients, families and carers and the CCGs have engaged families to support this.

To ensure continuity in service whilst these developments are undertaken and in recognition of families being able to plan future respite provision, the CCGs have wrote to patients, families and carers to confirm that they can now book respite stays until the end of September 2019, with days allocated based on current allocations, pro-rated from January 2019 to September 2019.

The CCGs will continue to provide updates to partners, and will communicate the outcome of the Secretary of State referral from two local authorities on these changes once this is confirmed.

Optimising the use of over the counter medicines

Working with all the clinical commissioning groups in the region, the CCG supported a behaviour change campaign which focused on persuading patients to purchase low cost over the counter medicines for self-care and minor conditions instead of using an NHS prescription. The NHS each year spends millions on medications that can be purchased over the counter at a lower cost than that which would be incurred by the NHS – for example, a pack of 12 anti-sickness tablets can be purchased for £2.18 from a pharmacy whereas the cost to the NHS is over £3 after including dispensing fees, and over £35 when you include GP consultation and other administration costs.

The costs of these products could be used to fund other NHS services for example; £22.8 million on constipation – enough to fund around 900 community nurses; £3 million on athlete’s

foot and other fungal infections – enough to fund 810 hip operations; £2.8 million on diarrhoea, enough to fund 2912 cataract operations.

A campaign to raise awareness with patients and the public around the costs of prescribing medicines that are routinely available for the patient to buy from pharmacies and other outlets, such as paracetamol and hay fever medication was developed. The overall aim was to save money on prescribing costs for items that patients can easily buy to treat self-limiting minor ailments, which would allow the savings to be used elsewhere in the healthcare system.

A suite of communications materials and tools were produced and distributed to GP practices, walk-in centres, A&E departments and pharmacies for prescribers who wanted to use it to help with the discussion during interaction with patients to promote self-care. The approach was supported by proactive communications through the media, information on CCG websites and social media.

During a 12 month period, the campaign made savings of over 1 million across the region helping redirect money to other urgent healthcare needs. In March 2018 NHS England released the findings from a national consultation and recommendations on the conditions for which over the counter items should not be routinely prescribed in primary care. The findings mirrored the local evidence and research showing that the North East and North Cumbria areas were ahead of the curve and had already made significant savings prior to the recommendations being released.

CCGs win landmark high court victory over pharma companies

Along with other CCGs in the region, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group won a landmark case against two multinational drug companies, saving millions of pounds in the treatment of the wet age-related macular degeneration (wet AMD). The victory follows the adoption of a choice policy by all 12 CCGs in the North East and North Cumbria, to offer patients the chance to be treated with Avastin as an alternative to the more expensive Lucentis or Eylea.

Drug companies Novartis and Bayer took legal action to try to stop the CCGs from offering Avastin to patients – even though it has been found by NICE to be just as clinically effective and safe. A well-known cancer drug, Avastin is widely used around the world, including the EU and private practice in the UK, to treat wet AMD. Avastin is around 30 times cheaper than the most expensive alternative.

In a landmark ruling, the judge dismissed the appeal by the companies on all four grounds. The claimants were also ordered to pay the CCGs' legal costs. The ruling provides vital clarity for the NHS in the region and nationally, and clinicians can be absolutely reassured that the use of Avastin for wet AMD is lawful, safe and effective.

Avastin is equally effective, and much less expensive and could save £13.5 million per year for the 12 CCGs involved, which can be ploughed straight back into caring for our patients. That's enough to pay for an extra 270 nurses or 266 heart transplants every year.

North East and North Cumbria Urgent and Emergency Care Network

The CCG is an active part of the North East and North Cumbria Urgent and Emergency Care Network (UECN) which brings together over 30 organisations to improve the quality, safety and equity of access to services. The UECN has led on a range of innovations which have contributed towards the region delivering some of England's best A&E performance figures.

Operating with a whole system approach, the strategic aims of the UECN include reducing unnecessary hospital admissions and A&E attendances, to encourage better use of GPs and pharmacists and to support patients to improve their own health.

This whole system approach includes the following developments:

The UEC-RAIDR complimented by the 'Flight Deck portal, this information database enables providers across the system to see where and when and in real-time Operational Pressure Escalation Levels (OPEL), ambulance activity, bed availability and emergency department waiting times both locally and regionally. This intelligence enables providers to safely manage and prioritise emergency care.

New NHS 111 Online service went live in July 2018 and provides a digital option for patients accessing urgent care in the North East and North Cumbria.
Patients are able to receive self-care advice via their smart phone, tablet or computer, be appropriately signposted to pharmacy and optician services, referred to GP services and receive telephone call-backs from clinicians when appropriate.

Direct GP bookings through NHS 111 with 96% of GP surgeries in the North East committed to accepting appointments through NHS 111, putting the region in the forefront of change within the NHS nationally. Patients are already benefiting from the convenience of a streamlined service, knowing that one call will get them the care they need.

NHS child health app helps parents who lack confidence or need guidance on how best to deal with common childhood illnesses as well as reducing the pressure on services. Children account for a high proportion of A&E attendances in the North East, but around 60% under-fives are discharged with no treatment.

Urgent treatment centres standardisation means that it will be much clearer and less confusing to patients about what centres offer to the public in terms of opening times, the types of staff present and what diagnostics may be available.

Digital care means thousands of patients are benefiting from better, safer care, thanks to a new system supported by the network. In the past, different parts of the NHS have had their own paper records and exchanged information using letters, telephone and fax. As a result, important information held by GPs, such as medications prescribed and recent test results – was not easily available to other healthcare professionals at the point of care. Now, in the North East region, 100% of the regions GP practices have agreed to share patient records with emergency doctors, nurses and paramedics, using the Medical Interoperability Gateway (MIG) system. The MIG offers secure, real-time access to a summary of GP-held records so clinical decisions are made using the most up-to-date information, such as diagnoses, medications, details of hospitals admissions and treatments. Over 40,000 patient records are successfully accessed each month, resulting in safer, faster, more effective care, with less time wasted getting hold of medical records, or answering questions more than once.

Urgent and emergency care regional campaign

The aim of the campaign is to raise awareness in the most effective way to influence people's decisions about the best use of health services, and significantly change the use of urgent care services across the North East.

The campaign ran for 12 months, mapped against peak surge activity at key times of the year. It was integrated with national campaigns by NHS England and Public Health England to deliver planned locally tailored communications activities.

Local activities included the use of digital, media advertising and out of home activity. The campaign will continue to be used as part of surge management and delivering against the insight developed as part of the behavioural analysis work into the views and behaviours of urgent and emergency care.

Northern CCG Forum and Northern CCG Joint Committee

In common with all CCGs in the region, we played an active role in the Northern Clinical Commissioning Group Forum which operated until May 2018. The forum provided leadership to the North East and North Cumbria health system, addressed national and regional policy issues and carried out business on a joint basis where this achieved the best outcome. This included areas like winter pressures, CQUIN, implementation of new services and avoidance of inequitable treatment through 'postcode prescribing'.

At its meeting in May 2018, the Forum agreed that it should be stood down and its business should transfer to the Northern CCG Joint Committee.

The CCG is a member of the Northern CCG Joint Committee which makes decisions on subjects recommended to it. These are confined to issues that pertain to all CCG areas in Cumbria and the North East initially the commissioning of specialist acute services and '111' services. During 2018/19 the Joint Committee also considered the following:

- Breast Symptomatic Services
- Specialised Commissioning within the emerging Integrated Care System (ICS)
- Sustaining quality clinical services across North Cumbria and the North East
- Communications and engagement for integrated health and care
- North of England Commissioning Support Unit (NECS) Annual Review 2017/18
- Collaboration with the Academic Health Science Network (AHSN) North East North Cumbria
- Local non-executive community networks
- Primary Care research Strategy

Where appropriate, meetings are held in public and members of the public are welcome to attend to observe the Joint Committee at work.

Healthier You: NHS Diabetes Prevention Programme

NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group joined The ‘Healthier You: NHS Diabetes Prevention Programme’ (NDPP) partnership between NHS England, Public Health England and Diabetes UK, which aims to deliver at scale, evidence-based behavioural interventions for individuals identified as being at high risk of developing Type 2 diabetes.

The programme aims to prevent or delay 18,000 cases of diabetes among the five-year cohort of 390,000 participants by the end of the fifth year. Type 2 diabetes currently costs the NHS £8.8 billion per year.

The programme focuses on three core goals - weight loss, dietary achievements and physical activity. People will be supported predominantly in face-to-face groups to achieve goals and make lifestyle changes and reduce their risk of developing Type 2 diabetes.

Adults (over-18) with ‘non-diabetic hyperglycaemia’ (NDH) are eligible for inclusion. The blood result indicating NDH must be from within the last 12 months to be eligible for referral and only the most recent blood reading can be used. The programme is currently rolled out to a number of ‘Trailblazer’ practices in the Hartlepool and Stockton areas.

Prescribing

The decision to prescribe is the most common intervention in the NHS. Hartlepool & Stockton-on-Tees CCG work collaboratively with other health professionals and social care providers to deliver evidence-based cost effective use of medication to maximise patient outcomes from medication prescribed to them. This is facilitated through the Tees Medicines Governance Group (TMGG) and the Northern Treatment Advisory Group (NTAG).

All CCG member practices receive practice-based prescribing support which includes audit work to support implementation of NICE guidance and medication related issues in general practice, support to encourage prescribing decisions in line with the Tees formulary and monitoring and analysis of prescribing patterns.

Medication review, with a particular focus on care home residents, is a key element of the CCG commissioned practice-based medicines optimisation workplan, where pharmacists and technicians work with practices and care homes to ensure the safe and effective use of medicines and to reduce the likelihood of medication-related hospital admissions. In 2018/19 2200 individual patient medication reviews were carried out by the team, generating approximately £250,000 of annual savings for the NHS, including £45,000 savings from avoiding patients being admitted to hospital.

A prescribing support tool provides pop-up information messages to support decision making at the point of prescribing, based on local and national best practice guidance, clinical effectiveness and cost-effectiveness. The Tees formulary and medicines optimisation websites are also available to support clinicians. Clinical engagement of healthcare professionals is key to the delivery of the medicines optimisation agenda and longer term strategy.

The CCG medicines optimisation workstream leads on local implementation of medicines related issues and provides guidance to local prescribers. This past year has been challenging in managing prescribing costs within primary care. The CCG has a Quality, Innovation, Productivity and Prevention Implementation (QIPP) plan for medicines optimisation as well as horizon scanning to identify/anticipate future budgetary pressures. This plan includes reviewing prescribing opportunities highlighted by NHS RightCare (a national programme to reduce unwarranted differences in care and improve health outcomes). In 2017/18 the medicines optimisation QIPP plan achieved over £2million of annual savings which have been reinvested into healthcare.

All practices receive regular prescribing updates, detailing performance against budget, prescribing cost growth and key therapeutic topics. The CCG medicines optimisation workstream review's practice level performance on a monthly basis and where this is at variance with other CCG member practices, a detailed analysis of prescribing is carried out following which action plans are developed to support practices to improve prescribing practices and processes.

NHS England introduced antibiotic prescribing targets in the CCG Quality Premium in 2015/16, which has continued each year since. Many practices in Hartlepool and Stockton have made excellent progress to date with this, reflecting the continued hard work that many prescribers undertake around this area on a day to day basis which has led to an 18% reduction in antibiotic prescribing across Hartlepool and Stockton from 2015/16 to 2018/19.

Assurance around the safe management of controlled drugs is provided to the CCG via quarterly prescribing reports presented to the medicines optimisation workstream, ensuring robust procedures are in place within primary care. Hartlepool & Stockton-on-Tees CCG is also a member of the NHS England Local Intelligence Network for Controlled Drugs.

New Models of Care (NMoC)

The overarching aim of the NMoC programme is to develop a strong and stable primary care and increase collaboration and integration across health and social care through:

- A combined focus on improved health outcomes
- An integrated workforce across primary and community care
- To a registered population of 30,000 - 50,000

By doing so the aspiration is to reduce confusion for patients and improve effectiveness of care delivered through the development of a collaborative system and integrated pathways of care.

NMoC are based on both personalised coordination of care and on system coordination of care. Greater involvement of people in their own treatment and care should lead to improved personalised coordination of care. This requires hub based health and social care teams to form to allow partnership working on multiple levels and joint care planning with a strong focus on:

- Supported self-management and wellbeing

- Care and support planning: Disease and care management

- Case management across locality-based generalist nursing and therapy teams with support from County/locality-based speciality teams

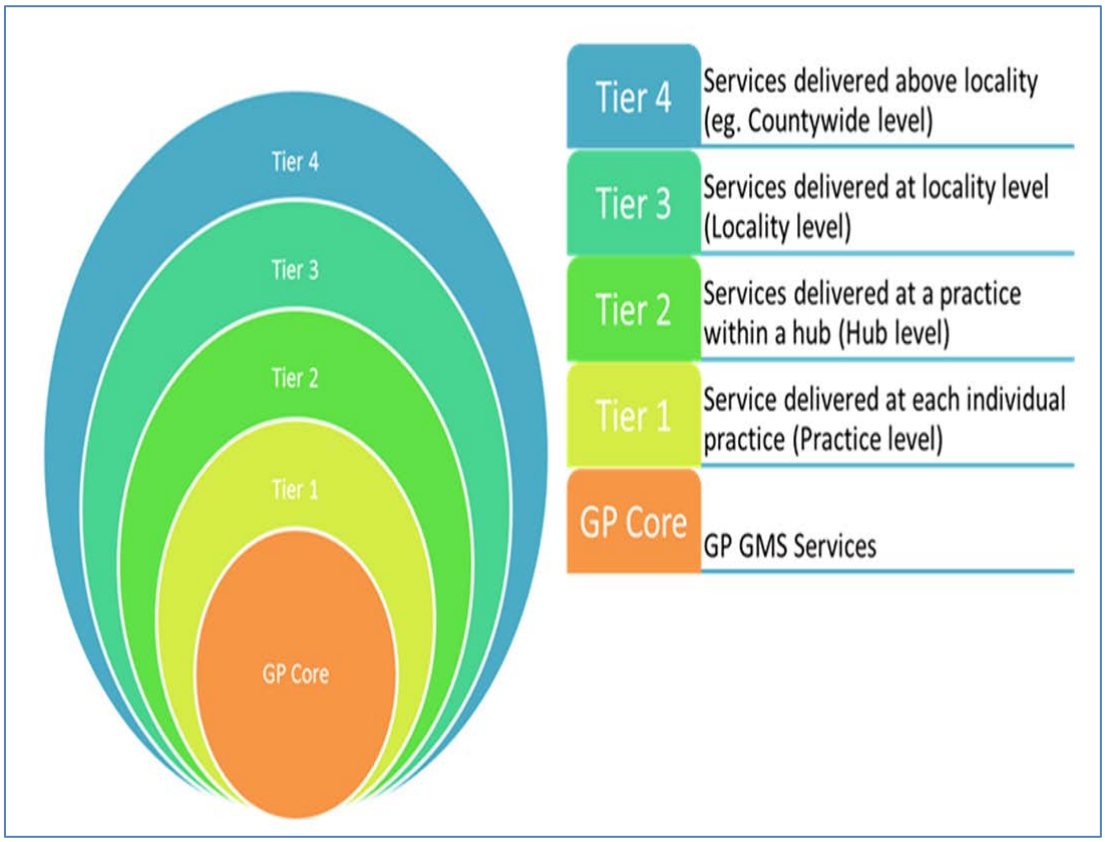
The delivery of NMoC requires the strengthening of care outside of hospital and traditional settings so that neighbourhoods, communities and individuals are able to take more control of their health and maintain independence for longer whilst preventing or delaying the need for more services in acute and community care. This requires a move away from the traditional model of care (see, treat and discharge) to a long term condition model where self-management support is a responsibility and an integral part of a community hub.

The success of the NMoC programme is dependent upon creating a coordinated and integrated system that is focused upon changing needs.

Creating a cross organisational workforce that is proactive will help to enable patients to move away from being passive recipients of care to informed and activated patients who have the skills required to self-manage their condition. This will be achieved through exploring the opportunities across providers to reduce duplication and maximise opportunities.

Figure 1 below displays the four tiers in which services will be identified for delivery, in line with vision for new models of care around population need.

Figure 1 – The delivery tiers of the NMoC



A task and finish group will be convened to develop an overarching strategic vision document to underpins the principles of new models of care in line with care delivered to populations of 30,000-50,000.

Key Issues and Risks

During 2018/19 the CCG has been managing a number of identified issues and risks, all of which have been actively managed and the CCG's risk register was fully reviewed at the end of 2018/19 to ensure that all risks are up to date with appropriate controls in place.
The key risks themes on the CCG's risk register relate to clinical engagement, Brexit, financial position and delivery, working with commissioning partners particularly local authorities and performance issues with regards to constitutional standards.

As at the end of the year, the CCG was actively managing 18 corporate risks. All of these risks have key controls identified against them and also the delivery of both external and internal assurance regarding these risks. They also include mitigating actions where appropriate and are subject to an action plan. Throughout the year, the CCG has worked hard to ensure any concerns or issues related to the achievement of Constitutional Standards such as waiting times have been managed proactively. Full details of the year-end position on these standards are provided under the Performance Summary and Performance Analysis sections.

The Governing Body regularly reviews the CCG's Assurance Framework and receives an assurance report on activity to maintain the corporate Risk register.

The Hartlepool and Stockton-on-Tees CCG Assurance Framework has also been reviewed and details of the principal risks can be found in the Governance Statement. The Assurance Frameworks were presented to the Audit and Risk Committee's on 5th March 2019 and Governing Body on 26th March 2019.

Financial Review

Overview

During the year we have worked hard to secure high quality services, making every effort to ensure we use the resources allocated to Hartlepool and Stockton-on-Tees CCG economically and with effectiveness and efficiency.

Robust systems of financial governance and financial management processes monitored by the CCG's finance committee have allowed all financial risks to be appropriately identified and managed during the year enabling the delivery of financial targets.

The CCG's financial position has been maintained in the current year and it is pleasing to report that we have again been successful in achieving our key statutory and administrative financial duties during the financial year ended 31 March 2019.

This continues to be a challenging time for the NHS with significant financial pressures and the financial performance outlined in the CCG's annual accounts is pleasing to see, reflecting the strong financial management within the organisation.

CCG allocations

Two distinct funding streams are provided to CCGs:

- Programme Budget Allocation – this funding relates to direct health care expenditure,
- Running Cost Allowance – this funding, amounting to £21.52 per head of population, is to cover the administrative costs of running the CCG.

The funding resources available to the CCG during the year were as follows:

	Programme Budget Allocation £'000	Running Cost Resources £'000	Total £'000
Initial baseline allocations	425,500	6,378	431,878
Delegated primary care commissioning budgets	40,561	0	40,561
Other in-year allocation adjustments	2,981	19	3,000
Total final allocations	**469,042**	**6,397**	**475,439**
*Total funding per head of population **	*£1,578*	*£21.52*	*£1,599*

** funding per head of population has been calculated based on the registered population of the CCG, as published by NHS England, of 297,299.*

Financial targets and performance for the year

CCG surplus position

In addition to the requirement to fulfil its statutory duties, the CCG is expected by NHS England to deliver a cumulative surplus of at least 1% of its funding allocation. This surplus is carried forward from one year to the next.

For Hartlepool and Stockton-on-Tees CCG, the cumulative surplus at 31 March 2018 was £11.387 million (2.4% of funding allocation), which carried forward to 2018/19. It was agreed with NHS England as part of a planned drawdown of that cumulative surplus that £0.110 million would be available to the CCG to spend in 2018/19 as an additional in-year allocation, leaving £11.277 million as the cumulative surplus.

During 2018/19, Hartlepool and Stockton-on-Tees CCG has delivered an in-year breakeven position, the control total agreed with NHS England.

A summary of the CCG's final surplus position at the end of the year is as follows:

	£ million	% of total funding
Surplus brought forward from prior year	11.39	2.4%
Agreed 2018/19 drawdown	-0.11	0.0%
Total funding allocation received for the year	475.44	100%
Total spent by the CCG	475.44	100%
Additional surplus delivered in year	0.00	0.0%
Final surplus carried forward to 2019/20	11.28	2.4%

It is important to note that this final surplus balance of £11.28 million is not a 'profit' or surplus generated during the financial year. The majority of it reflects a historical balance carried forward from previous years.

The CCG's successful results in 2018/19 are set out in the table below, with further detail included in note 23 of the full annual accounts published alongside this Annual Report.

Target	Outcome	Target Met?
Maintain expenditure within 'in-year' funding allocation	In-year breakeven position against an in-year funding allocation of £464.162 million	✓
Maintain running costs within separate running cost allowance	Surplus of £1.109 million delivered on running cost budgets	✓
Maintain capital spending within capital resource limit	No capital resource required and no capital spend in year	N/A
Ensure cash spending is within the cash limit set	Cash managed within available resources	✓

Expenditure not to exceed resource limits

Unlike commercial companies which make a profit or loss, CCGs are set resource limits within which they must contain net expenditure for the year. There are separate resource limits set for revenue and capital expenditure, with revenue expenditure limits further split between programme spend and running costs.

The CCG financial performance is reported on an in-year basis.

The CCG's final in-year programme budget allocation for 2018/19 was £457.765 million.

Operational financial balance

The funding for the CCG is based upon an allocation formula, taking into account population growth, deprivation and the impact of an ageing population, which has provided target allocations at a CCG level.

A minimum rate of growth funding was applied to all CCGs in 2018/19 of 2.7%, which in total amounted to £12.173 million for Hartlepool and Stockton-on-Tees CCG.

This funding is used to fund health care services including hospital and community health services (for both physical and mental health), prescribing costs for drugs and appliances, and continuing health care.

Relevant costs amounted to £458.874 million, when combined with the position reported on running costs below, this resulted in a total in-year breakeven position being delivered on all revenue budgets.

Running costs

As highlighted above, a separate running cost allowance is provided to all CCGs, amounting to £21.52 per head of population served for Hartlepool and Stockton-on-Tees, to cover the administrative costs of running the CCG.

There is a requirement to manage administrative costs within this allowance.

Total running costs for the year amounted to £5.288 million, compared to a running cost allowance of £6.397 million. That underspend on running costs was used during the year to increase spend on direct healthcare.

Capital resource limit

The CCG had no capital expenditure in 2018/19 and therefore did not require any capital resource, hence this target is not applicable in the current year. In future the capital requirements of the CCG, and any related capital resource received, are expected to be minimal.

Other financial targets and disclosures

In addition to the above statutory duties, CCGs have similar responsibilities to other NHS organisations to record performance against the Better Payment Practice Code (BPPC) published by the Department of Health.

Compliance with Better Payment Practice Code

The BPPC requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms.

Details of compliance with the code are given in note 5.1 to the financial statements.

Performance against the target is monitored by the CCG on a monthly basis with performance maintained at over 95% of invoices paid within 30 days of receipt, measured against both total invoice value and overall volume of invoices.

Prompt Payments Code

In addition to compliance against the BPPC, on 11 February 2014 the CCG became an approved signatory of The Prompt Payment Code. This initiative was devised by the government with The Institute of Credit Management (ICM) to tackle the crucial issue of late payment and to help small businesses. Suppliers can have confidence in any company that signs up to the code that they will be paid within clearly defined terms, and that there is a proper process for dealing with any payments that are in dispute.

Approved signatories undertake to:

- pay suppliers on time,
- give clear guidance to suppliers and resolve disputes as quickly as possible,
- encourage suppliers and customers to sign up to the code.

Setting of charges for information

The CCG has complied with HM Treasury's guidance on setting charges for information.

Utilisation of resources

Financial pressures arise each year, but the CCG was able to manage these by prudent financial planning and careful financial management.

One of the CCG's main objectives during the year was to maintain financial stability and probity while ensuring that resources were used as efficiently and effectively as possible in meeting the strategic aims as set out in the CCG's strategic and operational plans.

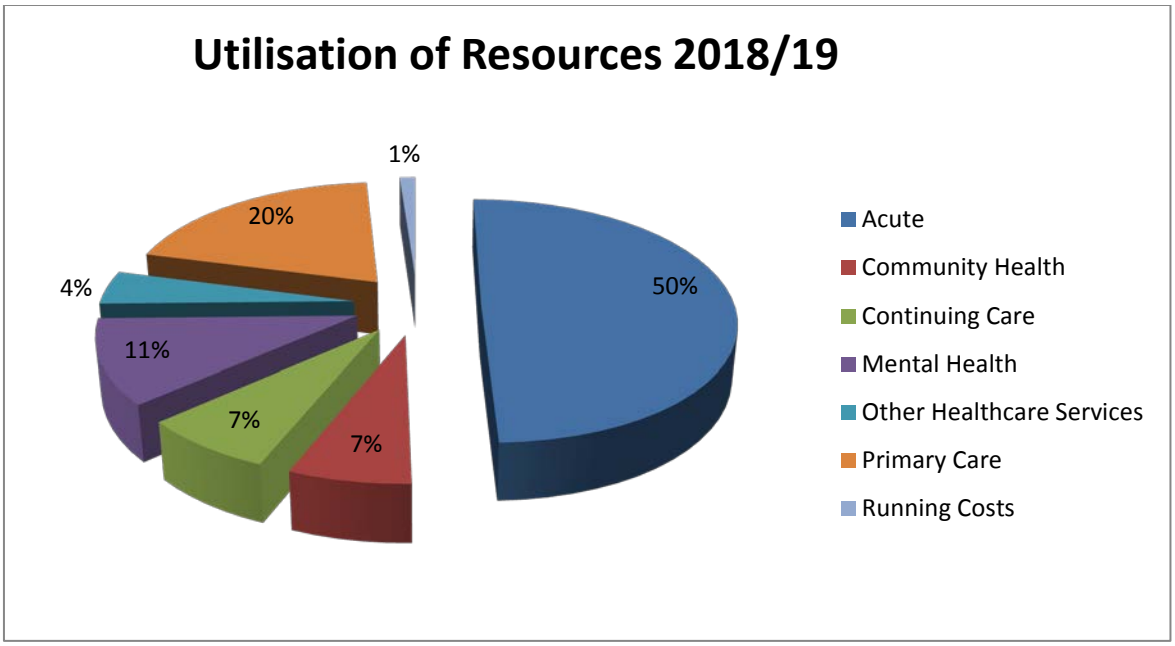
A number of financial challenges and risks were identified during the year and a range of actions were implemented to successfully address these pressures. This included delivery of additional efficiencies through the CCG's QIPP plan, as well as utilisation of relevant contingency funding.

One of the strategic aims of the CCG is to bring care closer to home, reducing the historic reliance on secondary care acute services in particular. This will be essential over the coming years to deliver the shifts in activity from secondary care services to primary and community care settings that will be required to support the delivery of the NHS Five Year Forward View and management of the financial pressures facing the NHS.

It is important that this transformation of care is managed in a planned and progressive manner and the CCG has remained committed to supporting its main providers of secondary care services to maintain a balanced local health economy. This is to ensure the delivery of key

targets and in overall terms the majority of funding currently continues to be spent on acute hospital services.

The utilisation of available resources in 2018/19 across the relevant areas of programme spend, can be seen below:



Pensions

Details of the accounting for pension liabilities can be found in the accounting policies and pension costs notes in the CCG's financial statements (notes 1.8.2 and 3.5 respectively). Further details of senior managers' pension benefits can be found in the Remuneration and Staff Report.

Audit and Assurance Committee

An Audit and Assurance Committee has operated throughout the year, chaired by the Lay Member for Governance and Audit. Details of other members of the committee can be found within the Members Report.

External auditors

Following a procurement and selection process undertaken by the CCG, Ernst Young were appointed as auditors to the CCG for 2018/19.

The cost of audit services can be found in note 4 of the CCG's financial statements.

The auditors bring an annual work plan to the Audit and Assurance Committee for approval. This states that the audit team are independent of the CCG and also would include any details of non-audit work if applicable. When considering whether the level of any non-audit work is appropriate the CCG would consider the composition of the team (and whether any audit team members are involved) and the level of fees.

Looking forward

The financial pressures facing the NHS are substantial and well documented, with the impact of an aging and growing population leading to significantly increased costs against a backdrop of limited financial resources.

Significant pressures continued to be evident during 2018/19, not only for the CCG but across the local health economy, and it is likely these pressures will continue to grow over the coming years.

The CCG has refreshed its operational plan for 2019/20 and is committed to working with local providers and partners as part of the Integrated Care System (ICS) and Integrated Care Partnerships (ICPs) to ensure sustainable, high quality services are available for our local population and across the ICS footprint.

The implementation of this plan in 2019/20 and delivery of the necessary financial efficiencies represents a significant challenge for the CCG. There are significant opportunities available to reduce variation in services, both from a quality and financial perspective, and this will be the focus of much of the work in 2019/20 to ensure best use of the limited financial resources available.

Performance Overview

This section provides a summary of the CCG's performance against key standards.

Referral to Treatment

Patients have the legal right to start their NHS consultant led treatment within a maximum of 18 weeks from referral.

CCG performance in 2018/19 for incomplete pathways is above target, reporting 93.4% against the 92% threshold.

No patient should be waiting more than 52 weeks for treatment. HaST CCG has reported 1 breach in 2018/19. In 2017/18 2 breaches in total were reported.

Diagnostic Test Waiting Times

No more that 1% of patients should wait over 6 weeks for a diagnostic test.

HaST CCG has achieved this target for 6 out of 12 months in 2018/19.

The main provider North Tees and Hartlepool Foundation Trust has achieved the target for 7 out of 12 months.

Cancer Waiting Times

In 2018/19, HaST CCG has met targets in 7 out of the 9 categories for cancer waiting times.

The main area of weakness is performance against the '62 day wait for treatment to commence following an urgent GP referral and subsequent cancer diagnosis' indicator. The position for 2018/19 is reported as 81.5% against the 85% target. This standard has remained non-compliant for 9 of the 12 months in 2018/19.

Patient level breach analysis is being undertaken to try and identify any trends within the breach reasons which can then inform further actions with the Trusts.

Although there are some capacity issues, there are an increasing number of complex pathways which seriously impact Trusts ability to achieve the target. Performance continues to be monitored through contract meetings and the CCG performance framework.

Ambulance Response Times

New national ambulance standards were introduced in 2018/19 which measure response times for the following 4 categories:

Category 1 (C1) - For calls to people with immediately life-threatening and time critical injuries and illnesses. These will be responded to in a mean average time of seven minutes and at least 9 out of 10 times before 15 minutes.

Category 2 (C2) - For emergency calls. Stroke patients will fall into this category and will get to hospital or a specialist stroke unit quicker because we can send the most appropriate vehicle

first time. These will be responded to in a mean average time of 18 minutes and at least 9 out of 10 times before 40 minutes.

Category 3 (C3) - For urgent calls. In some instances, patients in this category may be treated by ambulance staff in their own home. These types of calls will be responded to at least 9 out of 10 times before 120 minutes.

Category 4 (C4) - For less urgent calls. In some instances, patients may be given advice over the telephone or referred to another service such as a GP or pharmacist. These less urgent calls will be responded to at least 9 out of 10 times before 180 minutes.

In 2018/19 NEAS are meeting 3 out of the 6 response time measures. Mean response times for category 2 calls are over 22 minutes compared to the 18 minute standard, with 90th centile response times for these calls over 49 minutes with 40 minutes being the expected standard. The Category 3 90th centile response time is in excess of 2 hours and 34 minutes compared to the 2 hour standard.

Healthcare Acquired Infection

Reducing healthcare acquired infection remained a key challenge for the CCG and the local NHS throughout the year.

• MRSA (Methicillin Resistant Staphylococcus Aureus)

There is a zero tolerance of MRSA which means that all commissioner and provider targets are zero. The CCG has reported 2 cases this year.

• Clostridium Difficile

In 2018/19 the CCG have reported 105 attributed cases against a trajectory of 71.

Accident and Emergency (A&E) Performance

Provider organisations have a number of targets in relation to emergency care. One key target is that 95% of patients should wait no longer than four hours for treatment in an emergency department.

The main provider North Tees and Hartlepool Foundation Trust (NTHFT) have so far achieved the 95% target for all 12 months in 2018/19.

Waiting List Commitment

Providers and commissioners were required to ensure that the March 2019 waiting list position was no higher than the March 2018 level. Of the local acute trusts, South Tees Hospitals NHSFT and North Tees & Hartlepool NHSFT achieved this ambition. From a commissioner perspective however, the CCG did not achieve the target set. However, all organisations have plans in place and are committed to working towards the goal of ensuring that the March 2020 position is at least maintained at March 2019 levels.

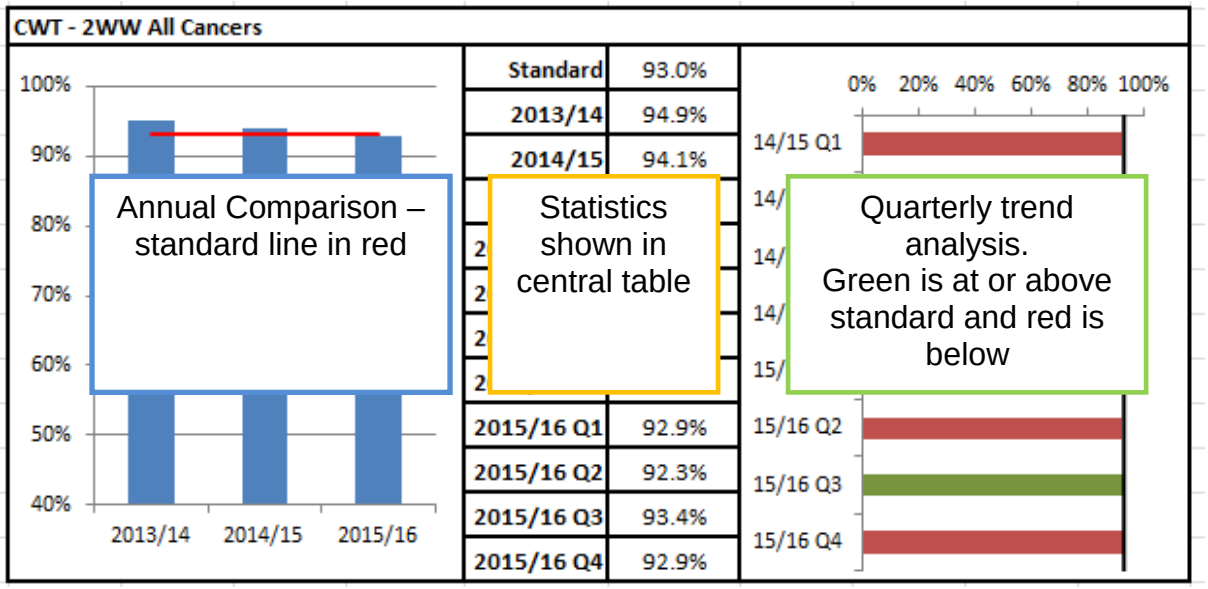
Performance analysis

CCG performance is reviewed by NHS England to ensure that they are delivering quality outcomes for patients, both locally and as part of the national standards. The following pages set out areas performing particularly well and some that still require improvement.

Indicators described include:

- A&E four hour waits
- Ambulance response times
- Ambulance handovers
- Cancer waiting times
- Reduction in avoidable emergency admissions
- Healthcare associated infections (MRSA and Clostridium difficile)
- Referral to treatment times
- Friends and Family Test

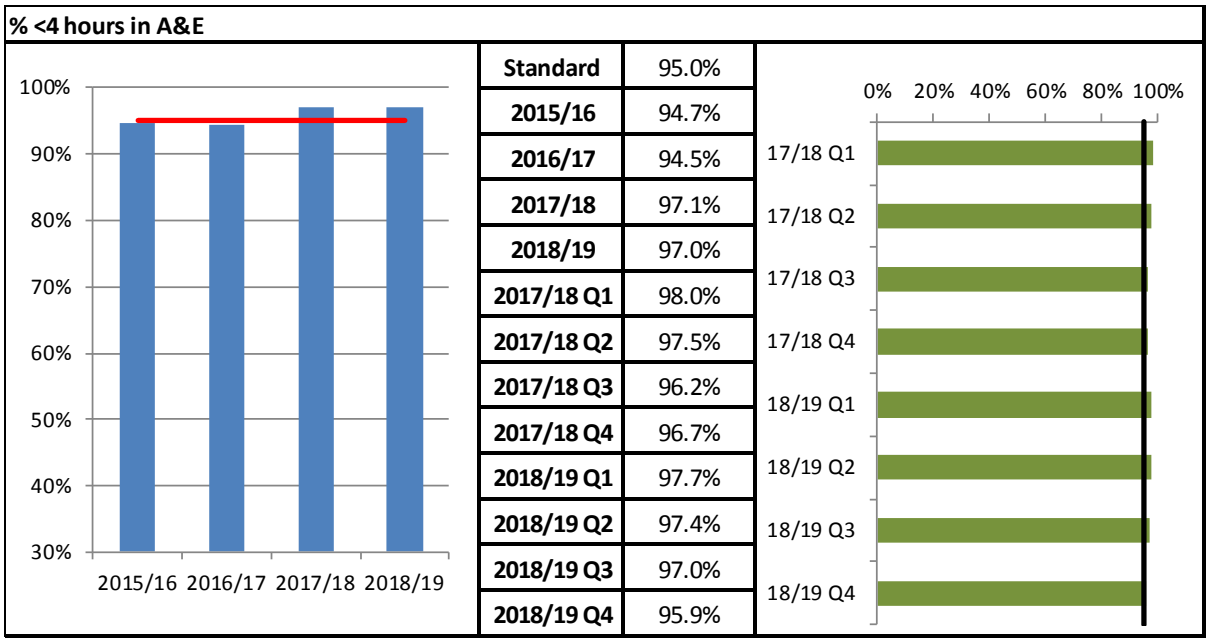
The indicators are set out in the following layout:



Breakdown of key performance standards

Urgent Care Performance

Four Hour Waits in Accident & Emergency:



Standard	95.0%
2015/16	94.7%
2016/17	94.5%
2017/18	97.1%
2018/19	97.0%
2017/18 Q1	98.0%
2017/18 Q2	97.5%
2017/18 Q3	96.2%
2017/18 Q4	96.7%
2018/19 Q1	97.7%
2018/19 Q2	97.4%
2018/19 Q3	97.0%
2018/19 Q4	95.9%

In 2018/19, 97% of patients who attended A&E were seen and treated within 4 hours. The provider performance is above the 95% standard for the second year running.

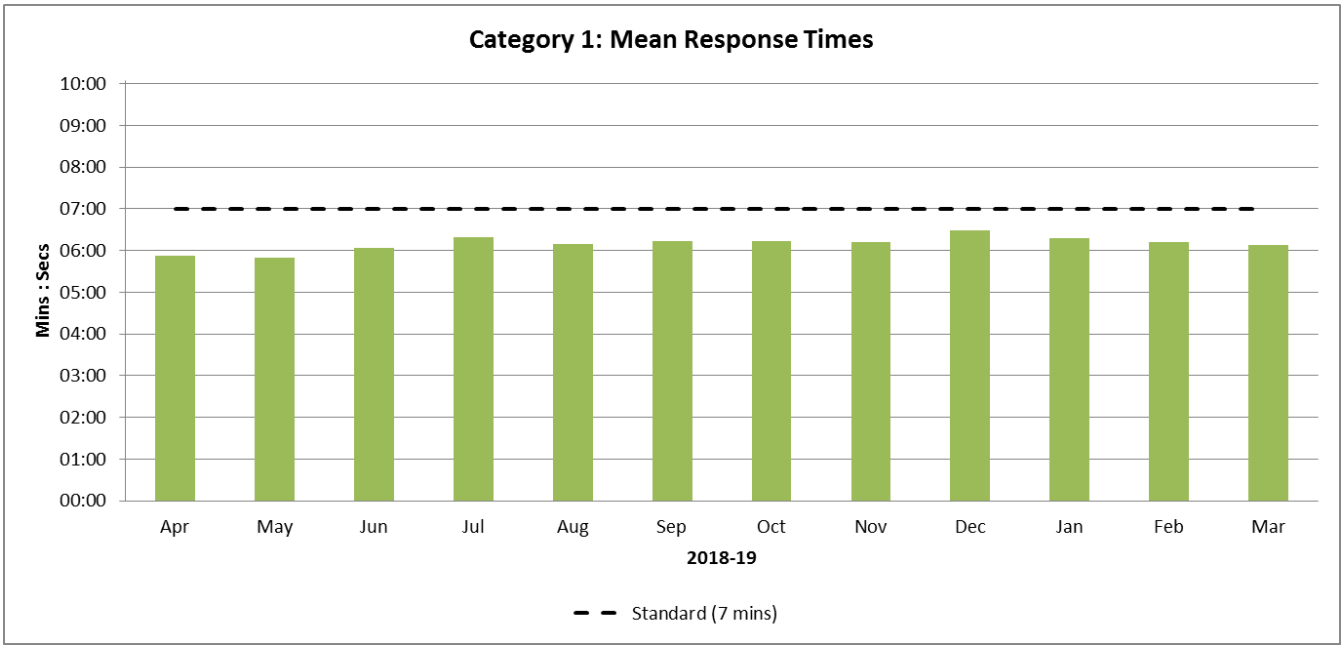
Ambulance Response Times:
We commission ambulance services from North East Ambulance Service NHS FT (NEAS) and specify that they comply with operational standards. New performance measures were introduced in 2018/19 which places calls into the following categories:

Category 1 (C1) - For calls to people with immediately life-threatening and time critical injuries and illnesses. These will be responded to in a mean average time of seven minutes and at least 9 out of 10 times before 15 minutes.

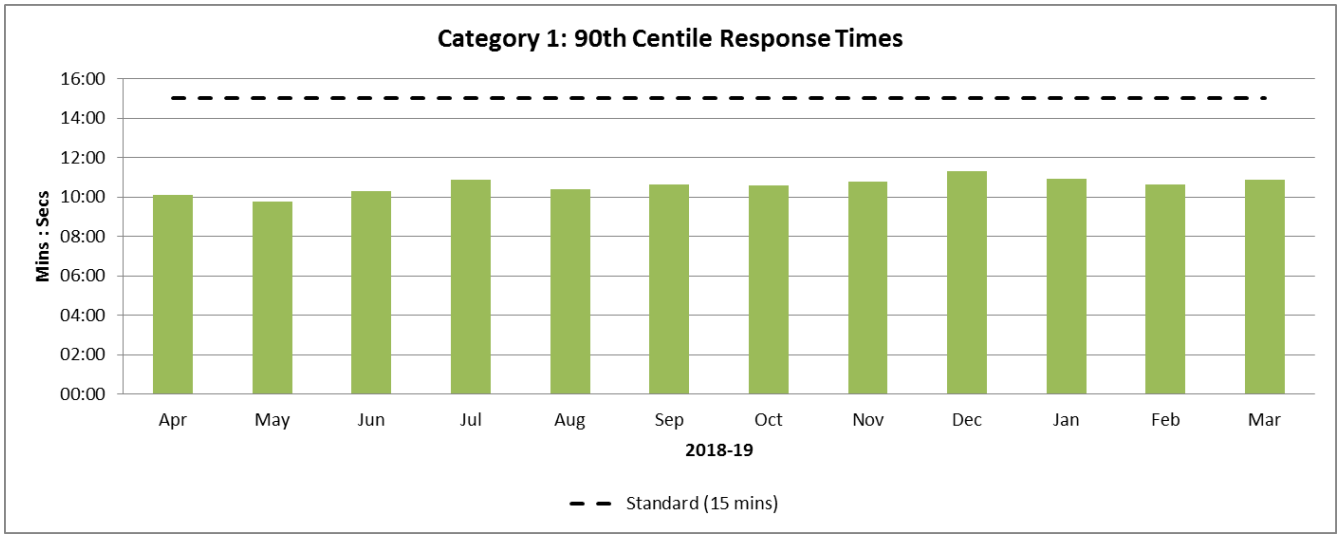
Category 2 (C2) - For emergency calls. Stroke patients will fall into this category and will get to hospital or a specialist stroke unit quicker because the most appropriate vehicle can be dispatched first time. These will be responded to in an average time of 18 minutes and at least 9 out of 10 times before 40 minutes.

Category 3 (C3) - For urgent calls. In some instances, patients in this category may be treated by ambulance staff in their own home. These types of calls will be responded to at least 9 out of 10 times before 120 minutes.

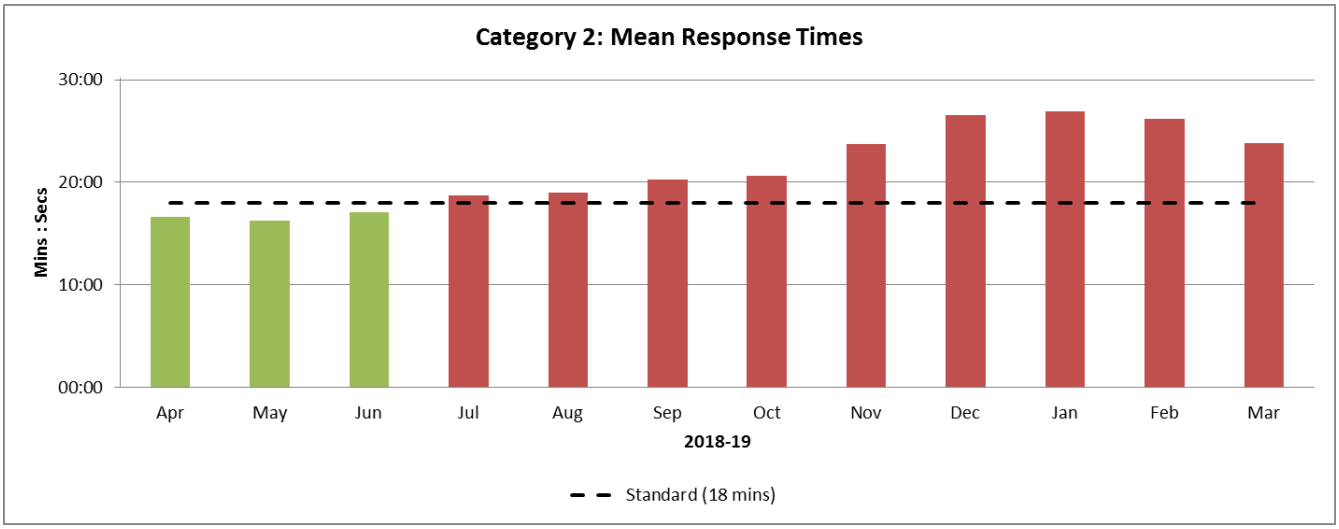
Category 4 (C4) - For less urgent calls. In some instances, patients may be given advice over the telephone or referred to another service such as a GP or pharmacist. These less urgent calls will be responded to at least 9 out of 10 times before 180 minutes.



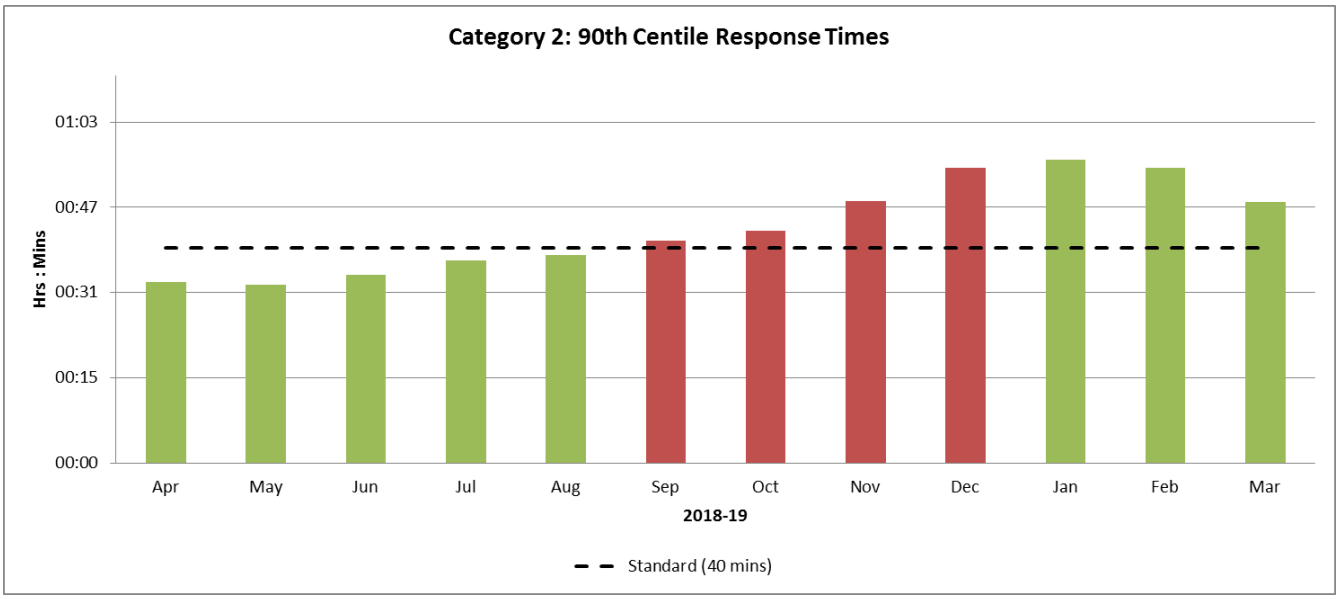
Since the new measures were introduced the mean Category 1 response times for NEAS have remained consistent and have continued to meet the national standard of 7 minutes.



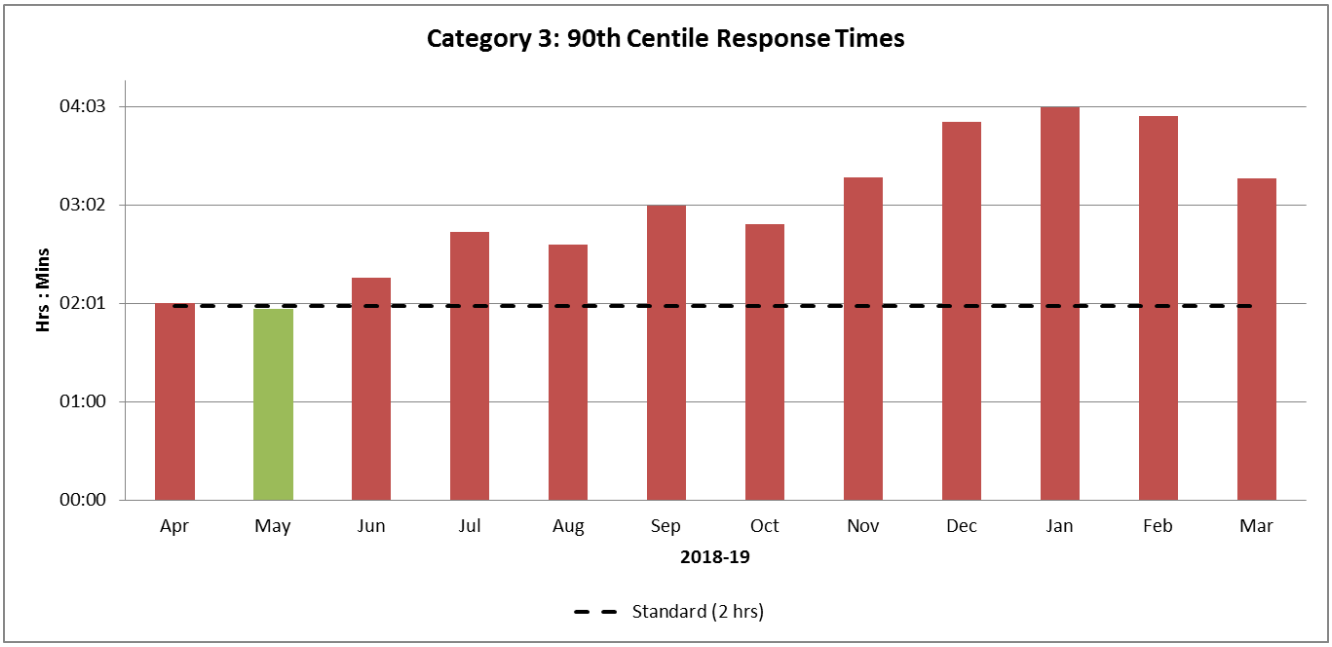
The Category 1 90th centile response times for NEAS have also remained consistent throughout 2018/19 and below the national standard of 15 minutes.



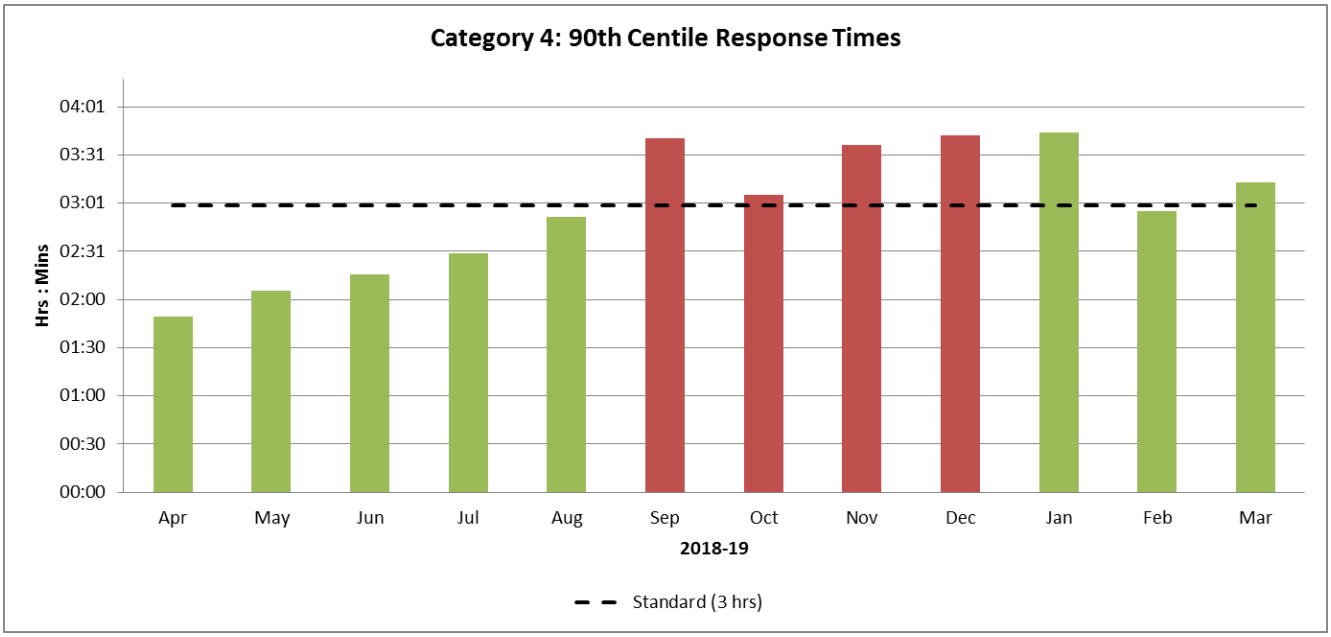
Since the new measures were introduced the mean Category 2 response times for NEAS have risen steadily over the year with longer response times into the winter months. Response times in this category have met the national standard for 3 months out of 12.



The Category 2 90th centile response times for NEAS have also risen throughout the year with the highest levels in the winter months. Response times met the standard for 8 months out of 12.



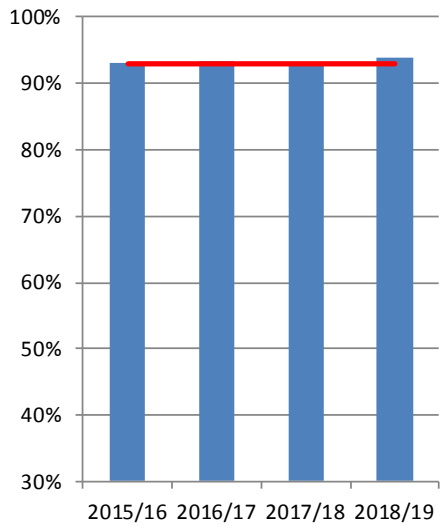
Since the new measures were introduced the Category 3 90th centile response times for NEAS have risen over the year with highest response times in November and December. Response times in this category have failed to meet the standard of 2 hours for 11 out of 12 months.



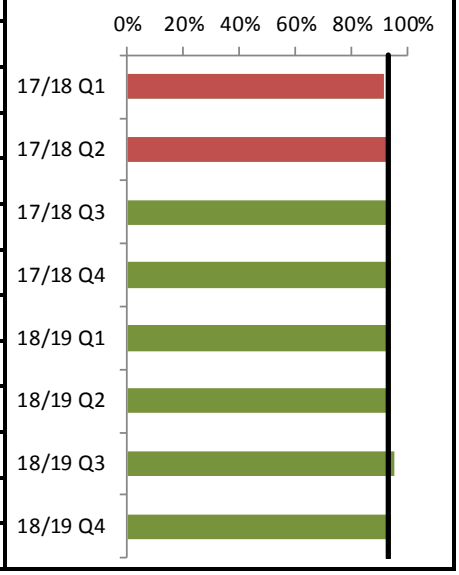
The Category 4 90th centile response times for NEAS have risen over the year with highest response times in September, November, December and January. Response times in this category have met the standard of 3 hours for 8 months out of 12.

Cancer Waiting Times

CWT - 2 Week Wait - All Cancers

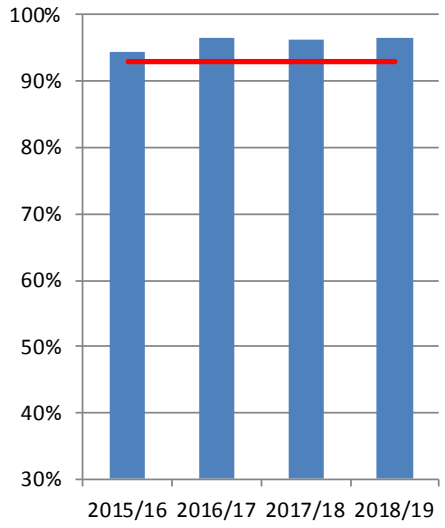


Standard	93.0%
2015/16	93.0%
2016/17	93.4%
2017/18	93.0%
2018/19	93.8%
2017/18 Q1	91.6%
2017/18 Q2	92.4%
2017/18 Q3	93.6%
2017/18 Q4	94.2%
2018/19 Q1	93.5%
2018/19 Q2	93.0%
2018/19 Q3	95.0%
2018/19 Q4	94.0%

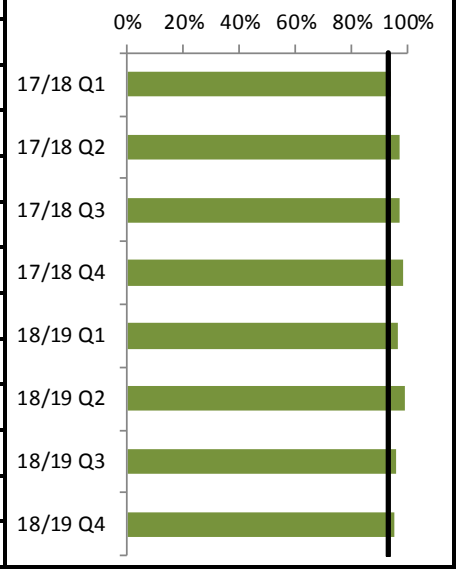


In 2018/19, 93.8% of patients referred by their GP urgently with suspected cancer were given an outpatient appointment within two weeks, which is an increase of 0.8 percentage points from 2017/18. Performance is above the 93% standard.

CWT - 2 Week Wait - Breast Symptomatic

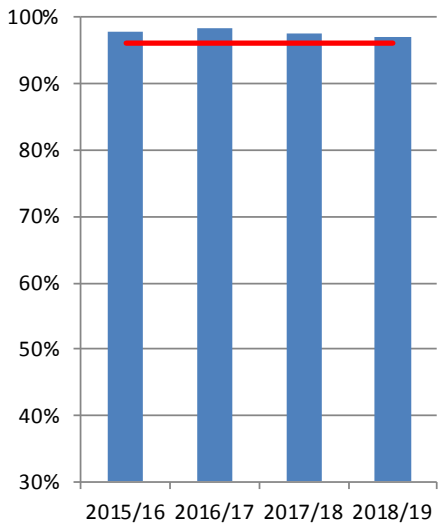


Standard	93.0%
2015/16	94.3%
2016/17	96.5%
2017/18	96.3%
2018/19	96.5%
2017/18 Q1	93.8%
2017/18 Q2	97.0%
2017/18 Q3	97.0%
2017/18 Q4	98.0%
2018/19 Q1	96.4%
2018/19 Q2	99.0%
2018/19 Q3	96.0%
2018/19 Q4	95.0%

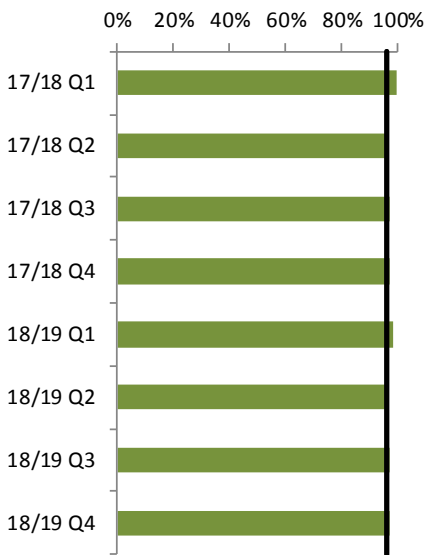


So far in 2018/19, 97.1% of patients who were referred urgently with breast symptoms were seen within two weeks. This represents an increase of 0.2 percentage points from 2017/18 with performance above the 93% standard.

CWT - 31 Day Treatment - All Cancers

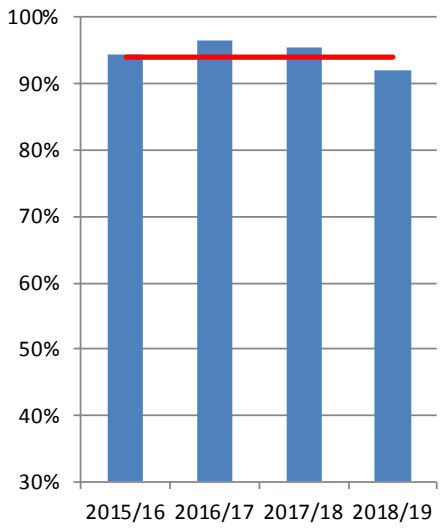


Standard	96.0%
2015/16	97.9%
2016/17	98.2%
2017/18	97.5%
2018/19	96.9%
2017/18 Q1	99.3%
2017/18 Q2	96.0%
2017/18 Q3	97.0%
2017/18 Q4	97.0%
2018/19 Q1	98.2%
2018/19 Q2	96.0%
2018/19 Q3	97.0%
2018/19 Q4	97.0%

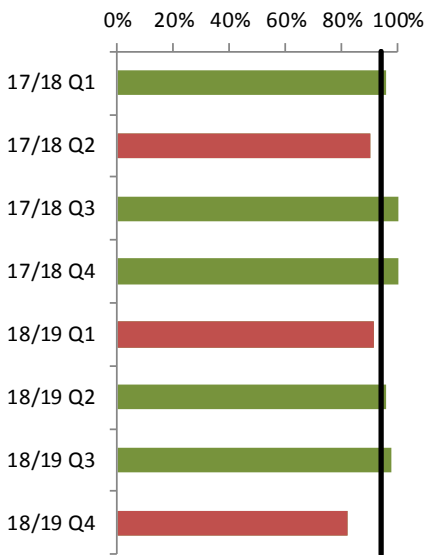


In 2018/19 so far, 96.9% of patients who were diagnosed with cancer waited less than 31 days for their treatment to commence. Performance does remains above the 96% standard.

CWT - 31 Day Treatment - Surgery

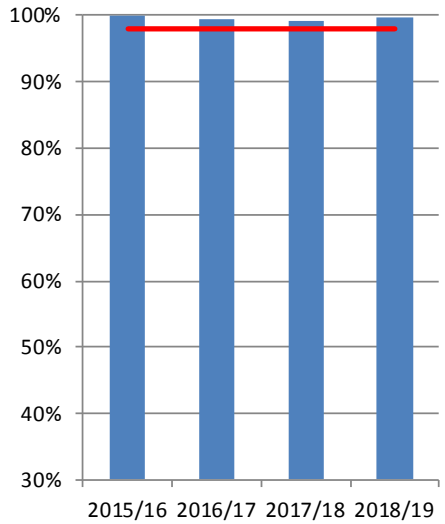


Standard	94.0%
2015/16	94.3%
2016/17	96.6%
2017/18	95.5%
2018/19	92.0%
2017/18 Q1	95.9%
2017/18 Q2	90.0%
2017/18 Q3	100.0%
2017/18 Q4	100.0%
2018/19 Q1	91.2%
2018/19 Q2	95.7%
2018/19 Q3	98.0%
2018/19 Q4	82.0%

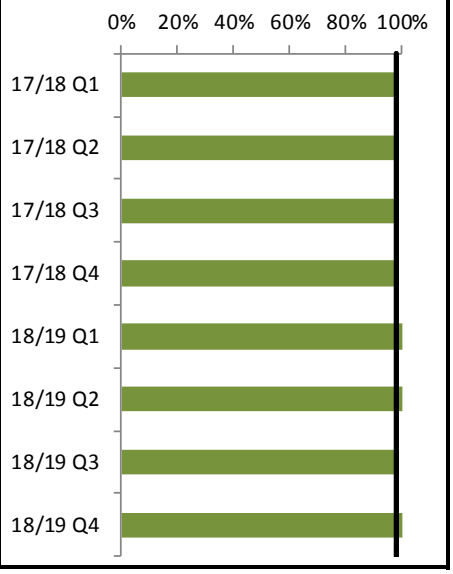


In 2018/19, 92% of people diagnosed with cancer and requiring surgery waited less than 31 days for that surgery, a decrease of 3.5 percentage points from the previous year. The CCG is below the 94% standard this year.

CWT - 31 Day Treatment - Anti Cancer Drug Regimen

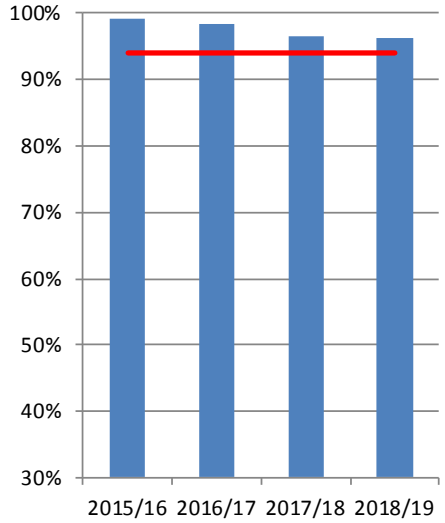


Standard	98.0%
2015/16	99.8%
2016/17	99.5%
2017/18	99.2%
2018/19	99.7%
2017/18 Q1	98.6%
2017/18 Q2	99.0%
2017/18 Q3	99.0%
2017/18 Q4	99.0%
2018/19 Q1	100.0%
2018/19 Q2	100.0%
2018/19 Q3	98.0%
2018/19 Q4	100.0%

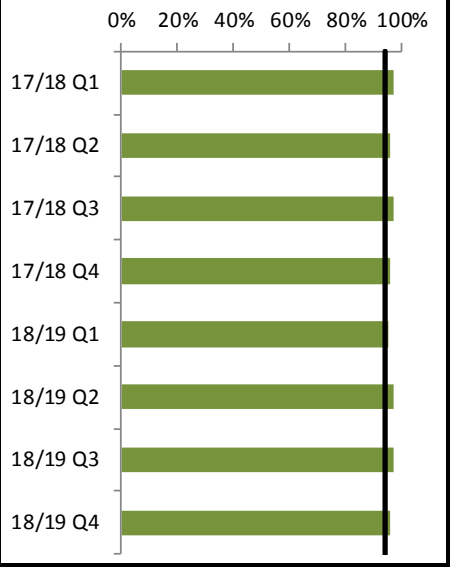


In 2018/19, 99.7% of patients who required drug treatment for their cancer diagnosis waited less than 31 days for that treatment, an increase from the previous year. The CCG has been above the standard for the last four years.

CWT - 31 Day Treatment - Radiotherapy

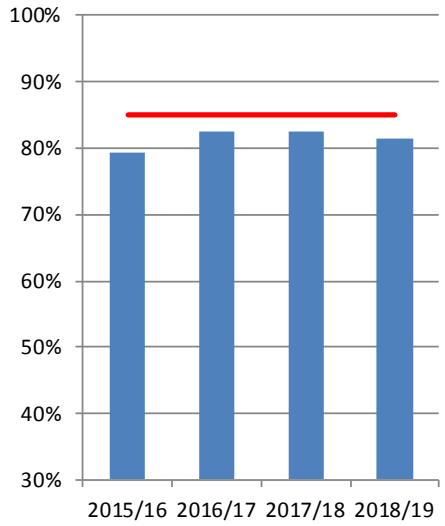


Standard	94.0%
2015/16	99.1%
2016/17	98.4%
2017/18	96.6%
2018/19	96.1%
2017/18 Q1	96.9%
2017/18 Q2	96.0%
2017/18 Q3	97.0%
2017/18 Q4	96.0%
2018/19 Q1	95.1%
2018/19 Q2	97.0%
2018/19 Q3	97.0%
2018/19 Q4	96.0%

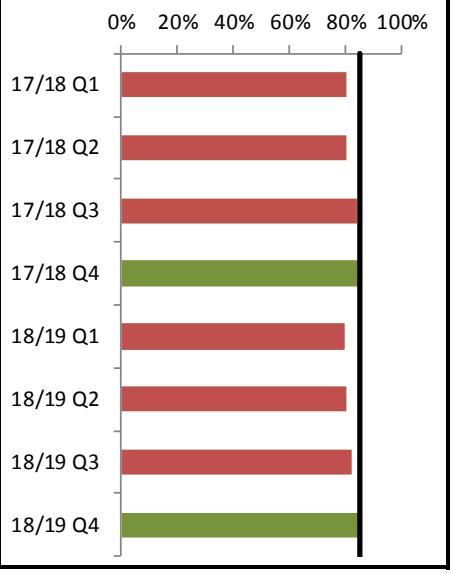


In 2018/19, 96.1% of patients who were diagnosed with cancer and required radiotherapy waited less than 31 days for treatment to commence. The CCG is above the 94% standard.

CWT - 62 Day Treatment - GP Referral

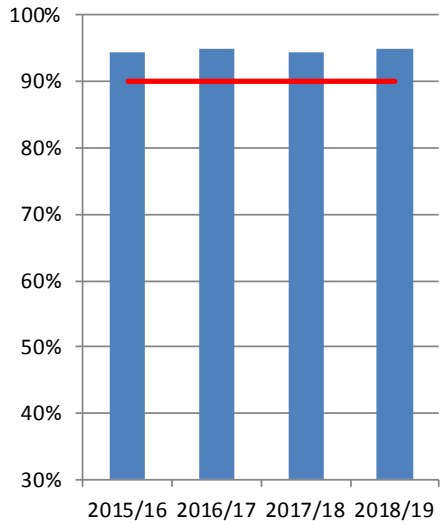


Standard	85.0%
2015/16	79.4%
2016/17	82.5%
2017/18	82.5%
2018/19	81.5%
2017/18 Q1	80.3%
2017/18 Q2	80.0%
2017/18 Q3	84.0%
2017/18 Q4	86.0%
2018/19 Q1	79.8%
2018/19 Q2	80.0%
2018/19 Q3	82.0%
2018/19 Q4	85.0%

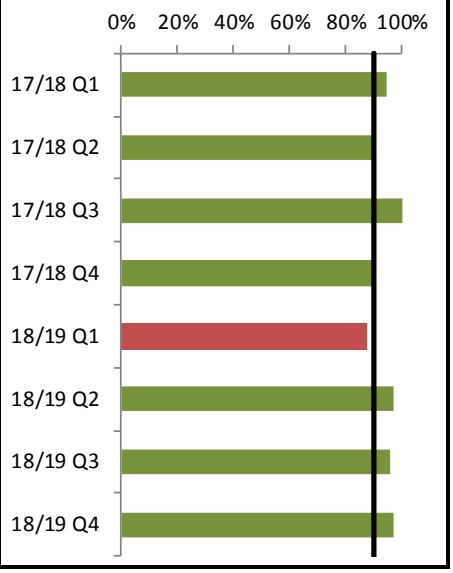


In 2018/19, 81.5% of patients who were diagnosed with cancer following an urgent referral from their GP waited less than 62 days from referral for treatment to commence. The CCG has not achieved the 85% standard.

CWT - 62 Day Treatment - Screening

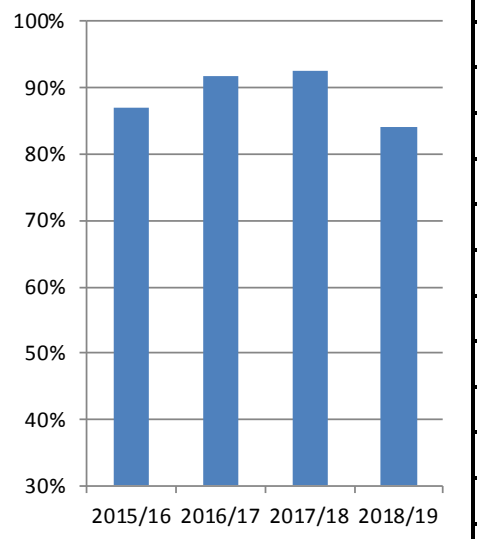


Standard	90.0%
2015/16	94.5%
2016/17	94.9%
2017/18	94.3%
2018/19	94.8%
2017/18 Q1	94.4%
2017/18 Q2	90.0%
2017/18 Q3	100.0%
2017/18 Q4	90.0%
2018/19 Q1	87.5%
2018/19 Q2	97.0%
2018/19 Q3	96.0%
2018/19 Q4	97.0%

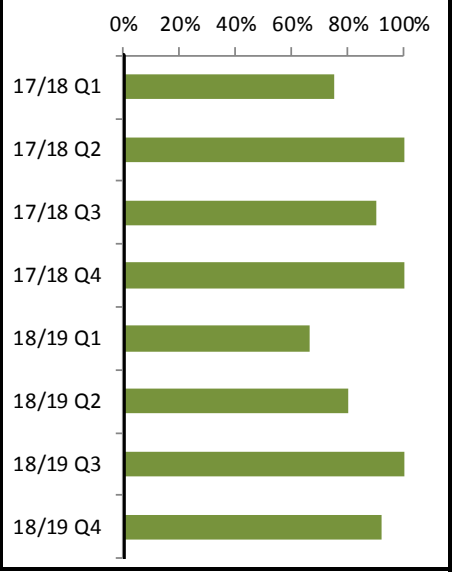


In 2018/19, 94.8% of patients who were diagnosed with cancer following referral from an NHS Screening Service waited less than 62 days from that referral for treatment to commence. This is slightly higher than last year and the CCG remains above the 90% standard.

CWT - 62 Day Treatment - Upgrade



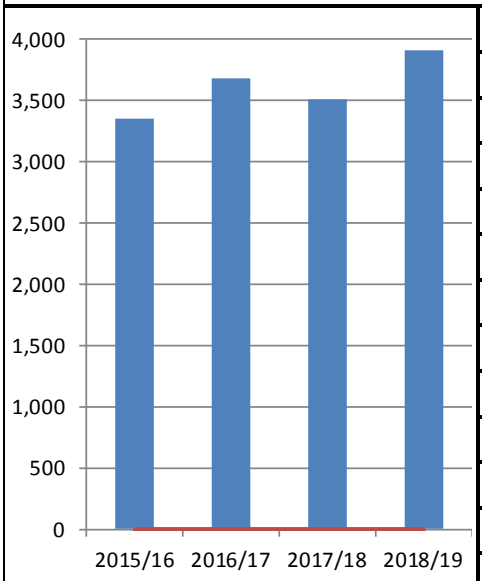
Standard	0.0%
2015/16	86.8%
2016/17	91.7%
2017/18	92.5%
2018/19	83.9%
2017/18 Q1	75.0%
2017/18 Q2	100.0%
2017/18 Q3	90.0%
2017/18 Q4	100.0%
2018/19 Q1	66.7%
2018/19 Q2	80.0%
2018/19 Q3	100.0%
2018/19 Q4	92.0%



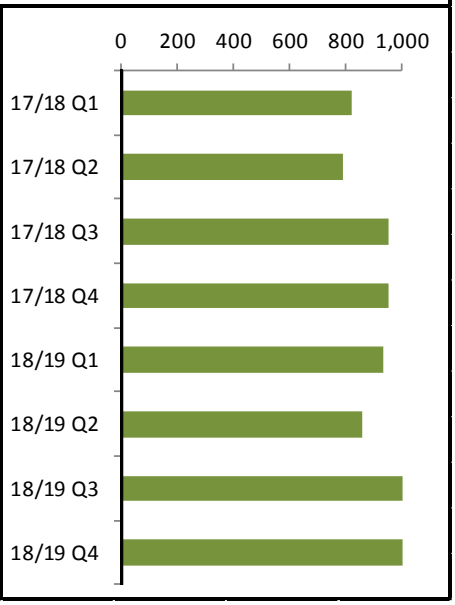
In 2018/19, 83.9% of patients who were diagnosed with cancer following a consultant's decision to upgrade their priority waited less than 62 days from the decision made for treatment to commence. This is a decrease from last year's performance, but it is important to note that the rates will tend to fluctuate widely as they are based on small numbers of patients.

Reduction in Avoidable Emergency Admissions

Avoidable Emergency Admissions



Standard	0
2015/16	3355
2016/17	3691
2017/18	3516
2018/19	3907
2017/18 Q1	824
2017/18 Q2	791
2017/18 Q3	951
2017/18 Q4	950
2018/19 Q1	933
2018/19 Q2	861
2018/19 Q3	1011
2018/19 Q4	1103

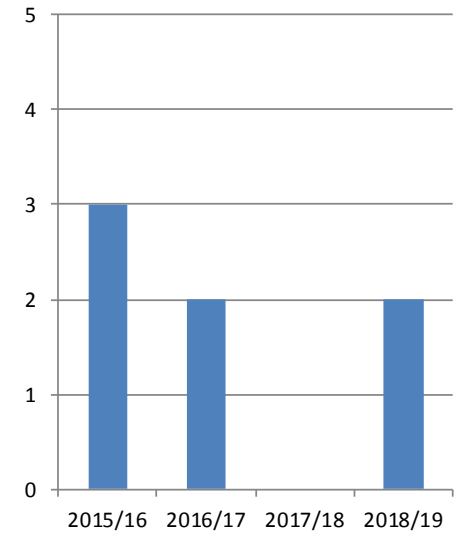


In 2018/19 there have been 3,907 avoidable emergency admissions per 100,000 head of population for HAST CCG.

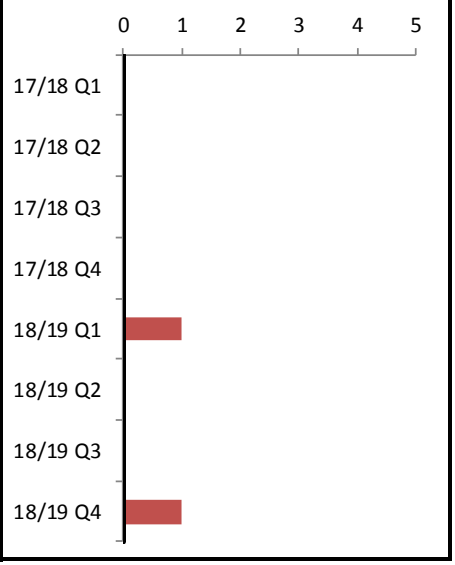
Healthcare Associated Infections (HCAI)

All CCGs have objectives for HCAIs set by NHS England. There is a zero tolerance of MSRA (Methicillin resistant Staphylococcus Aureus), which means that all commissioner and provider targets are zero.

MRSA Infection

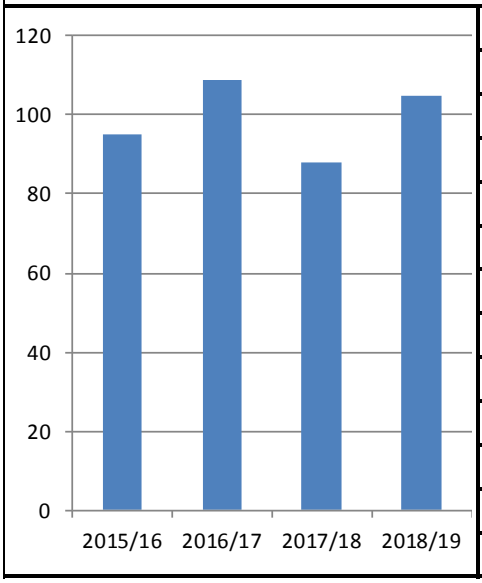


Standard	0
2015/16	3
2016/17	2
2017/18	0
2018/19	2
2017/18 Q1	0
2017/18 Q2	0
2017/18 Q3	0
2017/18 Q4	0
2018/19 Q1	1
2018/19 Q2	0
2018/19 Q3	0
2018/19 Q4	1

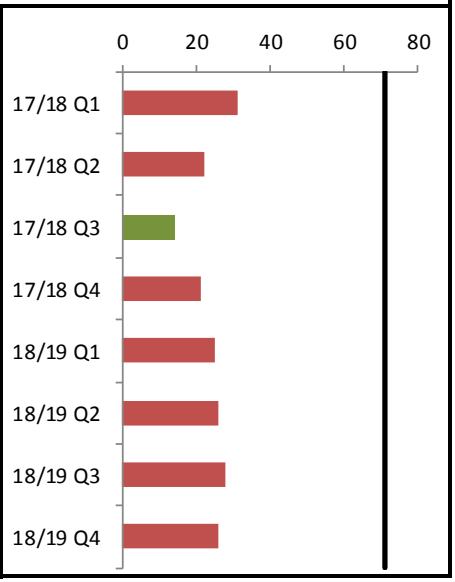


In 2018/19, there have been 2 reported incidents of MRSA compared to none in 2017/18 and 2 in 2016/17.

Clostridium difficile



Standard	71
2015/16	95
2016/17	109
2017/18	88
2018/19	105
2017/18 Q1	31
2017/18 Q2	22
2017/18 Q3	14
2017/18 Q4	21
2018/19 Q1	25
2018/19 Q2	26
2018/19 Q3	28
2018/19 Q4	26

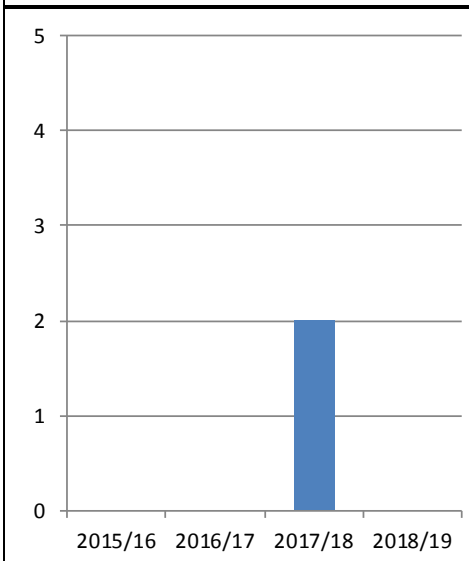


In 2018/19 there have been 105 cases of C.difficile attributable to the CCG among HAST patients. There were 88 reported cases in total last year.

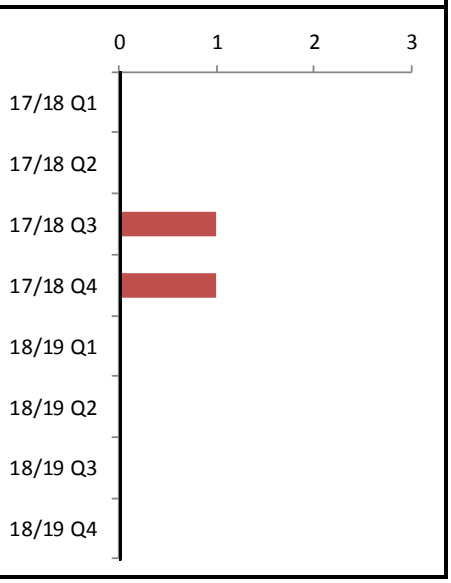
Mixed-Sex Accommodation

Under the NHS constitution, providers of NHS funded care are expected to eliminate mixed sex accommodation.

Mixed Sex Accommodation



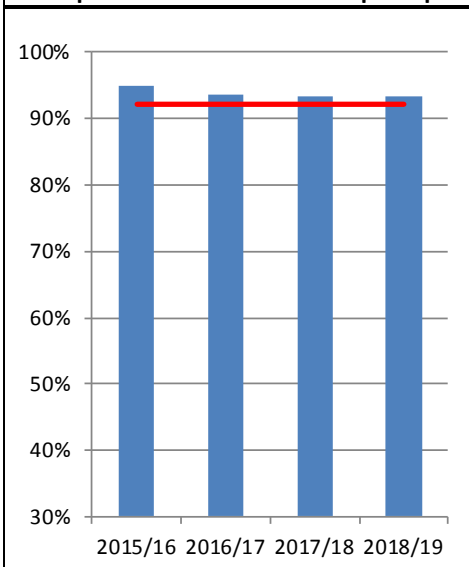
Standard	0
2015/16	0
2016/17	0
2017/18	2
2018/19	0
2017/18 Q1	0
2017/18 Q2	0
2017/18 Q3	1
2017/18 Q4	1
2018/19 Q1	0
2018/19 Q2	0
2018/19 Q3	0
2018/19 Q4	0



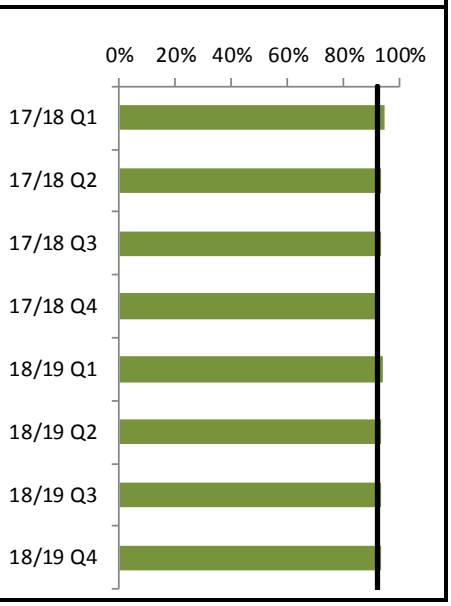
There have been no breaches in 2018/19 compared to 2 breaches reported in the previous year.

Referral to Treatment (RTT)

RTT % patients < 18 weeks incomplete pathways

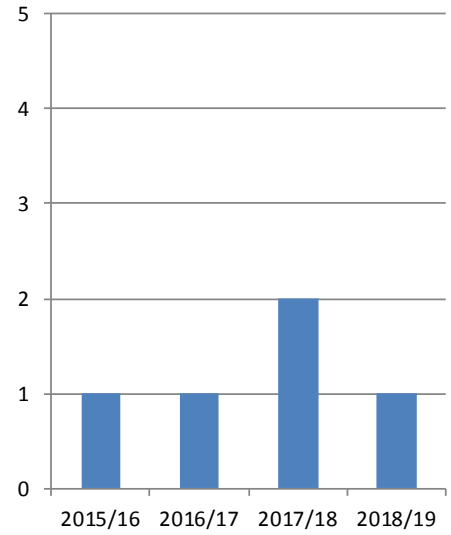


Standard	92.0%
2015/16	94.9%
2016/17	93.5%
2017/18	93.3%
2018/19	93.4%
2017/18 Q1	94.3%
2017/18 Q2	93.5%
2017/18 Q3	93.2%
2017/18 Q4	92.3%
2018/19 Q1	93.8%
2018/19 Q2	93.3%
2018/19 Q3	93.3%
2018/19 Q4	93.1%

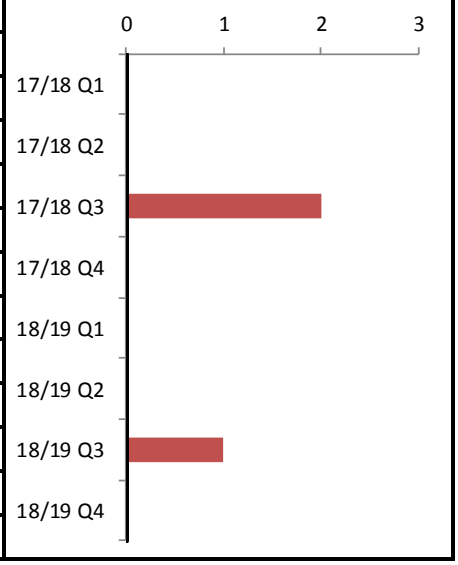


In 2018/19, 93.4% of patients who continue to wait for treatment have waited less than 18 weeks, a slight increase from the 2017/18 position. Performance remains above the standard expected.

RTT patients > 52 weeks incomplete pathways



Standard	0
2015/16	1
2016/17	1
2017/18	2
2018/19	1
2017/18 Q1	0
2017/18 Q2	0
2017/18 Q3	2
2017/18 Q4	0
2018/19 Q1	0
2018/19 Q2	0
2018/19 Q3	1
2018/19 Q4	0

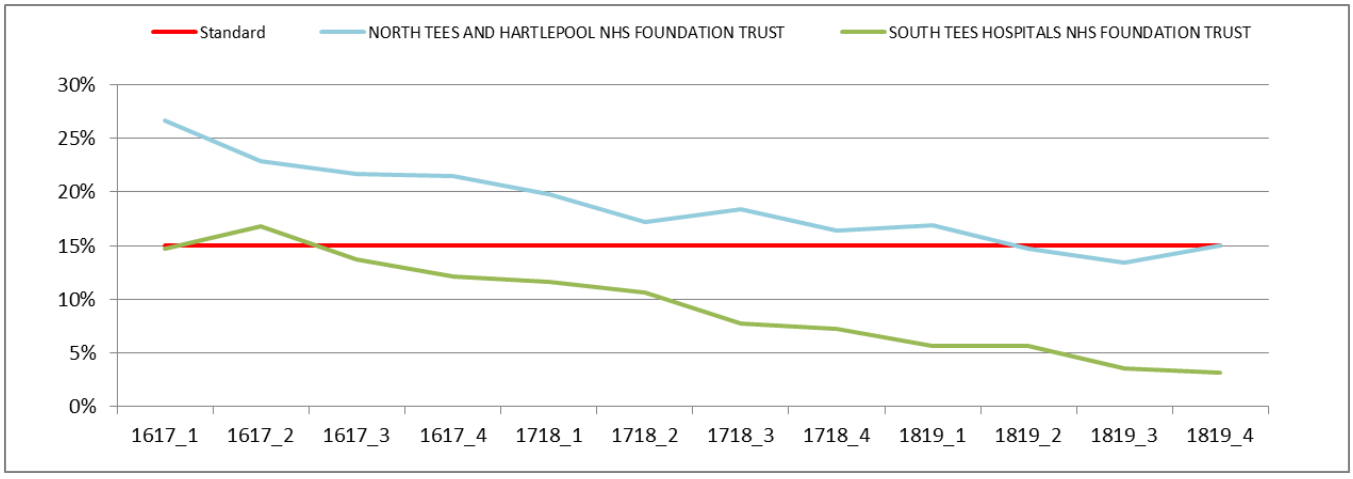


At the end of 2018/19, 1 patient is waiting for non-urgent consultant-led treatment and had waited longer than 52 weeks for that treatment to commence. This compares with 2 patients at the end of 2017/18.

Friends and Family Test (FFT)

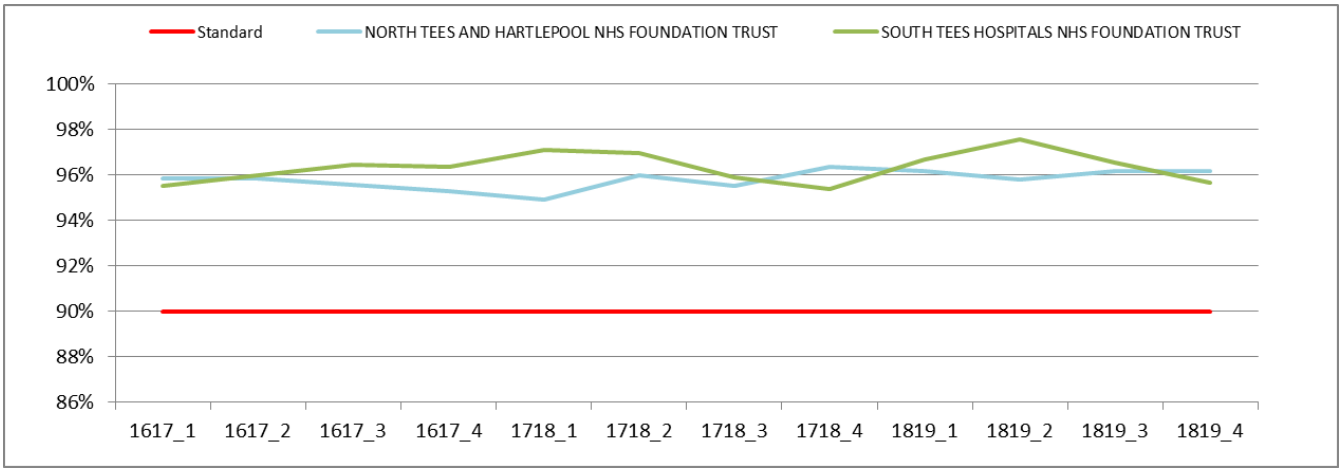
The friends and family test is intended to be a simple metric against which to measure patient experience.

FFT Inpatients Response:



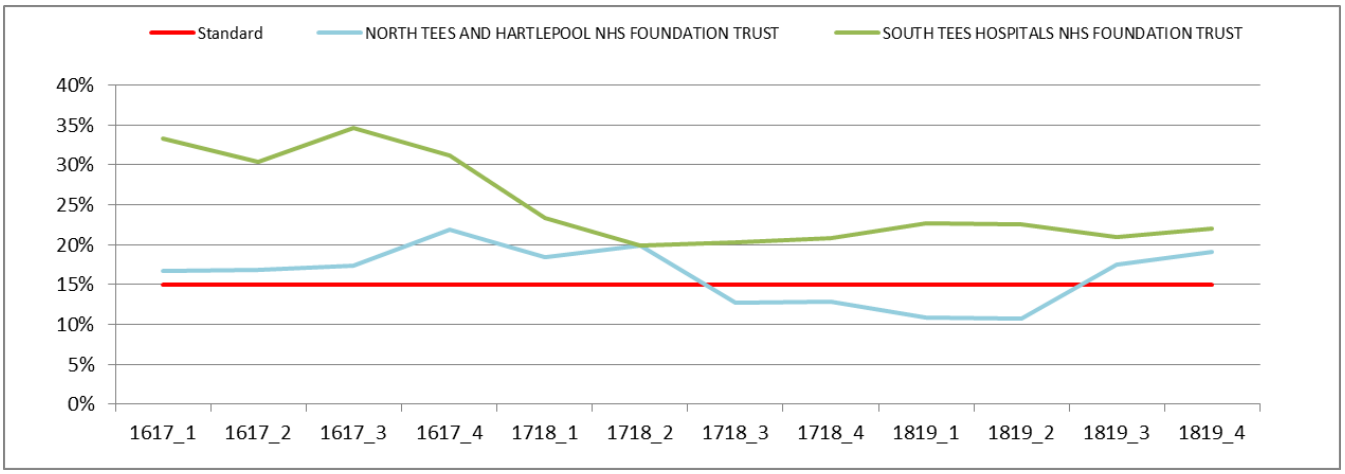
Friends and Family Test response rates for inpatients have decreased steadily for both trusts over the past few years. North Tees and Hartlepool NHS Foundation Trust has met the standard in April whereas South Tees Hospitals NHS Foundation Trust is below the 15% standard.

FFT Inpatients % Recommended:



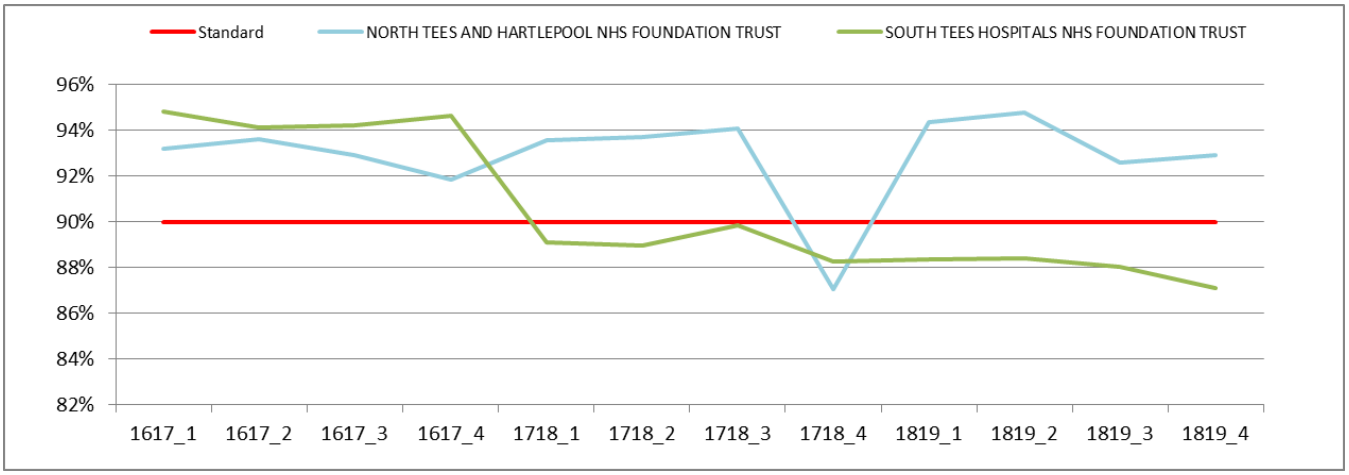
The satisfaction scores of inpatients recommending the service remains above the national target so far this year for both providers.

FFT A&E Response:



Friend and Family Test response rates for A&E patients have increased in later months for both Trusts and are now above the 15% standard.

FFT A&E % Recommended:



A&E satisfaction scores for North Tees and Hartlepool NHS Foundation Trust have decreased this year and are now below the 90% standard. However South Tees Hospitals NHS Foundation Trust scores have increased and are now above the standard.

MY NHS Performance

The NHS Five Year Forward View and the NHS Operational Planning and Contracting Guidance set out national ambitions for transformation in six clinical priority areas. The CCG's progress against these areas is reported to NHS England through the CCG Improvement and Assessment Framework. Further information can be found on the My NHS website.

The CCG's assessment against the six clinical priority areas, as published on My NHS, is shown below. The overall assessment of each area is based on the CCG's performance against a number of related factors.

Cancer	Dementia	Diabetes	Learning Disability	Maternity	Mental Health
52.6% of all newly diagnosed cases of cancer are diagnosed at an early stage	85.6% of the estimated number of people with dementia have a recorded diagnosis	39.8% of patients achieved all recommended NICE standards	69 per million registered population Good	19.6% of 750 mothers smoked at delivery	52.7% of people who finished treatment moving to recovery
82.2% of people treated within	79.9% of patients with dementia	100% participation in the National	50.5% of people on a GP learning	4.5 stillbirths and neonatal deaths per	6.1% of people who have

62 days	whose care plan has been reviewed in the preceding 12 months	Diabetes Audit	disability register received an annual health check	1,000 births	depression and/or anxiety disorders who have started treatment
71.3% one year survival		8.7% of people diagnosed with diabetes attended a structured education course	0.5% of the population (all ages) are included on a GP learning disability register	83.26 is the score out of 100 based on six survey questions about experience	89.4% of 85 people with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral
8.9 is the average score given by patients asked to rate their care on a scale from 1 to 10 (10 being best)				55.70 is the score out of 100 based on six survey questions about choice	0% Proportion of crisis resolution and home treatment (CRHT) services in the STP area able to meet selected core functions
Overall assessment: Good	**Overall assessment: Outstanding**	**Overall assessment: Good**	**Overall assessment: Requires Improvement**	**Overall assessment: Requires Improvement**	**Overall assessment: Good**

Sustainable Development

Introduction

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of by making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features. One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP) and this will be considered for the future. We do not currently use the Sustainable Development Assessment Tool (SDAT) tool.

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by taking opportunities to promote the benefits of sustainability to our staff.

Partnerships

As a commissioning and contracting organisation, we will need effective contract mechanisms to deliver our ambitions for sustainable healthcare delivery. The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Our procurement processes ask potential suppliers of NHS services to demonstrate consideration of environmental and social impacts of their business and/or service.

Performance

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. Our consumption is as follows:

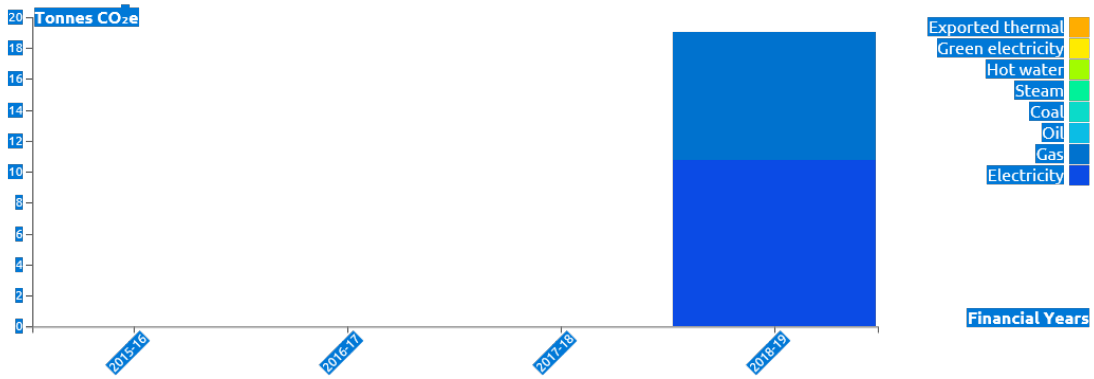
Energy

NHS Hartlepool and Stockton-On-Tees CCG has spent £6,051 on energy in 2018-19, which is a 0% increase on energy spend from last year.

Energy consumption in kWh

Energy consumption in kWh 2018-19

Electricity Consumed	30,557
Gas Consumed	38,998
Total	69,555



CO_2 Emissions (tCO_2e) P2018-19

Electricity	10.8
Gas	8.28
Total	19.1

Paper

The movement to a Paperless NHS can be supported by staff reducing the use of paper at all levels, this reduces the environmental impact of paper, reducing cost of paper to the NHS and can help improve information security.

Travel

We can improve local air quality and improve the health of our community by promoting active travel to our staff and to the patients and public that use our services.

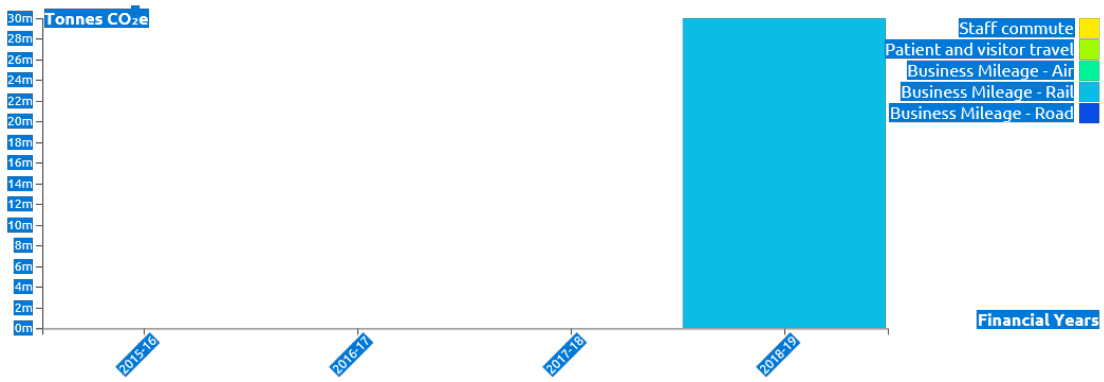
Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness and promote the use of technology such as teleconferencing to reduce travel. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.

Travel undertaken

All travel is shown in miles.

	2018-19
Business travel and fleet	95,260
Total	95,260

Carbon emissions resulting



CO2 Emissions (tCO2e)

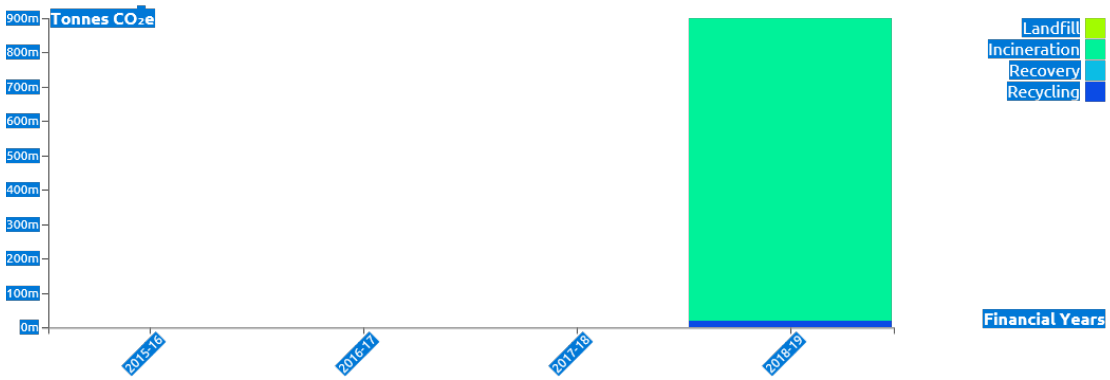
	2018-10
Business Mileage - Rail	0.03
Total	0.03

Waste

Waste produced

Waste in tonnes	2018-19
Waste recycling weight	1
Incineration disposal weight	4
Total	5

Carbon emissions resulting



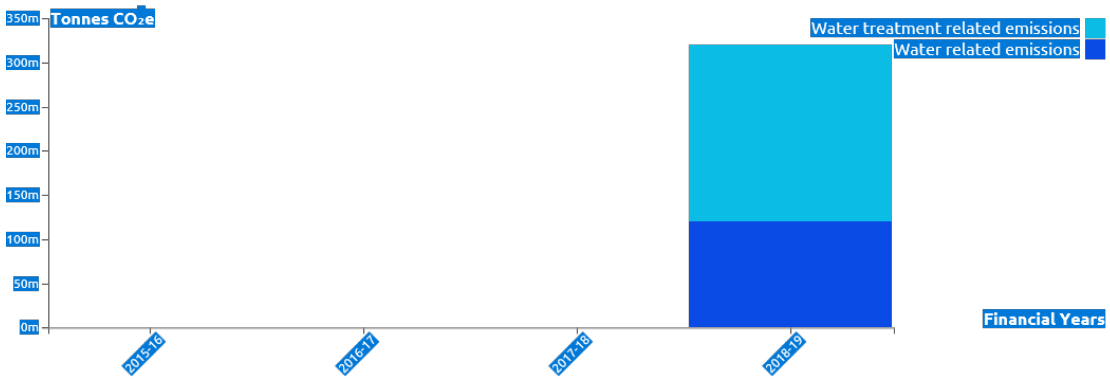
CO2 Emissions (tCO2e)

	2018-19
Recycling	0.02
Incineration	0.88
Total	0.9

Finite resource use - Water

Water	2018-19
Water volume (m^3)	361
Waste water volume (m^3)	289
Water and sewage cost (£)	1,738

Carbon emissions resulting



CO_2 Emissions (tCO_2e)	2018-19
Water related emissions	0.12
Water treatment related emissions	0.2
Total	0.32

Modelled Carbon Footprint

The information provided in the previous sections of this sustainability report uses the ERIC returns as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information estimates the impact of our supply chain from our spend. More information available here: http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx

The values in the table below are percentages.

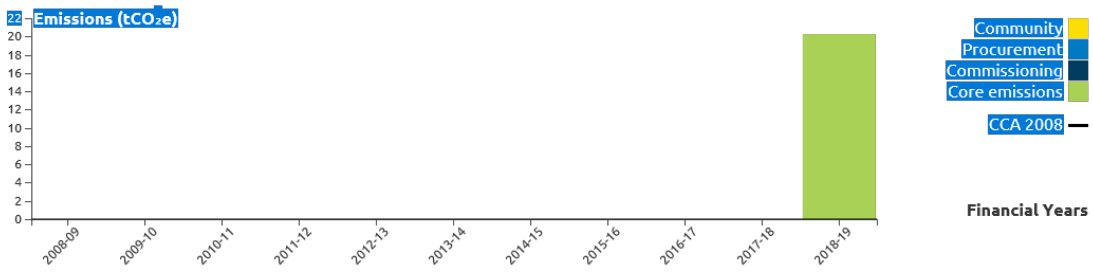
		2018-19
Core emissions		100
Commissioning		0
Procurement		0
Community		0
Total		100

Sustainable Development Unit (SDU) whole organisation carbon profile

Calculated from operating expenditure of £0,000 of which £0,000 is non-pay spend based on typical values for a Clinical Commissioning Group organisation.

CO_2 Emissions (tCO_2e)	2018-19
Electricity (net of any exports)	10.8
Gas	8.28
Oil	0
Thermal energy (net of any exports)	0
Leased Assets Energy Use (Upstream - Gas, Coal & Electricity)	0
Business travel and fleet	0.03
Waste and Water	1.22
Total	20.3

Carbon emissions progress



Social Value

Collectively as an organisation we recognise the contribution that commissioning, procurement and commercial can have in delivering sustainability and social value, and our duty under the Public Services Value Act.

Note: this report has been generated for the CCG using the Sustainable Development Unit's online sustainable reporting portal utilising data supplied to the CCG by NHS Property Services and any other relevant providers.

Improving Quality and Safeguarding

The CCG has a statutory duty to improve the quality of services provided for local people and a responsibility to ensure that we commission safe, good quality and effective services that result in positive experiences for patients. The CCG does this by securing continuous improvement in the quality of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness through the monitoring the effectiveness and safety of the services and the quality of the experience undergone by patients. We understand that securing continuous quality improvement in our commissioned services is an ongoing process and to ensure we remain sighted on all aspects of quality and are able to constructively challenge, scrutinise and assess individual providers' performance and service delivery, we have established robust internal and external quality assurance mechanisms.

These mechanisms are described in our Quality Strategic Framework. It outlines the CCG's approach to quality detailing how it manages and champions the local clinical quality agenda to ensure compliance with the CCG improvement and assessment framework. In order to effectively address quality issues with our commissioned services and seek assurance, we systematically undertake a range of activity. This activity informs and shapes the CCG Quality and Safeguarding Annual Work Programme. Priorities identified have been positively progressed through proactive collaboration with partners. Monitoring, evaluation and scrutiny of these areas of work have been completed through implementation of the CCG Quality Strategic Framework.

A range of quality assurance activities have been undertaken by the CCG in 2018/19, this includes listening to concerns, face to face contact, analysis of provider data and information, and the sharing of intelligence with relevant NHS commissioners, local authority organisations, Healthwatch and regulatory bodies.

Further detail of these activities is described below:

Quality, Performance and Finance Committee (QPF)

Their role is described within the annual governance statement later in the report.

Clinical Quality Review Groups (CQRGs)

Throughout 2018/19 work has continued with the four main NHS provider Trusts that we commission services from – North Tees and Hartlepool NHS Foundation Trust (NTHFT); South Tees Hospitals NHS Foundation Trust (STHFT); Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV); and North East Ambulance Service NHS Foundation Trust (NEAS) to monitor, evaluate and drive forward quality standards and we have held regular CQRG meetings involving CCG, GPs and Trust clinicians. These forums enable commissioners and providers to have a productive dialogue and provide the opportunity to identify innovation, best practice, areas for improvement, lessons learnt and evidence of improving patient outcomes. We are able to gain insight into the quality of care delivered to local people and promote lessons learnt.

CQRGs focus on areas of concern through in-depth analysis and discussion reported by exception, and also allows the promotion of best practice and quality outcomes.

Commissioner Assurance Visit Programme

An important part of seeking assurance from our providers is undertaking announced and unannounced visits to services which provide a valuable opportunity to gain patient and staff feedback, quality assurance, and meet families and providing services staff.

This programme of work is an integral part of the contract management and quality assurance processes, led by the Head of Quality and Safeguarding and involves a wide range of clinicians.

Before the visits take place intelligence is gathered from a range of sources to identify any key areas to visit or areas of concern: The intelligence gathered includes:

• Soft intelligence from GP practices and patient complaints.

• Quality Surveillance Groups chaired by NHS England.

• Regular contract review and monitoring meetings.

• Regular liaison between the Chief Officer and provider Chief Executives.

• Regular communication between the CCG Director of Nursing and Quality and the Provider Directors of Nursing.

Once the visit is complete a report is compiled by all members of the group who undertook the visit, this represents the findings from the visit. Areas of concern or that require improvement will be included in a provider action plan, and monitored through CQRG. Engagement in this programme is positive from both internal and external staff, and providers have engaged positively to clinical challenge, scrutiny and constructive feedback. The visits have been very positive with good evidence of care, staff knowledge, assessment and positive feedback from patients. One area demonstrated proactive action related to major patient fall with ward training and displaying eye catching fall reduction information for both patients and staff. Some areas of development were identified with two key themes; patient information boards did not always display up-to-date information and the lack of storage spaces in many areas which resulted in cluttered corridors which could increase the risk of falls and more difficult to keep clean. Older buildings are the main reason for this due to design and increase in the use of medical equipment.

Commissioning for Quality and Innovation (CQUIN)

The Commissioning for Quality and Innovation (CQUIN) is a payment framework that encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. A two year programme commenced in 2017 using key national schemes based on 13 clinical quality and transformational areas which aimed to improve quality and outcomes for patients including reducing health inequalities, encourage collaboration across different providers and improving the working lives of NHS staff. These included improving staff health and well-being; reducing the impact of serious infection; supporting proactive and safe discharge; improving the assessment of wounds and increase the proportion of NHS 111 referrals to services other than to the ambulance service or A&E. Providers submit quarterly compliance data and this is

monitored through CQRGs. The main provider has demonstrated full achievement in sepsis review for both inpatients and emergency department and good compliance in reducing frequent attenders to A&E with mental health needs. Challenges have included sepsis screening for inpatients with 66% compliance in Q4 and in risky behaviours advice and referral related to tobacco and alcohol.

Serious Incidents

Healthcare systems and processes can have weaknesses which can lead to errors. It is important the NHS system responds appropriately when things go wrong to ensure services and processes continue to improve.

We are responsible for ensuring there is an effective governance process in place to manage incidents that occur within providers or within the CCG. Incident investigations are undertaken to identify a root cause analysis and timeline of events, the process manages the incident to ensure lessons are learnt and improvements are embedded into practice.

The governance process is managed through the SIRMs system supported by the North of England Commissioning Support Unit (NECS) and CCG staff. Part of this process is the Serious Incident Panel, which is responsible for reviewing Serious Incidents, ensuring appropriate actions are taken and lessons are learnt. This panel is led by the CCG Director of Nursing and Quality who will only close an incident once assurance is gained, that the appropriate action has been taken to safeguard patients, prevent the incident happening again, and that lessons have been learnt to ensure patients receive quality care. Key themes and trends have been identified throughout 2018/19 and we have worked with providers to understand the processes that require improvement and agree actions that will be taken to improve quality of care.

Serious Incidents are subject to debate and scrutiny both during the panel and CQRGs held regularly with providers.

There is a current domestic homicide review and parallel mental health homicide review which was reported in 2018/19. Any key lessons learnt regarding health will form part of overall recommendations following publication.

Tees Infection Prevention and Control Collaborative (TIPCC)

The CCG has been working collaboratively across the Tees healthcare system through the established the TIPCC which commenced in October 2017. The collaborative has continued to develop and implement an action plan initially related to reducing gram negative blood stream infections. The key areas have included identifying best practice, in particular the role of hydration and the development of healthy hydration public information leaflet, training and education, surveillance and audit, interventions and development of performance indicators, resources for health and social care workers, communication and engagement and infrastructure within and across organisations. The CCG also participated in the national UTI collaborative which saw hydration initiatives in care homes and urinary catheter insertion cleansing pilot. The TIPPC links closely with NHS CNE regional HCAI Improvement Board where there is sharing of good practice. The key themes moving forward into 2019/20 are

engagement, education & training, service improvement, surveillance and monitoring and antibiotic stewardship.

Quality Surveillance Groups

We are a member of the local Quality Surveillance Groups (QSGs) which are led and co-ordinated by NHS England. These forums bring together regulators, commissioners and providers of services to review quality by sharing intelligence and local knowledge to help identify early signs of service failure or poor quality. In 2018/19 there has been a wide range of intelligence shared by the group in relation to services across acute, community, specialist mental health and learning disability, care homes and primary care services. Primary care services include services provided by all the following providers; GP practices, Dentists, Pharmacists and Optometrists. The QSG provides an opportunity to discuss concerns or risks with the quality of care delivered by providers at a local level, as well as gain an insight into regional and national quality concerns that are ongoing with providers.

NHS England Safeguarding Forum

The CCG has shared information and intelligence at the Safeguarding Forum, a health commissioner sub-group of the Quality Surveillance Group which has enabled focused attention on specific quality issues in relation to adult and children's services, and generated local solutions and opportunities for collaborative working across the North Durham, Durham Dales, Easington and Sedgefield, Darlington, Hartlepool and Stockton-On-Tees and South Tees CCG areas.

Safeguarding

The CCG has a close and effective working relationship with partner agencies which includes both Local Authorities and the police. We work closely together and share expertise to respond to early warning indicators, and address these in a timely and efficient manner.

The CCG is part of the now fully established Cleveland Anti-Slavery Network with the key aim to increase greater local awareness/intelligence and ensure an improved multi-agency response for those affected by Human Trafficking and Modern Slavery. The CCG is leading the development of a process to ensure when a victim of modern slavery or trafficked is identified their health needs are met. The CCG is a statutory member on the Hartlepool Borough Council Local Safeguarding Children Board (HSCB), Stockton-on-Tees Borough Council Local Safeguarding Children Board (SLSCB), and the Tees wide Safeguarding Adults Board (TSAB).

The adult and children's designated safeguarding leads attend the providers' safeguarding meetings and sub groups and provide expertise and challenge to these groups.

The Director of Nursing and Quality and Head of Quality and Adult Safeguarding nurses actively work with the Teeswide Safeguarding Adults Board. The CCG works with the Care Quality Commission (CQC) in relation to provider quality concerns. The CQC links include both the NHS providers and nursing home providers, so this involves additional close working across the health and social care economy.

The Designated Nurse Safeguarding Children and Adult Safeguarding lead continues to seek assurance from provider services relating to performance and has refreshed the Local Quality Requirements to include children with Special Educational Needs and Disabilities.

Learning Disabilities Mortality Review Programme has been established and is chaired by the Head of Quality and Adult Safeguarding for South Tees CCG and comprises of a multi-agency panel across Teesside involving all four local authorities and major health providers. This process reviews the life and death of any person with learning disabilities and shares good practice and any lessons learned.

The Designated Nurse Safeguarding Children and Looked After Children is responsible for providing expert safeguarding advice across the health economy, seeking assurance that commissioned services are fulfilling their safeguarding responsibilities, leading and influencing the safeguarding children agenda . This includes being a member of a variety of multi-agency sub-groups acting as a source of expertise across sectors on all matters regarding planning, strategy and identifying any gaps in service provision with regards to the safety of vulnerable children, child abuse, child deaths and Looked After Children.

During this reporting period the Designated Nurse Safeguarding Children and the Director of Nursing and Quality have been significantly involved in developing new safeguarding children partnership arrangements which will replace the current Local Safeguarding Children Boards by September 2019. The Hartlepool and Stockton-on Tees partnership aims to publish its arrangements by the end of March 2019.

Following the publication of the Hartlepool serious case review (Olivia and Yasmine) work has been underway to progress the actions from this review which are now complete. Three briefing sessions were delivered by the Designated Nurse Safeguarding Children and Local Authority colleagues to a variety of practitioners which included health, social care, education, across both Hartlepool and Stockton-on-Tees to share the learning from this review.

The Designated Nurse Safeguarding Children has supported one of the provider organisations to successfully develop and embed processes to increase compliance of Looked After Children health assessments for the vulnerable children taken into care. The focus for the forthcoming reporting period is to further strengthen the identification of health needs for our looked after children.

A collaborative approach between NHS Digital, North Tees & Hartlepool NHS Foundation Trust, both local authorities and the CCG has progressed the child protection information sharing process (CP-IS) where an alert is sent to the local authority where children who are subject to child protection plans or are looked after attend unscheduled care settings. The Trust plan to go live with this process by the end of March 2019.

Both Hartlepool and Stockton-on-Tees Local Authorities and the CCG have undergone local area inspections by CQC and Ofsted for children with Special Education Needs and Disabilities (SEND). Hartlepool had a revisit (beginning January 2019) following their initial inspection in October 2016 and Stockton-on-Tees had a full initial SEND inspection at the end of January 2019. The Hartlepool report was published end March 2019 and early findings have identified some improvements following the initial inspection however further work is required to

strengthen areas of weakness. The Stockton-on-Tees report is awaited however early indicators are that some strengths were identified but they too have areas of weakness which require a written statement of action.

The Adult and Children's Safeguarding leads attend the Local Authority domestic abuse strategic groups and have been contributing to the domestic abuse strategies in relation to domestic abuse. The Head of Quality and Adult Safeguarding participated in a Tees wide Task and Finish Group to redesign the Multi-Agency Risk Assessment Conference for victims of domestic abuse. Changes involved included increasing the frequency of the meetings, employing an independent chair and convening a Strategic Management Board. Following discussions with the Named GP, designated nurse, adult safeguarding lead and the domestic abuse coordinator for Stockton-on-Tees a pilot is underway in 3 GP practices in the area where Harbour (an organisation supporting victims of domestic abuse) is supporting staff and victims who present at the GP surgery. Early indicators demonstrate an increase in referrals to children's social care and an evaluation report is expected in April 2019.

The Named GP to Safeguarding Children has continued to produce and distribute bulletins containing pertinent information in relation to safeguarding children and adults, a 'think family approach', to all GP practices across the area. These have included:

• Learning from serious case reviews

• Impact of parental behaviours upon children, particularly adolescents

• Child sexual exploitation (CSE) and criminal exploitation

• Adverse childhood experiences

• Child not brought policy

• County lines

• Linking records

During this reporting period the delivery of GP peer engagement sessions has ceased and has been replaced by Level 3 safeguarding training sessions offered to GPs, Nurse Practitioners and those members of staff requiring this level of training across Tees. These are led by the Named GP Safeguarding Children and delivered by the safeguarding team including Designated Doctors and nurses safeguarding children and adult safeguarding leads. These sessions have proven extremely successful and will continue on a regular basis across Tees.

Engaging people and communities

NHS Hartlepool and Stockton-on-Tees CCG listens carefully to the views of our population including patients, carers, the general public, the voluntary and community sector and is committed to acting on the feedback we receive. By contributing their opinions about our current services and future needs, the community can take a greater role in decisions about healthcare provision in our area. During 2018/19 we have encouraged our communities to get involved in a wide variety of ways**.**

What are our statutory responsibilities?

Hartlepool and Stockton-on-Tees CCG is bound by several statutory and regulatory obligations with regards to engagement and involvement such as Section 14Z2 of the NHS Act 2006 (as amended 2012) to involve the public (individuals and communities you serve) in commissioning activities and the impact that engagement activity has had. Similarly, the Health and Social Care Act 2012 tells us that CCGs must show how the views of patients, carers, public, communities of interest and geography, Health and Wellbeing Boards, Local Authorities, and practice populations "… are translated into commissioning intelligence and shared decision-making."

The NHS Constitution enshrines public ownership of the NHS as a fundamental value:

"The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill, and when we cannot fully recover, to stay as well as we can to the end of our lives."

Everyone has a stake in the health of their community and an engaged and supportive public can provide a powerful mandate and resource for our CCG as we evolve.

The principles of participation

The CCG will ensure the principles of participation are applied by:

1. Reaching out to people and asking them how they want to be involved, avoiding assumptions.
2. Promoting equality and diversity and encouraging and respecting different beliefs and opinions.
3. Proactively seeking participation from people who experience health inequalities and poor health outcomes.
4. Providing clear and easy to understand information and seeking to facilitate involvement by all, recognising that everyone has different needs.
5. Planning and budgeting for participation early as possible.
6. Being open, honest and transparent in the way we work; telling people about the evidence base for decisions, and being clear about resource limitations and other relevant constraints. Where information has to be kept confidential, explaining why.
7. Recognising, recording and celebrating people's contributions and providing feedback on the results of involvement; showing people how they are valued.

The CCG has a Communication and Engagement strategy which supports the delivery of patient participation. You can view this strategy on our website www.hartlepoolandstocktonccg.nhs.uk

Our engagement and involvement objectives

Help people to help themselves: By expanding and improving the tools currently used by Hartlepool and Stockton-on-Tees CCG to engage with service users and the public we aim to give people the local knowledge, skills and confidence to be involved with their own health and wellbeing.

Getting the public involved in our decision making: By putting patients and the public at the heart of our decision making we can give local people a say on how our services are developed locally. We will do this through an effective engagement programme that is innovative and accessible and promotes continuous engagement with people from all areas of Hartlepool and Stockton-on-Tees.

Patient and Public Voice: To support the CCG to ensure that the patient and public voice is at the heart of the organisation and its business and that the appropriate engagement and involvement arrangements are in place to enable the CCG to meet its statutory requirements in relation to the duty to involve and consult (Section 14Z2 of the NHS Act 2006 (as amended 2012) These include ensuring that there are:

a. effective engagement, involvement and consultation mechanisms in place, and

b. arrangements in place for feeding back to key stakeholders about how their involvement has impacted on the development of services commissioned by NHS Hartlepool and Stockton-on-Tees CCG.

This will be achieved via a range of communication channels and will be delivered through the operational communications and engagement plan.

To help us achieve our objectives we will:

Ensure appropriate and proportional involvement from the third sector, community groups and communities, when commissioning proposals affect them, by ensuring on-going and effective conversations

- We will understand the profile and needs of our population, to ensure we offer everyone the opportunity to have a voice
- We will continue to build on and create new links with the third sector and community groups, through our community health ambassadors and our close working relationship with our local Healthwatch organisations. This will ensure that we use their experience and strengths to regularly engage with those people whose views are seldom heard.
- Always ensure that we feedback to individuals and groups who’ve contributed and/or provided us with feedback, in a timely way.

We seek patient views from people in all 9 protected characteristics and other disadvantaged groups via the CCG's communication and engagement strategy.

Community Health Ambassadors

Our Community Health Ambassadors programme continues to go from strength to strength**.** Recruited from the local community the health ambassadors help us to effectively engage with local people in the planning, development and commissioning of health services, with a particular focus on engaging people from minority, marginalised and disadvantaged groups and communities.

Since 2015 the CCG has worked in partnership with Catalyst and Xivvi to recruit and manage a team of volunteers who represent a wide range of communities from across all areas of Hartlepool and Stockton-on-Tees including those with learning difficulties/disabilities and their carers, BME community, deaf community, blind community, homeless community, over 50's/ageing population, ex-offenders, faith groups, mental health and more.

Ambassadors are encouraged to provide feedback and recommendations that are solution focussed, allowing the CCG to provide a practical response to concerns and issues; whilst also providing a real opportunity to improve patient experience when accessing health services.

We currently have 5 ambassadors for Hartlepool and 19 for Stockton-on-Tees and we are actively recruiting. The CHA volunteers represent or are involved with a range of organisations/groups detailed below;

Stockton-on-Tees:

- SNAPS
- Thornaby Residents
- One More Life
- Volunteering Matters
- North of Tees Dementia Collaborative
- Middlesbrough & Stockton MIND
- Norton Medical Centre PPG
- Eaglescliffe Medical Centre PPG
- Yarm PPG
- People Plus
- Healthwatch Stockton
- Little Sprouts
- Groundwork
- Trans Aware
- Over 50's Forum
- Christians Against Poverty

Hartlepool:

- Hartlepool Blind Welfare Centre
- Epilepsy Outlook
- Hartlepool Families First

- Home Group
- Hartlepool Deaf Centre

The Ambassadors are a mix of employees and community volunteers who both make the most of their existing relationships via personal and professional networks to provide feedback to the CCG on key priorities as required. The ambassadors are also kept up to date with current projects, campaigns and changes to NHS services so that they can share this information with their communities. The role is very flexible without a strict time commitment expected and therefore the level of input from individual volunteers can vary.

A range of inclusive communication methods are used to ensure ambassadors and the wider publics' diverse requirements are accommodated including:

Internal – Support, feedback and guidance:

- Quarterly peer support meetings
- Monthly coffee mornings
- 1-1 meetings
- Social media groups
- Email/telephone

External – Communication, feedback and promotion:

- Printed and online surveys
- Printed/digital materials including leaflets, business cards, pens, banners, ID Badges etc.
- Website and public Twitter/Facebook pages
- Public events/stalls
- Local printed press
- Radio slots with Stockton Radio and Hartlepool Radio
- Catalyst mailing lists including weekly e-bulletin (1,000 VCSE members)
- CHA Volunteers' networks, friends/family and community groups

A summary of the Community Health Ambassadors activities in 2018 is available under Get Involved page on the CCG website.

Engagement events

The CCG has held a number of engagement events in 2018/19 asking local people to get involved in local CCG decision making. These included the following as an example;

<u>Transforming the Autism pathway in partnership with parents</u>

In 2018 NHS Hartlepool & Stockton-on-Tees Clinical Commissioning Group (CCG) engaged with parents about their experience of the autism pathway, to understand more around the gaps in support.

The Stockton Parent Carer Forum and '1 Hart, 1 Mind, 1 Future' Parent Carer Forum in Hartlepool provided invaluable advice as to the wording of the survey and supported us in the distribution. Across Hartlepool & Stockton we received 140 responses. To enhance the responses we received, we attended Parent Carer Forum meetings to hear people's views and to enable a 2 way conversation to take place as to how things needed to be improved. We

worked with the Parent Carer Forums leads to develop a service specification which was flexible enough to begin to meet the needs identified.

The Parent Carer Forums have agreed to review the service with us to ensure it meets the needs of parents and children in Hartlepool & Stockton.

In addition to this new service, working groups have been established to look at developing a needs led pathway of support which will lead to a more co-ordinated response from health, local authority, education and voluntary and community groups. This group is looking at how existing services can be improved or reshaped to meet the presenting needs of children and their families. There is a parent carer representative on these groups and we are currently developing a plan as to how a wider parent carer voice can be captured. The CCG and Local Authority has agreed to attend parent carer forums to ensure we keep families up to date as things progress and to listen to feedback with regard to what is and isn't working.

My NHS

By signing up to My NHS, a free membership database, local people can influence decisions about their healthcare, receive e-mail updates about local services and receive invitations to events. My NHS for the CCG currently has 743 members. We refreshed our marketing materials so they were GDPR compliant in 2018/19 and are currently recruiting new members.

Governing Body and Annual General Meeting (AGM)

We hold our Governing Body meetings and our AGM in public. In 2018, the AGM was held on Tuesday 3rd July at Billingham Forum and was open to the public. The AGM was an opportunity to celebrate the NHS 70th Birthday which was also Health Information Week. To celebrate we held a health fair attracting over 15 stallholders followed by the Annual General Meeting.

At each Governing Body meeting we hold a 'question time' when members of the public can ask questions and make comments on items on the agenda. In addition, our Governing Body includes a lay member with responsibility for patient and public engagement that ensures that the interests of patients, the public and community are included in the heart of discussions.

Website

Our website www.hartlepoolandstocktonccg.nhs.uk includes up-to-date information on local news and campaigns, key documents and objectives. The website also promotes opportunities for local people to have their say via local events and surveys.

Social Media

The CCG has a Facebook page and Twitter feed to keep our followers up to date with health and CCG information. Follow us on Facebook at www.facebook.com/HASTCCG or on Twitter @HaSTCCG

Patients and Families

Through the Commissioner Assurance Visits programme the CCG also actively engages with patients, families and carers that are currently in receipt of services. This valuable source of information is used to validate the Friends and Family Test information as well as ensuring feedback in relation to information about quality and patient experience.

Healthwatch

Local Healthwatch organisations are well placed to carry out engagement activity because of their links with patients and the public and local networks, including the VCSE sector and local authority health overview and scrutiny committees. These links also enable local Healthwatch organisations to engage with harder to reach groups and those who have difficulties accessing services. Local Healthwatch provide a good source of existing patient and public insight into how services are being used at a local level and this information can help inform commissioning decisions.

Patient Participation Groups

We carried out a mapping exercise of our practice Patient Participation Groups (PPGs) in 2018 with a view to improving communication with practices and patient reps and we now invite PPGs to join our Community Health Ambassador events. We promote membership of PPGs and contact them with regard to patient engagement and consultation.

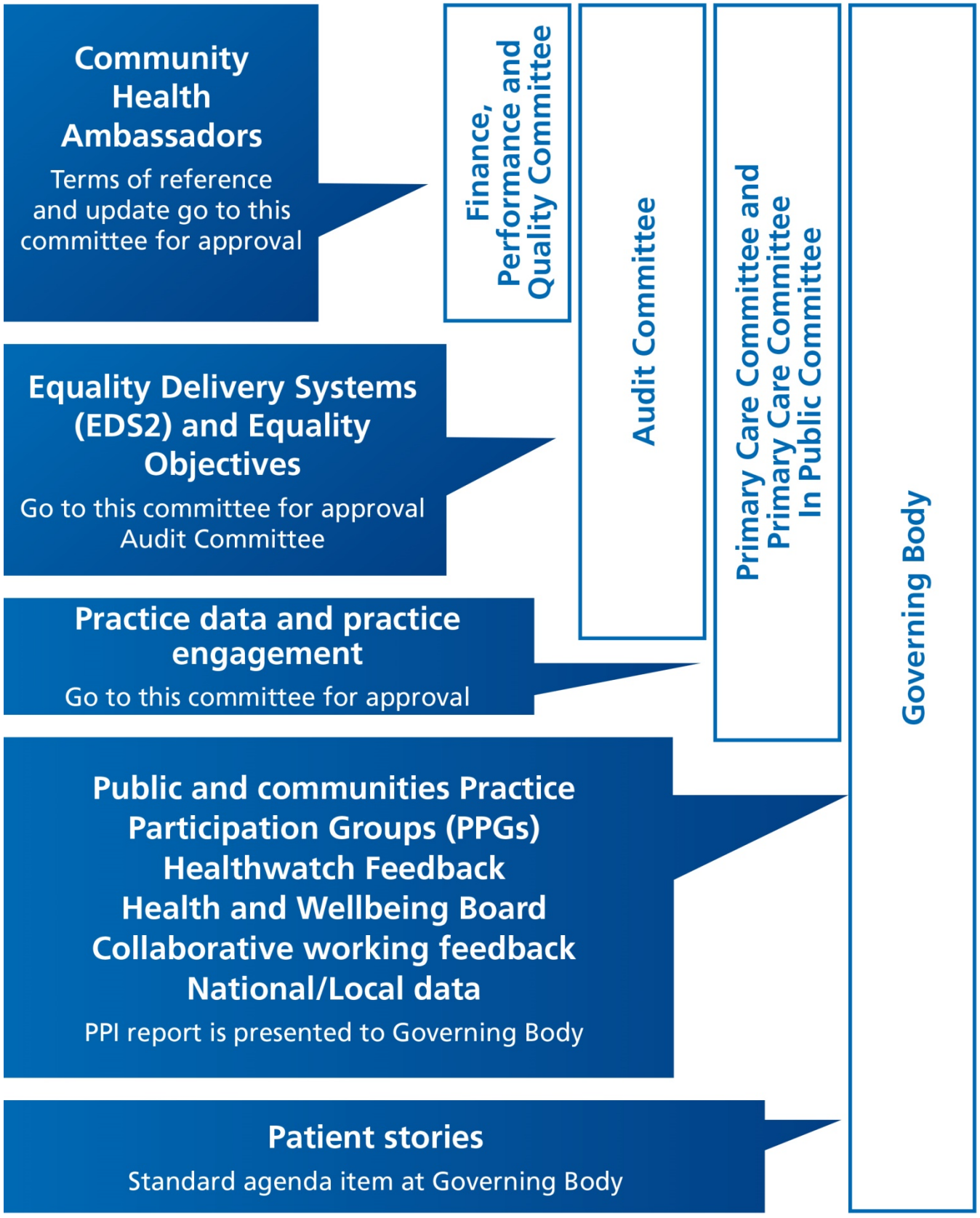
Lay Member for Patient and Public Involvement

The Lay Member brings specific expertise and experience, as well as their knowledge as a member of the local community, to the work of the governing body. Their help to ensure that in all aspects of the CCG's business the public voice of the local population is heard.

Any input from patients in relation to public voice and patient experience captured by the Governing Body Patient and Public Involvement (PPI) Lay Member are documented within the minutes. This includes details of the patient story that is a standard agenda item at the CCG Governing Body meetings.

Our long standing PPI Lay Member Hilary Thompson recently replaced by Steve Rose in 2019 is the Patient and Public Involvement (PPI) Lay Member and member of the Governing Body and they share verbal regular updates on PPI activity at the governing body, captured in the minutes.

Patient involvement governance process



Reducing health inequality

Our commitment to equality and diversity is driven by the principles of the NHS Constitution, the Equality Act 2010 and the Human Rights Act 1998, and also by the duties of the Health and Social Care Act 2012 (section 14T) to reduce health inequalities, promote patient involvement and involve and consult with the public.

We have demonstrated our commitment to taking Equality, Diversity and Human Rights (EDHR) in everything we do, whether that is commissioning services, employing people, developing policies, communicating, consulting or involving people in our work as evidenced below.

Public Sector Equality Duty (PSED)

We understand that we are required under the Public Sector Equality Duty (PSED) which is set out in s149 of the Equality Act 2010, to have due regard to:

- Eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the (Equality) Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not.

We are also required as part of the Specific Duties Regulations 2011 to publish:

Equality objectives, at least every four years.

Information to demonstrate our compliance with the public sector equality duty.

Governance

Equality, Diversity and Health Inequalities is governed and reports into the Audit and Risk committee and the Governing Body. The committee ensures we are compliant with legislative, mandatory and regulatory requirements regarding equality and diversity, develops and delivers national and regional diversity-related initiatives within the CCG, provides a forum for sharing issues and opportunities, functions as a two-way conduit for information dissemination and escalation, monitors progress against the equality strategy and supports us in the achievement of key equality and diversity objectives.

A quarterly Governance Assurance Report is submitted to the board outlining relevant updates in relation to Equality, Diversity and Health Inequalities.

Equality Strategy
Our Equality Strategy was refreshed in 2016 and aims to ensure that the CCG promotes equality of opportunity to all our patients, their families and carers, and our staff, and to proactively address discrimination of any kind.

We are fully committed to meeting the diverse needs of our local population and workforce, ensuring that none are placed at a disadvantage.

The Equality Delivery System 2 - Our Equality Objectives

We have implemented the Equality Delivery System (EDS2) framework and have been using the tool to support the mainstreaming of equalities into all our core business functions to support us in meeting the Public Sector Equality Duty (PSED) and to improve our performance for the community, patients, carers and staff with protected characteristics that are outlined within the Equality Act 2010. Working through the EDS2 framework has provided an opportunity to raise equality in service commissioning and gain insight into the local population's diverse health needs.

The Governing Body and Audit and Risk committee approved plans detailing actions we will take to ensure that individuals, communities and staff are treated equitably.

We have used the NHS Equality Delivery System 2 (EDS2) to develop and prepare our equality objectives, our action plan and objectives are outlined below:

Objective 1 – Continuously improve engagement, and ensure that services are commissioned and designed to meet the needs of patients for all 9 protected characteristics.
Objective 2 – Improve and simplify the Complaints Process for patients and increase awareness of current services available.
Objective 3 – Continuously monitor and review staff satisfaction to ensure they are engaged, supported and have the tools to carry out their roles effectively.
Objective 4 – Ensure that the CCG Governing Body actively leads and promotes Equality and Diversity throughout the organisation.

Our Staff - Encouraging Diversity
We encourage a diverse range of people to apply to and work for us as we recognise the benefits such diversity brings to the quality of our work and the nature of our organisation. We continue to offer guaranteed interviews to applicants with a disability who are identified as meeting the essential criteria for any advertised roles; and reasonable adjustments under the Equality Act 2010 are considered and implemented during the recruitment process and during employment.

By working closely with DWP, we have maintained our 'Level 2 Disability Employer' status for 2018 - 2020 by demonstrating our commitment to employing the right people for our business and continually developing our people.

Workforce Race Equality Standard

In accordance with the Public Sector Equality Duty and the NHS Equality and Diversity Council's agreed measures to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace, the CCG has shown due regard to the Workforce Race Equality Standard (WRES). We have due regard to the standard by seeking assurance of compliance from trusts and aim to improve workplace experiences and representation at all levels for black and minority ethnic staff.

Equality Impact Assessments

Our Equality Impact Assessment (EIA) Toolkit has been implemented into core business processes to provide a comprehensive insight into our local population, patients and staff's diverse health needs.

The tool covers all equality groups offered protection under the Equality Act 2010 (Race, Disability, Gender, Age, Sexual Orientation, Religion/Belief, Marriage and Civil Partnership and Gender Re-assignment) in addition to Human Rights and Carers, as well as including prompts for engagement with protected groups the tool also aids compliance with the Accessible Information Standard.

Our EIA process ensures that we can consider the impact or effect of our policies, procedures and functions on the population we serve. For any negative impacts identified we will take immediate steps to deal with such issues as part of the action plan set out in the tool. This will ensure equity of service delivery is available for all as well as the opportunity to continuously monitor progress against challenges identified to monitor and reduce inequality for our local population.

The EIA is embedded into our governance process and sign off from the Governing Body is required for monitoring and completion.

Accessible Information Standard

The Accessible Information Standard aims to make sure that disabled people have access to information that they can understand, and access to any communication support they might need.

The standard tells organisations how to make information accessible to patients, service users and their carers and parents. This includes making sure that people get information in different formats if they need it, such as large print, braille, easy read, and via email.

The CCG works with the Patient and Public Groups (PPG's), Community Health Ambassadors and CCG staff to ask for feedback on accessible communications and develop appropriate information formats.

Further information can be found at:

https://www.england.nhs.uk/ourwork/accessibleinfo/

Health Inequalities

We have regard to the need to reduce inequalities between patients in accessing health services for our local population.

We understand our local population and local health needs, through the use of joint strategic needs assessments (JSNAs) and we collate additional supporting data including local health profiles as well as qualitative data through our local engagement initiatives which aim to engage hard to reach groups.

We are an organisation made up of 33 GP practices across the area that covers a population of around 300,000.

The Joint Strategic Needs Assessment (JSNA) highlights the main health and wellbeing priorities for the residents of Stockton-on-Tees and Hartlepool taking account of data and information on inequalities within and between communities. A range of plans, strategies, and policies have been developed to help us work effectively in partnership to make a difference to the lives of residents.

The JSNA states the health conditions that most affect people in Hartlepool and Stockton-on-Tees include:

- Cardiovascular disease – including heart disease and strokes
- Cancer
- Smoking-related illness
- Alcohol related illness
- Mental health including dementia

Health Inequalities are spread across the CCG and localities e.g. smoking prevalence varying from 16% to 48%, and emergency admissions for heart disease two and a half times more likely in the most deprived wards than in the least deprived.

The life expectancy of males is 78 years and women 81 years. Life expectancy is 14.9 years lower for men and 13.9 years lower for women in the most deprived areas of Stockton-on-Tees than in the least deprived areas, and 11.7 years lower for men and 10.2 years lower for women in the most deprived areas of Hartlepool than in the least deprived areas.

We work in partnership with local NHS Trusts as well as local voluntary sector organisations and community groups to identify the needs of the diverse local community we serve to improve health and healthcare for the local population.

For our CCG area, only 1.2% of hospitalisation records have an unknown ethnic group compared to the national England average of 6.6%.

We seek the views of patients, carers and the public through individual feedback/input, consultations, working with other organisations and community groups, attendance at community events and engagement activity including patient surveys, focus groups and Healthwatch. We work closely with patients through Patients groups, have developed a Community Health Ambassadors group and have undertaken numerous engagement events as part of the Better Health Programme.

As the local commissioners of health services, we seek to ensure that the services that are purchased on behalf of our local population reflect their needs. We appreciate that to deliver this requires meaningful consultation and involvement of all our stakeholders. We aim to ensure that comments and feedback from our local communities are captured and, where possible, giving local people the opportunity to influence local health services and enable people to have their say using a variety of communication methods enabling them to influence the way NHS health services are commissioned.

Through our Commissioning Support Unit, we have continued to work closely with other local NHS organisations to support the regional working that has been a legacy of the Equality, Diversity and Human Rights Regional Leads Meetings. Nationally we have were awarded E&D Partner status for 2016/17 and have continued to work closely with partners as part of the alumni programme.

Further information can be found at:

Health Profiles 2018:

Public Health England – Local Health: http://www.localhealth.org.uk

Hartlepool JSNA: http://www.teesjsna.org.uk/hartlepool/

Stockton JSNA: http://www.teesjsna.org.uk/stockton/

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Health and wellbeing strategy

The CCG is an active member of the Hartlepool and Stockton-on-Tees Health and Wellbeing Boards and contributes to the delivery of the joint health and wellbeing strategies for both local authorities (Hartlepool Joint Health and Wellbeing Strategy 2018 – 2025), (Stockton-on-Tees Joint Health and Wellbeing Strategy 2019-2023).

The Health and Wellbeing Board is responsible for understanding the health and wellbeing needs of local populations and co-ordinating the NHS, public health and social care services in collaboration with other local agencies. Senior clinical leaders and the Chief Officer sit on the HWBs in each locality with Public Health colleagues and wider partners, including Healthwatch and the minutes of the Board come to the CCG Governing Body. This ensures that there is clinical and strategic awareness of the locality priorities which can be reflected in the health and wellbeing workstream and the CCG plans.

Hartlepool

The Joint Health and Wellbeing Strategy was approved by Full Council and the governing body of the Hartlepool and Stockton-on-Tees Clinical Commissioning Group in March 2018

Hartlepool's Joint Health and Wellbeing Strategy 2018 – 2015, which the Health and Wellbeing Board has signed up to has agreed a vision that Hartlepool will develop a culture and environment that promotes and supports health and wellbeing for all and an ambition is to improve health and wellbeing outcomes and reduce inequalities for our population. Hartlepool has other key ongoing programmes such as 'Hartlepool Matters' and the 'Sustainability and Transformation Partnership (STP)' that are concurrently shaping the future of health and wellbeing in the Borough. The implementation of this revised strategy, together with these ongoing programmes and other projects that are led by the Voluntary and Community Sector (VCS) will contribute to achieve the priorities outlined in the joint strategy.

The HWB considered its achievements from the previous strategy, findings from the JSNA and local intelligence from partners and agreed four main priority areas to focus on during the lifetime of this strategy – Starting, Working, Ageing and Living Well. After our consultation with the general public we have added an additional priority – Dying Well.

The Health and Wellbeing Board operates within a set of principles and values. The Joint Health and Wellbeing Strategy provides the opportunity to maximise partnerships and evidence base, generating new ways of tackling health and wellbeing challenges. This includes recognising and mobilising the talents, skills and assets of local communities to maximise health and wellbeing outcomes.

The Health and Wellbeing Board has collective responsibility for local delivery, and the joint health and wellbeing strategy for Hartlepool and will hold the Integrated Care System (ICS) to account for ensuring delivery in improvement areas whilst enhancing the experience and health outcomes for the people of Hartlepool.

As well as ICS plans, the CCG and local authority are working towards; Improving Mental Health & Emotional Wellbeing, Reducing Drug and Alcohol harm, Reducing Health Inequalities and Dying well.

Further details on the plan can be found here:

https://www.hartlepool.gov.uk/info/20015/social_care_and_health/685/joint_health_and_wellbeing_strategy/1

Hartlepool - Joint Strategic Needs Assessment (JSNA)

The Hartlepool JSNA. Is currently being refreshed. The NHS Act 2007(updated in 2012) required Local Authorities and their partner CCGs to prepare a JSNA. The Hartlepool JSNA has not been formally refreshed since 2015. Work commenced on the refresh in August 2018.

Better Care Fund

The Health and Wellbeing Board is receives regular performance updates regarding the Better Care Fund against the indicators in the Hartlepool Better Care Fund Plan.

The Better Care Fund has been in place since 2015/16 and provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets into a single pooled budget that is focused on integration.

The 2017 policy framework introduced two key changes requiring plans to be developed for the two year period 2017-2019 rather than a single year and reducing the number of national conditions from eight to four.

The four national conditions are:

1. That a BCF Plan, including at least the minimum contribution to the pooled fund specified in the BCF allocations, must be signed off by the H&WB and by the constituent LAs and CCGs;

2. A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation;

3. That a specific proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and

4. Implementation of the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care.

The Hartlepool plan describes how partners continue to build on improvements against these former conditions which relate to seven day services across, improved data sharing between health and social care and a joint approach to assessments and care planning.

In addition, local authorities now benefit from the additional funding for social care announced in the Spring Budget 2017 which must be pooled within the BCF Pooled Budget. This is a Direct Grant to Local Government for the purposes of:

- Meeting adult social care needs;
- Reducing pressures on the NHS, including supporting more people to be

- discharged from hospital when they are ready; and
- Ensuring that the local social care provider market is supported.
-

The 2015 Spending Review set out the Government's intention that, by 2020, health and social care will be more fully integrated across England. BCF plans set out how CCGs and local authorities are working towards fuller integration and better co-ordinated care, both within the BCF and in wider services. Narrative plans set out the joint vision and approach for integration, including how the work in the BCF plan complements the direction set in the Next Steps on the NHS Five Year Forward View, the development of Sustainability and Transformation Partnerships (STPs), the requirements of the Care Act (2014) and wider local government transformation in the area covered by the plan.

The Hartlepool BCF Plan 2017-2019 was approved in October 2017, as reported to the Health & Wellbeing Board in December 2017.

Sustainability and Transformation Partnership / Integrated Care Systems

The CCG updates the Board with regard to Sustainability and Transformation Partnership / Integrated Care Systems and a communications pack providing information on the emerging health picture across the North East and North Cumbria was submitted for Board Members information

The CCG also shares its Annual Report and Financial Plans with the Board.

Children and Young People's Mental Health Provision

This year the CCG has carried out a review of Mental Health and Wellbeing Services for Children and Young People and produced a 'Transforming Children and Young People's Mental Health Provision – Refresh of Local Transformation Plan' which provides an update on the five year Children and Young People's Mental Health and Wellbeing Plan for Hartlepool and Stockton-on-Tees. The original plan was established in line with the national ambition and principles set out in Future in Mind – Promoting, protecting and improving our children and young people's mental health and wellbeing.

This summary document contributes to the strategy and has been developed with and in consultation with a representative on the Health and Wellbeing Board for Hartlepool Borough Council on 15 May 2019.

Stockton-on-Tees

The CCG works as part of the Health and Wellbeing Board (HWB) for each local authority. The HWB is responsible for understanding the health and wellbeing needs of local populations and co-ordinating the NHS, public health and social care in collaboration with other local agencies. Senior clinical leaders and the Chief Officer sit on the HWBs in each locality with Public Health colleagues and wider partnership groups, including Healthwatch. This ensures that there is clinical and strategic awareness of the locality priorities which can be reflected in the health and wellbeing workstream and the CCG plans. Some members of The Health and Wellbeing Board also regularly attend the CCG Governing Body meetings to ensure an awareness of our commissioning priorities and plans including our annual report.

The Stockton-on-Tees Joint Health and Wellbeing Strategy 2019-2023 highlights the long-term priorities of ‘giving children the best start in life’ and ‘preventing and reducing ill- health’.

This sits alongside a programme of work to further develop the Board to work innovatively as a multi-agency team, to address the key health and wellbeing challenges in the Borough where we can have the maximum impact across the population. Both the Board and Strategy work will focus on taking a community assets-based approach, with engagement and co-production with communities and a range of partners at their heart. Communities have a wealth of strengths, networks and resources that we can support and build on. This refocus from more traditional models of service provision is needed to ensure we really understand and address the needs of our local population and tackle health inequalities in a more sustainable way.

The three key priorities of the strategy are:

1) All children and families get the best start in life

2) All people in Stockton-on-Tees live well and live longer

3) All people in Stockton-on-Tees live in healthy places and sustainable communities

The intention is to enable the H&WB to focus on the areas where collective efforts will make the biggest impact on the health and wellbeing outcomes of local residents across the Stockton-on-Tees. The key issues as highlighted in the Joint Strategic Needs Assessment (JSNA) are:

- Not all communities in Stockton are as healthy as we would like them to be with big inequalities in life expectancy and health outcomes between areas of Stockton-on-Tees.

- Residents are living longer but those extra years of life are not always spent in good health. Individuals are more likely to live with multiple long term chronic conditions (many of which are largely preventable) or live into old age with frailty or dementia.

- There are more demands on the money available to the health and social care system so there is a need to plan carefully about how to spend public money to ensure maximum health gain.

This summary document contributes to the strategy and has been developed with and in consultation with a representative on the Health and Wellbeing Board for Stockton-on-Tees Borough Council on 14 May 2019.

The NHS Long Term Plan 2019-29

The CCG presented the NHS Long Term Plan 2019 – 29 to the Board. The plan creates a new service model with greater emphasis on population health management, personalisation and joined up care including the establishment of Integrated Care Systems, strengthened primary and community care, more responsive urgent care services, greater use of digital technologies.

•More NHS action on prevention and health inequality

•A focus on care quality and outcomes

•Comprehensive workforce development plan

•Mainstreaming digitally enabled care

•Increased funding and better VfM

Transforming Children & Young People's Mental Health Provision – Refresh of Local Transformation Plans

The CCG has refreshed the Local Transformation Plan re: Children & Young People's Mental Health Provision, and in particular a stronger focus on system wide change proposals.

In 2014 the government produced 'Future in Mind – Promoting, protecting and improving our children and young people's mental health and wellbeing1. A requirement of Future in Mind was for areas to develop a local transformation plan focused on improving access to help and support when needed and improve how children and young people's mental health services are organised, commissioned and provided. There was a further requirement to update this plan annually.

The transformation plan provides a framework to improve the emotional wellbeing and mental health of all Children and Young people across Hartlepool and Stockton-on-Tees. The aim of the plan is to make it easier for children, young people, parents and carers to access help and support when needed and to improve mental health services for children and young people.

The plan sets out a shared vision, reflects on the work already undertaken, sets high level objectives, and an action plan which takes into consideration specific areas of focus for local authority areas.

The CCG has also presented a paper to the Board re: the NHS Diabetes Prevention Programme which has been launched locally and Members also received presentations relating to the CCG Financial and Operational Plans 2018/19 and Annual Report.

ACCOUNTABILITY REPORT

Dr Neil O’Brien
Accountable Officer
28 May 2019

Corporate Governance Report

Members Report

Member practices

In 2018/19 the CCG was made up of the following 33 member practices:

Practice	Address
Alma Medical Centre	Nolan Place, Stockton-on-Tees, TS18 2BP
Arrival Medical Practice	Endurance House, Clarence Street, Stockton-on-Tees, TS18 2EP
Birchtree Practice	The Health Centre, Lawson Street, Stockton-on-Tees TS18 1HU
Densham Surgery	The Health Centre, Lawson Street, Stockton-on-Tees TS18 1HU
Dovecot Surgery	The Health Centre, Lawson Street, Stockton-on-Tees TS18 1HU
Dr Rasool	Abbey Health Centre, Finchale Avenue, Billingham TS23 2DG
Eaglescliffe Medical Practice	Sunningdale Drive, Eaglescliffe, Stockton-on-Tees TS16 9EA
Elm Tree Surgery	51 Westbury Street, Thornaby, Stockton-on-Tees TS17 6NP
Kingsway Medical Centre	Kingsway, Billingham, TS23 2LS
Marsh House Medical Centre	Abbey Health Centre, Finchale Avenue, Billingham TS23 2DG
Melrose Medical Centre	38 Melrose Avenue, Billingham, Stockton TS23 2JW
Norton Medical Centre	Billingham Road, Norton, TS20 2UZ
Park Lane Surgery	Redmarshall Street, Stillington, Stockton-on-Tees TS21 1JS
Queens Park Medical Centre	Farrer Street, Stockton-on-Tees, TS18 2AW
Queenstree Practice	Billingham Health Centre, Queensway, Billingham TS23 2LA
Riverside Medical Practice	Alma Street, Stockton-on-Tees, TS18 2AP
Roseberry Practice	Abbey Health Centre, Finchale Avenue, Billingham TS23 2DG
Tennant Street	Tennant Street, High Newham Road, Stockton-on-Tees TS18 2AT
Thornaby & Barwick Medical Group	Thornaby Health Centre, Trenchard Avenue, Stockton-on-Tees, TS17 0EE

Practice	Address
Woodbridge Medical Practice	Thornaby Health Centre, Trenchard Avenue, Stockton-on-Tees, TS17 0EE
Woodlands Family Medical Centre	106 Yarm Lane, Stockton, TS18 1YE
Yarm Medical Practice	1 Worsall Road, Yarm, Stockton, TS15 9DD
Hart Medical Practice	1 Surgery Lane, Hartlepool, TS24 9DN
McKenzie Group Practice	17 Kendal Road, Hartlepool, TS25 1QU
The Headland Medical Centre	2 Grove Street, The Headland, Hartlepool, TS24 0NZ
Drs Koh and Trory	The Health Centre, Victoria Road, Hartlepool, TS26 8DF
Gladstone House Surgery	The Health Centre, Victoria Road, Hartlepool, TS26 8DF
Bankhouse Surgery	One Life Centre, Park Road, Hartlepool, TS24 7PW
Chadwick Practice	One Life Centre, Park Road, Hartlepool, TS24 7PW
Havelock Grange Practice	One Life Centre, Park Road, Hartlepool, TS24 7PW
Seaton Surgery	Station Lane, Seaton Carew, Hartlepool, TS25 1AX
West View Millennium Surgery	West View Road, Hartlepool, TS24 9LJ
Wynyard Road Medical Centre	Wynyard Road, Hartlepool, TS25 3DQ

Clinical Council of Members

The Clinical Council of Members is the mechanism through which the individual member practice representatives come together for collective decision-making as a member organisation. This ensures active participation by each member practice in the functions of the CCG in accordance with its constitution, standing orders and scheme of reservation and delegation. Each practice nominates a representative of the practice to participate in meetings.

Composition of Governing Body and Director Profiles

2018/19 has seen some significant changes in the management of the CCG. The five CCGs in Durham and Tees Valley – NHS Darlington CCG, NHS Durham Dales, Easington and Sedgefield CCG, NHS Hartlepool and Stockton-on-Tees CCG, NHS North Durham CCG and NHS South Tees CCG – agreed to move towards more collaborative working in order to:

- Strengthen commissioning capacity and leadership by combining existing CCG skills and resources to enable the delivery of ambitious transformational programmes
- Respond to the Five Year Forward View which describes a number of organisational models where financial and clinical risks are shared across providers
- Meet the agenda for change - NHS England has communicated a clear policy position for all CCGs to consider closer partnership working.

The CCGs agreed that combining existing CCG skills and resources would strengthen commissioning capacity and capability to deliver an ambitious transformational programme and support shared responsibility; support delivery of the STP and emerging Integrated Care Partnership working while also freeing up capacity to focus on the delivery of placed based work in our local communities.

In July the Governing Bodies of the five CCGs approved a recommendation to have a joint leadership and management team with a single Accountable Officer for all five CCGs.

Director Profiles

Dr Boleslaw Posmyk, Chair

Dr Posmyk qualified as a doctor in Leeds in 1981 and became a GP in Hartlepool from 1986 where he still practices while living in Wolviston. He gradually became interested in medical management via the Diabetes Local Implementation Team, and then joined the Hartlepool PCT Professional Executive Committee. He then became a representative on the Hartlepool PBC Group prior to becoming Chair. Dr Posmyk was elected to be the Locality GP Representative and Chair of the then Hartlepool Shadow Pathfinder Committee and has now been elected to his third term as the Chair of the Governing Body for the CCG.

Dr Neil O'Brien, Chief Clinical Officer (from 1 October 2018)

Dr O'Brien has been a local GP in Chester-le-Street for over 20 years. He has developed a special interest in cardiology and has previously worked as a GP with special interest in this area. Neil is the SRO lead for the regional demand management work stream and Breast Cancer. Neil is a practicing clinician which strengthens his influence with local practices and other clinicians. Neil is also the Chief Clinical Officer for 4 other CCG's that work collaboratively as part of a shared management arrangement in County Durham and the

Tees Valley. Neil is a member of the ICS management group representing the needs of local populations as Cumbria and the North East progress to become a shadow ICS.

Mrs Nicola Bailey, Chief Officer (from 1 October 2018)

Nicola was the acting Chief Executive for Hartlepool Borough Council and has previously held posts such as Director of Child and Adult Services. Nicola began her early career by training and working as a nurse in the NHS before moving to working in integrated services between the NHS and the Local Government in Cheshire. With over 20 years of working in a managerial and leadership capacity within health and Local Government she has had extensive experience of managing and leading organisations through change, developing integrated services and solutions and working at a senior board level. Nicola was the shared Chief Operating Officer between North Durham CCG and DDES CCG prior to the development of the shared management arrangement for the 5 CCGs in the southern collaborative. She is the Cumbria and North East SRO for LDTC programme and chair of the southern collaborative MH/LD NHS Partnership with TEWV NHS FT.

Mr John Flook, Lay Member (Audit and Governance)

As lay member for Governance and Audit, John will draw on his wealth of NHS and financial expertise. A qualified accountant, he has worked in the Health Service for forty nine years including twenty as Director of Finance in the North East. He has advised Ministers and served on several national bodies including the NHS Counter Fraud Authority, the General Pharmaceutical Council and Sport England Audit Committee. He is also currently the Senior Non-Executive Board member on NHS Professionals.

Mr Andie Mackay, Lay Member for Finance

Andie served as a firefighter for over 28 years, gaining strategic management experience with the County Durham and Darlington Fire and Rescue Service. Andie graduated from Teesside University in 2010 with a Master's in Business and Administration (MBA) with a particular focus on Transformational Leadership. Andie joined Stockton BC as a senior manager leading Construction and Facility Services as part of the Community Services directorate of the council.

Mr Graeme Niven, Chief Finance Officer

Mr Niven is an experienced NHS Executive Director and has worked in Teesside since 2003. He qualified as a Chartered Institute of Management Accountant in 1994. He was

appointed as Chief Finance Officer for Darlington CCG in January 2017 as part of the joint management arrangements with Hartlepool and Stockton-on-Tees CCG where he has been Chief Finance Officer since the CCG's inception. He has worked in the NHS for over 30 years in varying roles including in a community and mental health provider, regional role and commissioning roles.

Ms Jean Golightly, Director of Quality and Nursing

As a Registered Nurse, Ms Golightly has previous experience of working in areas from across the healthcare landscape, including time spent overseas. Following this, she returned to the NHS to work in a number of large hospital Trusts, holding posts in Clinical Governance and management of a variety of clinical services, prior to joining the CCG. Ms Golightly's role is a joint appointment with South Tees CCG. As the CCGs' Director of Nursing and Quality, in addition to Child and Adult Safeguarding, her portfolio includes monitoring the quality and safety of patient care, as well the experiences that patients have when receiving care from our commissioned services.

Dr Saleem Hassan, Stockton-on-Tees locality lead and GP member

Dr Hassan qualified as a doctor in Aberdeen in 2000 and completed the Northumbria GP vocational training scheme in 2005. He has been working as a GP in a large Stockton surgery since then. He also performs minor surgery within his practice. He joined the CCG in June 2016. He also has extensive experience of working in local urgent care services for many years.

Dr Nick Timlin, Hartlepool locality lead and GP member

Dr Timlin qualified as a doctor in Manchester in 1984 and completed the Cleveland vocational training scheme, starting work as a GP principal in 1990. Dr Timlin was born in Hartlepool and has worked as a GP in Hartlepool since 1990. Dr Timlin is also a fully qualified forensic medical examiner and occupational physician and has worked for Cleveland police and local firms. He is also a GP trainer, working at Durham and Tees Valley Vocational Training Scheme and has worked alongside the CCG since it was formed in 2013.

Dr Adam Din, Governing Body GP

Dr Din completed his medical degree and graduated with a BMBS (Bachelor of Medicine & Bachelor of Surgery) from the University of Exeter in 2011. Dr Din initially had some

experience working within Orthopaedic Surgery in Yorkshire before starting his GP training within the North East. Dr Din joined as partner of Havelock practice in 2017 and continued to work as a GP Partner with an interest in Minor Surgery, also working with the local Urgent Care Centre in the Out of Hours Service.

Dr Judith Donkin, Governing Body GP

Dr Judith Donkin has joined NHS Hartlepool and Stockton on Tees Clinical Commissioning Group as a Governing Body member. Dr Donkin started her health care career as a registered general nurse, qualifying and working at Hartlepool then North Tees Hospital. She made the decision to retrain as a doctor and graduated from Leicester in 1999 and completed the Tees GP vocational training scheme in 2005. Since that time she has worked as a GP in Billingham. Alongside her GP role she developed her interests in medical education and completed a Masters in Medical Education. She has the pleasure of teaching medical students for Durham and Newcastle University.

Mr Steve Rose, Lay Member Patient and Public Involvement

Steve Rose is Chief Executive of Catalyst Stockton-on-Tees, the voice, representation and support for Stockton-on-Tees' VCSE community. Steve came to Catalyst following a career which included working in theatre, youth work, and regeneration. Steve was appointed as Chief Executive of Catalyst Stockton-on-Tees in 2013. Since then Steve has overseen the expansion of Catalyst's projects and staff, and encouraged the growth of Catalyst's Health and Wellbeing Programme; eventually leading to Catalyst winning a national award for Catalyst's collaborative work with the Hartlepool and Stockton CCG. Steve is still actively involved in volunteering in the region.

Dr Charles Stanley, Secondary Care Consultant

Dr Stanley is a consultant child and adolescent psychiatrist and currently undertakes this role in Leeds. He is an honorary senior lecturer in child and adolescent psychiatry at the University of Leeds. He is also an associate medical director at Leeds Community Healthcare NHS Trust. Prior to training in psychiatry, he worked as a hospital-based paediatrician. Charles is the Secondary Care Consultant on the Governing Body.

Other key Director roles:

Mrs Karen Hawkins, Director of Commissioning and Transformation

Karen has spent her entire career in public service, she took up the joint post of Director of Commissioning and Transformation across Hartlepool and Stockton-on-Tees and Darlington CCGs in December 2016. Before this she was Associate Director for Commissioning and Delivery for Hartlepool and Stockton-on-Tees CCG. Karen has a strong commissioning and contracting background and has held a variety of senior positions in the NHS, across both primary and acute care.

Ms Lisa Tempest, Director of Planning and Assurance

Lisa joined Darlington CCG from South Tees Hospitals NHS Foundation Trust, where she was Chief Operating Officer for the Community Services Division. Prior to joining the NHS in 2008, Lisa worked for BASF plc, National Power plc and Nike Inc.

Audit and Risk Committee

Audit and Risk Committee

The Audit and Risk Committee has operated throughout the year, chaired by Mr John Flook, Lay Member for Audit and Governance. The Committee meets together with the equivalent Committee in Darlington CCG as 'Committees in Common' to enable common issues to be discussed together and facilitate joint working across both CCGs.

Members of the Audit and Risk Committee are:

Mr John Flook	Lay Member (Audit and Governance)
Mrs Hilary Thompson	Lay Member (patient and public involvement) until November 2018
Mr Steve Rose	Lay Member (Patient and Public involvement) from February 2019
Mr Andie Mackay	Lay Member

Dr Adam Din	Governing Body GP

Other Committee structures are referenced fully in the Governance Statement and the Remuneration and Staff Report details members of the Remuneration Committee.

Register of Interests

All members of the Governing Body and its Committees are required to declare any interests they have in accordance with the CCG's Standards of Business Conduct and Declarations of Interest Policy. They are required to review and update their declarations of interest on an annual basis and also highlight any new interests within 28 days of them becoming apparent. The Registers of Declarations of Interest and Gifts & Hospitality are maintained throughout the year and will be kept for 6 years. The registers are made available to the public on request or via the CCG's website at: https://www.hartlepoolandstocktonccg.nhs.uk/media_category/declarations-of-conflict-of-interest/

Where interests are identified within meetings, these are declared by the individual and appropriate action is agreed, including whether the individual needs to withdraw from discussions.

To further support CCGs to manage conflicts of interest, NHSE have launched new online training. The training package has been developed in collaboration with NHS Clinical Commissioners and aims to raise awareness of the risks of conflicts of interest and how to identify and manage them. The training has been rolled out to all relevant staff and 100% compliance was achieved ahead of the deadline on 31st January 2019.

Personal data related incidents

There have been no personal data related incidents or data security breaches during 2018/19 that required disclosure to the Information Commissioner.

Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

Hartlepool and Stockton-on-Tees CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2019 and is published on our website at https://www.hartlepoolandstocktonccg.nhs.uk/wp-content/uploads/2019/04/Modern-Slavery-Statement.pdf

Emergency preparedness, resilience and response

We have undertaken a self-assessment against the NHS England core standards for Emergency Preparedness, Resilience and Response. In this self-assessment we demonstrated substantial assurance against the new core standards. There was only one area that the CCG does not comply and prevents the attainment of full compliance; this is the auditing of the Business Continuity Plan. This has been discussed with the Chief Finance Officer and as the CCG has been successful in its implementation of the Business Continuity Plan on a number of occasions, this is not considered a priority area for the limited number of audit days available to the CCG.

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Dr Neil O'Brien to be the Accountable Officer of NHS Hartlepool and Stockton-on-Tees CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,

- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),

- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).

- The relevant responsibilities of accounting officers under Managing Public Money,

- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)),

- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that Ernst Young auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.

Dr Neil O'Brien
Accountable Officer
28 May 2019

Governance Statement

Introduction and context

NHS Hartlepool and Stockton-on-Tees CCG is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The clinical commissioning group's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2018, the clinical commissioning group was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

The CCG has a Constitution based on the Department of Health's original Model

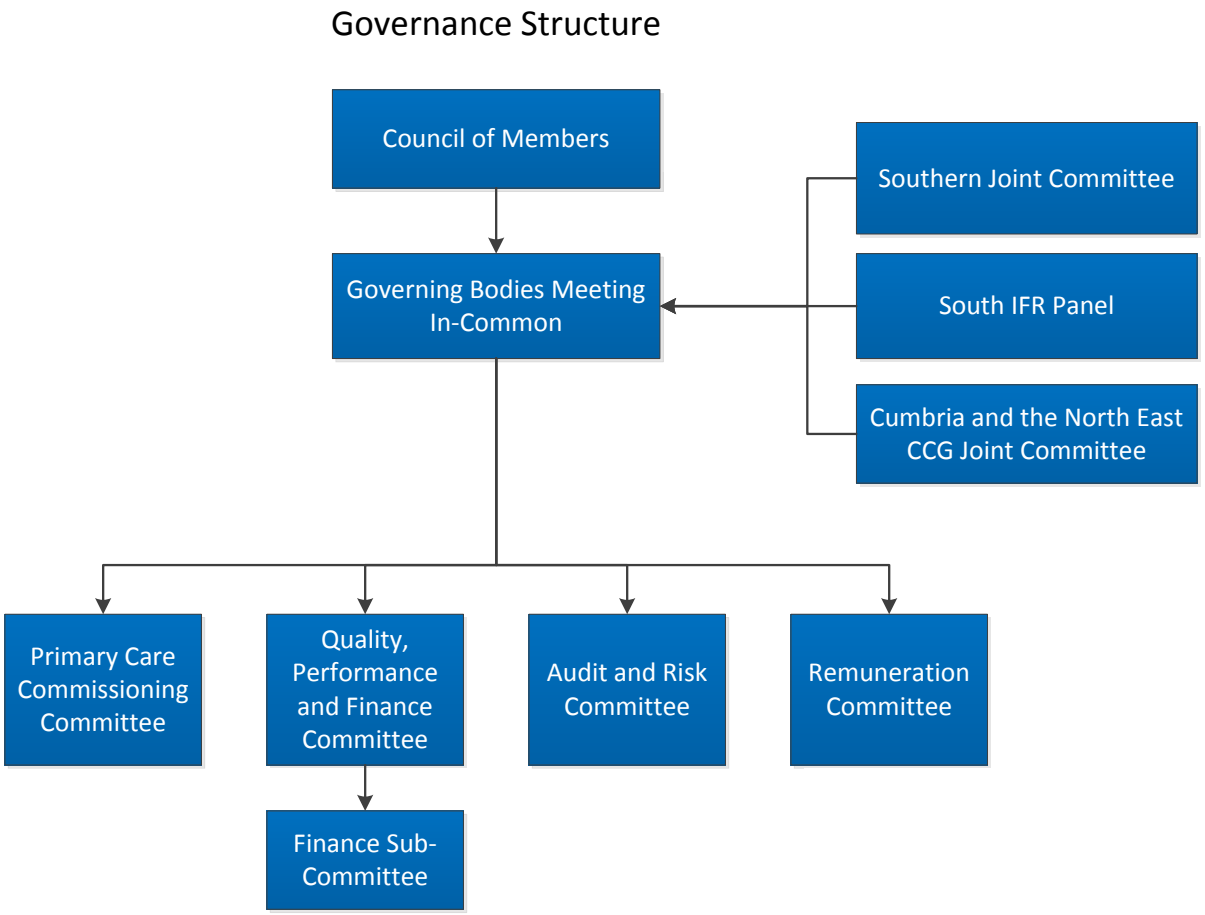
Template. The Constitution was reviewed against the Department of Health's revised Model Template during 2018/19 in order to ensure it remained legally compliant and took into account any guidance provided and legal requirements put in place since its adoption. This review also reflected changes in the CCG's management structure and closer collaborative working; NHS England approval of the revised Constitution is awaited.

The review of the Constitution confirmed that it complies with the elements of the self-certification checklist, including:

- specifying the arrangements made by the CCG for the discharge of its functions;
- specifying the arrangements made by the CCG for the discharge of the functions of the Governing Body;
- the procedures to be followed by the CCG in making decisions;
- the arrangements it has made to secure that individuals to whom health services are being, or may be, provided pursuant to its commissioning arrangements are involved;
- arrangements made by the CCG for discharging its duties in respect of registers of interest and management of conflicts of interest;
- arrangements made by the CCG for ensuring that there is transparency about the decisions of the group and the manner in which they are made.

Throughout 2018/19 the CCG has continued to operate with a governance structure that reflects guidance and best practice. Where appropriate, the CCG continues to hold meetings in-common with NHS Darlington CCG; these include: Governing Body, Audit and Risk Committee; Primary Care Commissioning Committee, Remuneration Committee and the Quality, Performance and Finance Committee.

The Committee structure in place throughout 2018/19 is shown below.



Council of Members

The Council of Members comprises a representative of each member practice and ensures that the Group's activities retain a clear clinical focus with member engagement.

The main areas covered by the Council of Members during this year include:

- 2017-18 Annual Report and Accounts
- Discussions on collaborative working arrangements
- 360 Survey – Clinical Leadership Development
- Primary Care Developments
- Approval of the revised CCG Constitution
- Updates on the NHS Long Term Plan.

The Council of Members delegate approval of a range of functions to the Governing Body. Membership of the Council of Members consists of the healthcare professional nominated by each member practice to act on its behalf in dealings with the CCG and to represent that member practice at meetings of the Council of Members.

A description of the Governing Body and its Committees is provided below, together with a record of attendance.

Figure 2: Governing Body and Committee Membership attendance record

Name	Title	Audit and Risk Committee (5)	Quality, Performance and Finance Committee (12)	Governing Body (7)	Remuneration Committee (5)	Primary Care Commissioning Committee (10)
Ali Wilson	Chief Officer (until retired in September 2018)		5/6	3/4		1/6
Dr Neil O'Brien	Chief Clinical Officer (from October 2018)		4/6	3/3		1/4
Nicola Bailey	Chief Officer (from October 2018)		3/6	2/3		2/4
Dr Boleslaw Posmyk	Chair of the Governing Body			7/7	4/5	
Andie Mackay	Lay member	3/5	12/12	7/7		10/10

Dr Charles Stanley	Secondary Care Doctor			7/7	1/5	
Jean Golightly	Director of Nursing and Quality		10/12	5/7		7/10
Graeme Niven	Chief Finance Officer		10/12	7/7		8/10
Dr Adam Din	Governing Body GP	1/3		4/7		
Dr Judith Donkin	Governing Body GP			5/7		
John Flook	Lay Member-Audit and Governance	5/5		5/7	2/5	
Hilary Thompson	Lay Member PPI (until retired in November 2018)	3/3		5/5	2/3	7/8
Steve Rose	Lay Member PPI (from February 2019)	1/1		1/1	1/1	
Dr Saleem Hassan	GP Locality Lead (Stockton)		8/12	6/7		
Dr Nick Timlin	GP Locality Lead (Hartlepool)		8/12	5/7		

Governing Body

During the year 2018/19, the CCG's Governing Body met on 6 occasions in public. A number of 'In Committee meetings' were also held to discuss work in progress and items of a confidential nature prior to public disclosure. An annual cycle of business was in place, which enables it to discharge the duties conferred upon it. Where appropriate, matters are delegated to a Committee or individual and this is outlined within the CCG's Scheme of Reservation and Delegation. Agendas are structured to deal with strategic, performance, quality assurance, risk and governance issues. The arrangements meet the requirements of best practice guidance in respect of risk management and ensure that a strong accountability framework has been established. They reflect the public service values of accountability, probity and openness and specify as Accountable Officer my responsibility for ensuring that these values are met within the CCG.

Key areas of discussion throughout the year have included:

- approval of CCG financial and operational plans;
- review and approval of decisions relating to commissioned services;
- review and approval of corporate governance arrangements including: changes to the Constitution and Scheme of Reservation and Delegation, terms of reference and arrangements for risk;
- review of Assurance Framework
- review of emergency preparedness, resilience and response arrangements;
- quality and safeguarding (including complaints);
- patient stories;
- Director of Public Health Reports;
- 360 Stakeholder Survey
- approval of recommendations made by the Remuneration Committee;

- review of progress against plans, financial targets, performance, measures and clinical quality standards, and

- review and approval of decisions relating to commissioned services.

The Governing Body also receives confirmed minutes from each of its Committees to enable it to consider the work and effectiveness of the respective Committee and to receive assurance relating to delivery of their terms of reference.

Throughout the year the Governing Body undertook a process of 'critique' to review the effectiveness of the meetings. This process ensures continuous learning and development to improve effectiveness.

The Governing Body is committed to ensuring that sufficient time is devoted to allowing members to discuss key strategic issues as well as being able to reflect on its own performance and ensure that arrangements are in place to allow for further development and improvement. As part of this, we have held 7 Governing Body Development Sessions.

Established Committees

The Governing Body Committees have authority under the Scheme of Delegation to establish sub-committees or sub-groups to enable them to fulfil their role. Each of the Governing Body Committees has detailed terms of reference. Each Committee is authorised by the Governing Body to pursue any activity within their terms of reference and within the scheme of reservation and delegation.

Remuneration Committee

The Remuneration Committee is a statutory Committee established to advise/recommend to the Governing Body the appropriate remuneration and terms of service for the Chief Clinical Officer/Chief Officer and other staff paid through the Very Senior Manager Pay Framework. The Committee also advises/recommends to the Governing Body remuneration for the role of Chair, remuneration and terms of service of Governing Body clinical representatives and reviews any business cases for early retirement and redundancy. Full details of the membership and attendance of the Committee is included at *Figure 2: Governing Body and Committee Meetings Attendance Record*. The Committee's terms of reference are referenced within the CCG's Constitution and are available on the CCG's website.

Key areas that the Committee have focussed on during the year include:

- Remuneration for Senior Management Roles
- Accountable Officer Remuneration
- Chair Remuneration
- Annual Performance Report from Human Resources & Organisational Development
- Pay Awards for those on Non Agenda for Change (AfC) and Very Senior Manager (VSM) contracts.

Audit and Risk Committee

Full details of the membership and attendance of the Committee is included at *Figure 1: Governing Body and Committee Meetings Attendance Record*.

The Audit and Risk Committee supports the Governing Body in its function of ensuring the CCG has made appropriate arrangements to ensure functions are exercised effectively, efficiently and economically and that all relevant principles of good governance are adhered to.

In line with the requirements of the NHS Audit Committee Handbook and NHS Codes of Conduct and Accountability, the Committee provides the organisation with an independent and objective review of systems of internal control, risk and governance processes and arrangements and compliance with laws, guidance and regulations governing the NHS.

The Committee Chair is a lay member of the Governing Body and has no executive powers, other than those specifically delegated in its terms of reference. The Committee's terms of reference are referenced within the CCG's Constitution and are available on the CCG's website. Annually, the Committee also carries out a self-assessment of its effectiveness, which is undertaken with support from Internal Audit and the Committee considered itself to be operating effectively.

The Committee's terms of reference are reviewed annually and the cycle of business includes review of the CCG Governing Body Assurance Framework and corporate risk register as well as considering the work of both internal audit (including counter fraud) and external audit.

Membership is outlined in the members report section of the annual report.

Significantly during the year through its cycle of business, the Audit and Risk Committee have received the following assurances:

- Internal Audit Progress Reports
- External Audit Progress Reports
- Chief Finance Officer Reports
- Head of Internal Audit Opinion
- Approval of Audit and Counter Fraud Plans
- Review of Corporate Risk Register and Assurance Framework
- Annual Report and Accounts
- Consideration of assurances provided relating to the CCG's governance responsibilities (including: equality & diversity, health & safety, business continuity, corporate governance, information governance (including cyber security), mandatory training and research & development).

Quality, Performance and Finance Committee

This Committee provides assurance to the Governing Body of effective management in relation to finance, contracts, performance and quality, including the delivery of Quality, Innovation, Productivity and Performance (QIPP). The Committee's cycle of business includes overseeing that commissioned services are being delivered in a high quality and safe manner and performance is managed according to the agreed terms of the Service Level Agreements and formal Contracts and that appropriate corrective action is being taken to address areas of underperformance, including changes to future contracts where necessary.

Full details of the membership and attendance of the Committee is included at *Figure 1: Governing Body and Committee Meetings Attendance Record* and the Members Report. The Committee's terms of reference are referenced within the CCG's Constitution and are available on the CCG's website.

One of the Quality, Performance and Finance Committee's key responsibilities is to seek assurance that the CCG is commissioning safe care for patients and this is undertaken by monitoring provider performance and adherence to quality standards.

Significantly during the year through its cycle of business, the Quality Performance and Finance Committee has considered the following issues:

- Overall financial position of the CCG
- Quality monitoring reports on provider commissioned services, including the reporting of serious untoward incidents
- Provider reports in relation to complaints, claims and untoward incidents
- Provider healthcare acquired infections
- Achievement of QIPP
- Performance monitoring of provider contracts
- Monitoring delivery of the 2018/19 financial plan
- Operational and financial plans.

The Committee has reviewed their terms of reference annually and its effectiveness on an ongoing basis and has produced an annual report of its work.

Primary Care Commissioning Committee

The Committee has a primary purpose of commissioning primary medical services for the people of Hartlepool and Stockton-on-Tees. Six of these meetings were held in public. Healthwatch, the Local Authority and the Local Medical Committee were invited to attend all meetings.

The role of the Committee is to carry out the functions relating to the commissioning of primary medical services under Section 13Z of the NHS Act, except those relating to individual GP performance management, which have been reserved to NHS England. During 2018/19, this included the following activities:

- Approving practice mergers, boundary changes and list closures
- Considered pharmacy applications
- Receive updates on International Recruitment

- Review the GP Retention Scheme Summaries
- Receive Primary Care Finance updates
- Review the Primary Care Assurance Framework
- Making decisions on discretionary payment (e.g. returner/retainer schemes).

In performing its role the Committee exercised its management of the delegated functions in accordance with the Agreement entered into between NHS England and the CCG, which sits alongside the delegation and terms of reference. The terms of reference have been reviewed during the year.

The Southern Individual Funding Request Panel

The Funding Panel, which is a collaboration between CCGs and is accountable to the CCG's Governing Body, considers all Individual Funding Requests and decides whether or not to support individual requests on the basis of the information provided with the request to the Committee. Requests are assessed for access to treatment within the commissioning authority of the CCG.

Joint Committees

Southern Collaborative Joint Committee

The Joint Collaborative of the Southern Clinical Commissioning Groups is a joint Committee of: NHS Darlington CCG, NHS Durham Dales, Easington and Sedgefield CCG, NHS North Durham CCG, NHS Hambleton, Richmondshire and Whitby CCG, NHS Hartlepool and Stockton-on-Tees CCG and NHS South Tees CCG.

During the year 2018/19, the Joint Committee met on one occasion to consider its Terms of Reference, business cycle, integrated care systems and partnerships and the workings of the southern collaborative of CCGs.

Cumbria and the North East CCG Joint Committee

The CCG is a member of the Cumbria and the North East CCG Joint Committee. Membership includes:

- NHS Darlington CCG

- NHS Durham Dales, Easington & Sedgefield CCG
- NHS Hambleton, Richmondshire & Whitby CCG
- NHS Hartlepool and Stockton-on-Tees CCG
- NHS Newcastle Gateshead CCG
- NHS North Cumbria CCG
- NHS North Durham CCG
- NHS Northumberland CCG
- NHS North Tyneside CCG
- NHS South Tees CCG
- NHS South Tyneside CCG
- NHS Sunderland CCG

The role of this Committee is to make decisions on subjects recommended to it by the Northern CCG Forum which will develop an annual work plan for the Joint Committee to be approved by each of the CCGs as part of the annual review of the Terms of Reference. These will be confined to issues that pertain to all CCG areas in Cumbria and the North East.

Other Committees of which the CCG is a partner

The CCG is a member of the Hartlepool Borough Council Health and Wellbeing Board and Stockton-on-Tees Borough Council Health and Wellbeing Board and membership is in accordance with the Council's governance arrangements.

The CCG is also a statutory member on the Hartlepool Local Safeguarding Children Board and Stockton-on-Tees Local Safeguarding Children Board. These bodies are led by our local authority partners.

UK Corporate Governance Code

Although NHS Bodies are not required to comply with the UK Code of Corporate Governance, the CCG takes a robust approach to its application of good governance principles and continuous improvement. Throughout 2018/19, this has included carrying out post-meeting critiques of the Governing Body to ensure that immediate improvements can be made where feasible; dedicated development sessions held with the Governing Body as

well as staff development days that have also incorporated elements of governance to ensure an embedded approach.

The guidance contained within the Code enables assessment of Governing Body effectiveness against the criteria of: leadership, effectiveness, accountability, remuneration and relations with stakeholders. There are numerous arrangements in place within the CCG's assurance processes that capture performance and progress against these, for example the 360 degree Stakeholder Survey and the Improvement Assessment Framework carried out by NHS England.

Discharge of Statutory Functions

During establishment of the CCG, the arrangements put in place to govern the organisation were developed with extensive expert, external legal input to ensure compliance with all relevant legislation. That legal advice also informed the matters reserved for the Clinical Council of Members and Governing Body decisions and scheme of delegation. All subsequent changes to the Constitution or Scheme of Delegation have been confirmed as appropriate by NHS England (most recent proposed changes are awaiting final NHSE approval).

In light of recommendations of the 2013 Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. The clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director.

Risk management arrangements and effectiveness

As the CCG responds to new challenges and the continually changing demands of the local health economy, so does the CCG's system of risk management and internal control. The risk management framework provides a number of ways in which the CCG identify and mitigate risks. The CCG has an established corporate policy set which informs our knowledge, and guides our actions and behaviours. These policies ensure the CCG conducts their business appropriately, comply with legal requirements and protect their patients and staff from avoidable harm.

The CCG's risk management policy continues to be compliant with good practice and legislation and sets out our organisation wide approach to managing risk at all levels within the CCG. The CCG's aims are to:

- Ensure that risks to the achievement of CCG's objectives are understood and effectively managed
- Maintain a risk management framework to assure the Governing Body that strategic and operational risks are being effectively managed
- Ensure that risk management is a cohesive element of the internal control systems within the CCG's corporate governance framework
- Ensure that risk management is an integral part of the CCG culture and its operating systems
- Ensure that the CCG meets its statutory obligations including those relating to health and safety and data protection
- Assure all stakeholders, staff and partner organisations that the CCG is committed to managing risk appropriately.

Capacity to handle risk

Strong leadership and an effective governance structure are vital elements of the CCG's capacity to handling risk. The governance arrangements as outlined above meet the requirements of best practice guidance in respect of risk management and ensure that a strong accountability framework has been established and is maintained.

The CCG has clear lines of accountability with defined responsibilities and objectives relating to all aspects of risk reporting and management. The Governing Body has overall responsibility for governance, assurance and management of risk and has a duty to assure itself that the organisation has properly identified the risks it faces and that it has the processes and controls in place to mitigate those risks and the impact they have on the organisation and its stakeholders.

The Chief Clinical Officer has overall responsibility for ensuring the implementation of an effective Risk Management Policy, systems and controls, however, this is delegated to the Director of Planning, Performance and Assurance as the nominated lead for co-ordination of

governance and risk management throughout the CCG and has overall responsibility for ensuring the implementation of the risk management policy and framework.

The CCG's directors are familiar with the main risks in their area of activity and lead in the management of these risks where required, and ensure the processes for managing risk within their services teams are appropriately delegated and clearly understood by managers.

The CCG's risk appetite has been agreed by the Governing Body. As with all organisations, there is a level of risk inherent within healthcare commissioning. Risks that are regarded as normal business are managed at an operational level and are not escalated onto the Corporate Risk Register unless it is considered that the risk could adversely impact upon the CCG's ability to deliver its strategic aims and statutory duties. If the CCG's assessment of a risk indicates that it is becoming more likely to have a significant impact, then it is also included on the CCG's Assurance Framework that is considered by the Governing Body.

In addition, the CCG contracts with the Commissioning Support Unit for provision of expert risk management advice and training as well as facilitating the sharing of good practice.

Risk Assessment and review

Risk is identified in accordance with the CCG's Risk Management Policy and risk management is embedded in the organisation via a number of mechanisms. Risk identification is undertaken in a number of ways, through horizon scanning by the Executive team, through identification by sub-committees of the Governing Body, through identification and escalation by individual Executive Directors and also by the Governing Body. The assessment is carried out using the CCG's risk assessment guidance that is based on current national guidance.

There is an established process in place within the CCG that includes the review of the risk register and the assessment of the effectiveness of the identified controls.

Corporate risks are reviewed at four levels within the CCG. The first level is during the day-to-day operations of the CCG, where staff work within the policies of the CCG. Risks are

identified within departments and the CCG management team. The CCG Corporate Governance & Risk Officer liaises with all risk owners to discuss and assess risks at this level.

The second level is a full review of the risk register with the CCG's Executive Committee. This review allows GPs, senior CCG officers and members of the CSU the opportunity to consider the range and severity of the risks the CCG is assessing. This is an important step in the consideration of risks as it gives the opportunity for a broader discussion on the risks, controls and actions as well as a form of peer review to highlight related risks or impact on other areas.

The third level is the corporate oversight provided by the Audit and Risk Committee. This Committee reviews the CCG's risk register and Assurance Framework at each meeting, validating the scoring identified and seeking further assurances if required.

The fourth level of review is at the Governing Body where the Governing Body Assurance Framework is considered at most meetings. Risks with a residual score of 15 are automatically included in the Assurance Framework.

Furthermore, the incident reporting system identifies the risks that have already (or nearly) occurred from incidents or near misses. The CCG's strategic planning system ensures that all organisational objectives are rated for risks to achievement of delivery; and our performance management system rates all objectives for risk to delivery. In addition, all Governing Body reports are assessed for equality impact and all reports are assessed to provide evidence of assurance for the Assurance Framework and/or mitigate risk included on the CCG's Risk Register.

As at the end of the year, the CCG was actively managing 18 corporate risks. All of these risks have key controls identified against them and also the delivery of both external and internal assurance regarding these risks. They also include mitigating actions where appropriate and are subject to an action plan.

None of the risks have been assessed as impacting upon the CCG's licence or governance, risk management and internal control processes.

Principal risks

The table below gives an overview of the risk that the Governing Body consider to be the most significant (as of 31/03/2019) and gives some examples of the actions that have been taken to mitigate against them.

Principal Risks from the CCG Assurance Framework	Key actions and controls
If the CCG is unable to deliver its QIPP agenda, there is a risk of non-delivery of the financial position including the 1% surplus business rules.	• Financial plan for 2018/19 in place • Financial Recovery Plan and monitoring regime in place • Bi-monthly monitoring of the financial position at Governing Body • Monthly monitoring of the financial position at the QPF Committee and Finance sub-committee • NECS provision of financial management to the CCG and Business Intelligence Services • Ongoing monitoring of QIPP position and overall financial position on a monthly basis • Monitored at monthly PMO meeting • Contingency reserve in place • QIPP pipeline schemes in place • Monthly financial monitoring with NHSE • Revised Financial Governance Arrangements in place to ensure a higher level of accountability is in place for delivery of QIPP and monthly reporting of QIPP performance. • GP Variation process

In line with the Department of Health & Social Care's operational guidance on EU Exit, the five CCG collaborative have worked closely and in conjunction with Local Authority colleagues and providers (including GP Practices) in order to understand any risks that could impact on the provision of services to our population. The main area of consideration was protecting the supply of medicines and to help with this, we provided briefings to Practices as well as information leaflets for our patients. We have put in place mitigation for all identified risks but continue to evaluate risks and issues as the political situation develops.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control has been in place in the CCG for the year ended 31 March 2019 and up to the date of the approval of the Annual Report and Accounts.

Internal control is driven by our policies and procedures and embedded in our programme of mandatory staff training.

A significant feature of our organisational structure continues to be the large proportion of the administrative function of the CCG that is provided via a contract with a commissioning support unit (North of England Commissioning Support). Our policies and procedures are designed to reflect this organisational arrangement, as well as the service monitoring with the North of England Commissioning Support Unit. The commissioning support unit works with NHS Shared Business Services who provide the transaction processing services and financial ledger facilities for NHS England and all CCGs.

The CCG works closely with the commissioning support unit to ensure tight budgetary control, where the CCG gain a good understanding of debtors and creditors to facilitate accurate cash-flow forecasting and to ensure the NHS Shared Business Services financial ledger is accurate to enable NHS England to carry out their reporting requirements. The CCG achieves this through regular dialogue between the CSU and the CCG's CFO, monthly reconciliation sign off controls by the CCG and the production of clear, concise and accurate reporting.

In addition, the CCG works with NHS England primary care financial team in relation to primary care financial transactions. The CCG receive primary care financial transaction reports on a monthly basis.

The CCG contracts with other support service providers and their sub-contractors. The CCG's payroll services are provided by Northumbria Healthcare NHS Foundation Trust using the electronic staff record service provided by McKesson UK.

These support services commission service auditor reports that are available to their clients' auditors to assess internal control risk for the purposes of planning and executing their financial audit. The CCG itself continually reviews its financial performance and is subject to monthly reviews of its ledgers by NHS England.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

The audit of conflicts of interest management has been undertaken during the year by the CCG's internal auditors (AuditOne) in line with the published audit framework. The following issues were in the scope of the audit and a substantial level of assurance has been indicated:

- Governance arrangements, including that: policies/procedures comply with legal requirements and statutory guidance; appropriate number of lay members and a conflict of interest guardian is/are appointed; and required training has been provided;
- Declarations of interests and gifts and hospitality, including that: declarations are being made and recorded in accordance with legal requirements and statutory guidance;
- Registers of interests, gifts and hospitality and procurement decisions, including that: each of these registers are maintained and published in accordance with legal requirements and statutory guidance;
- Decision making processes and contract monitoring, including that: there are mechanisms for the management of conflicts within meetings, when making procurement decisions and in relation to contract management;

- Reporting concerns and identifying and managing breaches/ non-compliance, including that: processes are in place for managing breaches and for the publications of anonymised details of breaches on the CCG's website.

There was only one minor recommendation made by the Auditors to ensure that Minutes accurately record how conflicts have been managed within meetings.

Data Quality

The CSU Data Management service has processes and systems in place to assess the quality and completeness of commissioning data managed on behalf of the CCG. Data is checked at all stages of processing through CSU systems and finally on publication of reports/analysis. Data is compared against historic and planned levels to provide assurance on completeness as well as with peer organisations in the form of benchmarking analysis.

Processes are in place to raise any data quality issues with providers on a monthly basis, feedback from these challenges is utilised to alter any processing routines as required. The CCG utilises contract levers where necessary to ensure high quality data is captured at source and to minimise any updating of data once received by commissioners. Reconciliation accounts for each contract highlight any discrepancies between provider and commissioner data that are then investigated and resolved.

Significant validations steps are in place in all routine data processing tasks to ensure poor quality data is not made available for analysis and then subsequently used as the basis for commissioning decisions.

The CCG relies on NECS to process other types of personal data, for example Human Resources or some patient data in order to fulfil its functions. NECS complies with the data quality requirements of the Data Security and Protection Toolkit and has procedures in place to ensure the quality of the data.

Data Security and Protection / Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by a data security and protection toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The CCG place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The CCG have established an information governance management framework comprising an approved strategy, a suite of approved policies and procedures, a programme of mandatory training, an Information Governance Handbook for staff, information risk management, incident management and has also adopted and implemented NHS Digital's (HSCIC) Guide to the Notification of Data Security and Protection Incidents.

The organisation has in place an Incident Reporting and Management Framework for the reporting of data security and protection incidents to the Information Commissioner. This Framework outlines the scope of responsibilities and details the reporting procedures to be used in the event of a data security breach. There have been no Information Governance 'reportable' breaches during 2018/19.

The Information Governance agenda is discussed at the Audit and Assurance Committee and any specific day to day issues would be raised at the Executive Committee. The CCG has appointed a Caldicott Guardian (Dr Kai Sander) and Senior Information Risk Owner (Mr Graeme Niven).

The Data Security and Protection Toolkit has been provided by NHS Digital to support performance monitoring of progress on Information Governance in the NHS. The CCG has published the Data Security and Protection Toolkit Version for 2018/19 and has answered all mandatory requirements as well as making good progress towards answering a number of non-mandatory requirements.

The CCG complies with its statutory duty to respond to requests for information. During the year, the CCG received 243 requests under the Freedom of Information Act 2000 and 3 subject access requests under the Data Protection Act 2018. All the requests were responded to within the statutory timescales.

Business Critical Models

The CCG is aware of the quality assurance requirements in respect of business critical models contained within the recommendations in the Macpherson report and I consider that appropriate arrangements are in place to provide sufficient quality assurance.

Third party assurances

Many of the CCG's support services in Finance and Human Resources are outsourced to the North of England Commissioning Support Unit (NECS), hosted by NHS England. Assurance is provided by NHS England's internal auditors, Deloitte LLP, via ISAE 3402 Type II reports. The reports cover a combined period of 1 March 2018 to 31 March 2019. The mandated National Payroll and Finance systems operated by NHS Shared Business Services underpin these functions and are also subject to annual independent audit under the same international standard. In addition, the CCG has continued to seek assurances from the North of England Commissioning Support Unit on actions arising from the whole system, processes and controls review carried out by Audit One during March 2018 in Continuing Healthcare Care clinical and administration systems.

A service auditor reporting process has continued to provide assurance over the effectiveness of controls and processes within NECS. A report has been received to cover the year to 31 March 2019; the detailed findings of which have been reviewed and are not considered to significantly impact on the CCG.

In addition to the majority of commissioning support services which are provided by NECS, the CCG has also outsourced certain other systems and services to third party providers. The national Integrated Single Financial Environment (ISFE) and procurement systems are provided by NHS Shared Business Services and the national Electronic Staff Records (ESR) system is provided by McKesson.

There are also various other outsourced services and systems relating to primary care services. A Service Auditor Report has been provided by Capita and no significant issues have arisen.

Payroll services are also received from a third party provider in Northumbria Healthcare NHS Foundation Trust. The CCG's own system of internal controls provides assurance over the operation of payroll, this includes the Scheme of Reservation and Delegation and prime financial policies which govern and set levels of authorisation, together with subsequent monthly payroll reviews. Again no significant issues have been identified from the review of payroll information during the year. Audit One have issued substantial assurance in relation

to NHS Payroll services for payroll documentation processed for the year ended 31 March 2019.

Control Issues

No significant control issues have been identified during the year requiring disclosure within this governance statement.

Review of economy, efficiency & effectiveness of the use of resources

The CCG has well developed systems and processes in place for managing its resources. The Quality, Performance and Finance Committee and Finance Sub-Committee have continuously monitored the financial position of the CCG throughout the year and highlighted risks to the Governing Body regarding the effective and efficient use of resources.

The Governing Body approved the CCG's financial plans for 2018/19 and have received an updated financial position at each of their Governing Body meetings. This includes the opportunity to ask questions of the Executive relating to assurance of the delivery of the CCG's financial objectives. They have also actively sought assurance from the Quality, Performance and Finance Committee as well as from the Audit and Risk Committee via internal and external audit reports that the CCG is ensuring value for money in the use of its resources.

As part of the planning process, a range of benchmarking tools are used including the commissioning for value packs and CCG outcomes benchmarking support packs published by NHS England. These tools provide comparative information on the CCG's spend and resulting outcomes, allowing the effectiveness of CCG spending to be assessed and incorporated into strategic plans and budgets. This benchmarking is a key element for all commissioning processes to help determine value for money for new services and pathways.

Central management costs, known as the CCG's running cost allowance was £6,397,000 for 2018/19. The CCG operated within the running cost allowance during the year.

For 2018/19 NHS Resolution Provisions Report identified that Hartlepool and Stockton-on-Tees CCG have not received any clinical negligence claims.

Internal Audit reports have been undertaken in relation to financial planning and budget setting. Substantial assurance has been provided in relation to these areas.

As part of their annual audit, the CCG's external auditors are required to satisfy themselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources. They do this by examining documentary evidence and through discussions with senior managers. Their audit work is made available to and reviewed by the Audit and Risk Committee.

As part of the CCG Improvement and Assessment Framework (IAF), developed by NHS England, the quality of the CCG's leadership is one of the 58 indicators assessed. It assesses how CCGs work with partners, the governance arrangements that CCGs have in place to ensure they act with integrity and how robustly the senior leaders of a CCG, both clinicians and managers, are performing their leadership role.

The CCG has self-assessed its final performance against the quality of leadership indicators for 2018/19 as green star (the top rating available). Performance against this indicator is currently being assessed by NHSE and will be published in July 2019. The latest published available assessment of the CCG against the quality of leadership indicator relates to 2017/18 and is available on the My NHS website.

Delegation of functions

This is covered under third party assurances section.

Counter fraud arrangements

Counter fraud activity plays a key part in determining risks to the organisation's financial viability and probity

The CCG adheres to NHS Protect Standards for Commissioners: Fraud, Bribery and Corruption. A comprehensive counter fraud service, including an accredited Counter Fraud Specialist, is commissioned through our internal auditors (AuditOne) to undertake counter fraud work proportionate to identified risks. A full assessment against the counter fraud standards self-review tool (SRT) was undertaken and presented to the Audit Committee in April 2018 and reflected an increasingly in-depth approach to counter fraud work. The Audit Committee also received details of the Counter Fraud workplan for 2018/19, which demonstrated a more collaborative approach with pooled resources and a more robust risk-

based workplan. The revised approach allowed for easier scrutiny and transparency of the counter fraud service.

Counter fraud activity plays a key part in determining risks to the organisation's financial viability and probity and the previous year's review an in-year review of Audit One's counter fraud service has resulted in a more in-depth approach to risk identification and assessment. This will continue to develop over the coming year.

The CCG Audit and Risk Committee receives a report against each of the Standards for Commissioners on annual basis as part of the counter-fraud annual report.

Counter-fraud requirements and regulations have been specifically discussed during the year to cement their knowledge and understanding of counter-fraud arrangements, with all employees also required to complete e-learning training. In addition, notifications and briefings regarding actual and potential fraud are circulated to key staff to ensure counter-fraud vigilance is maintained and enable payment systems to be reviewed for emerging risks.

The CCG's Chief Finance Officer continues to be the executive lead for counter-fraud matters. Any issue relating to tackling fraud, bribery and corruption is supported by the Chief Finance Officer who in accordance with the Counter-Fraud policy would report such incidents to the Audit and Risk Committee.

Head of Internal Audit Opinion

Head of Internal Audit Opinion on the Effectiveness of the System of Internal Control at NHS Hartlepool and Stockton-on-Tees CCG for the year ending 31 March 2019

Roles and responsibilities

The Accountable Officer is responsible for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is an annual statement by the Accountable Officer, on behalf of the Governing Body, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;

- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process; and

- the conduct and results of the review of the effectiveness of the system of internal control, including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the Annual Governance Statement requirements.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon, and limited to, the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans, generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Accountable Officer takes into account in making the Annual Governance Statement. The Accountable Officer will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement.

The Head of Internal Audit Opinion

The purpose of my annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpins the organisation's own assessment of the effectiveness of the system of internal control. This Opinion will in turn assist in the completion of the Annual Governance Statement.

My opinion is set out as follows:

1. Overall opinion;
2. Basis of the opinion;
3. Commentary.

1. Overall Opinion

From my review of your systems of internal control, I am providing substantial assurance that the system of internal control has been effectively designed to meet the organisation's objectives, and that controls are being consistently applied.

2. Basis of the Opinion

The basis for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes for governance and the management of risk;

2. An assessment of the range of individual opinions arising from audit assignments, contained within risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses;

3. Brought forward Internal Audit assurances;

4. An assessment of the organisation's response to Internal Audit recommendations; and

5. Consideration of significant factors outside the work of Internal Audit.

3. Commentary

Opinion Area	Commentary
Design and operation of the Assurance Framework and supporting processes	The Business Assurance Framework has been updated for 2018/19 and presented to both the Audit and Risk Committee and Governing Body during the year. Our review of the CCG's governance and risk management

Opinion Area	Commentary
	arrangements identified no issues of concern and was assigned 'substantial assurance'. On this basis we are content that the Board Assurance Framework provides a reasonable basis to support the CCG's Annual Governance Statement.
Outturn of Internal Audit Plan	During the year 2018/19 we have undertaken our work in accordance with the Internal Audit annual plan. A table of individual opinions arising from audit assignments reported throughout the year is contained at **Appendix A**. We have reported our findings to the Chief Finance Officer and Chief Officer (and other Executive colleagues where applicable). Our progress reports to the Audit and Risk Committee set out the areas covered by internal audit work during the year, our results and matters arising. To date, all reports issued during the year (where an assurance level has been given) have been assigned an assurance level of substantial. No significant issues have been identified in our work to date. By way of commentary, it should also be noted that there have been no 'limited assurance' final reports issued for 2018/19.
Brought forward Internal Audit assurances	A 'good assurance' Head of Internal Audit Opinion was given for the year ended 31 March 2018; and there are no material outstanding matters brought forward that will impact on the Head of Internal Audit Opinion for 2018/19.
Response to Internal Audit recommendations	There is a formal process in place to follow up on outstanding actions to address issues identified in internal audit reports. Progress against outstanding actions is reported in regular progress reports to the Audit and Risk Committee, with specific attention drawn to any actions where the target date has been deferred, or where no update has been received from officers

Opinion Area	Commentary
	within the CCG. There are no significant outstanding issues that impact upon the overall opinion.
Significant factors outside the work of internal audit	Whilst the Head of Internal Audit Opinion provides the CCG with assurances in relation to the areas covered by the internal audit plan, it is only one of the sources of assurance available to the CCG. As the CCG outsources many of its functions, assurances from third parties are equally as important when the CCG is preparing its Annual Governance Statement. Although we have reviewed the third party reports available, we have not taken account of these in providing our overall Head of Internal Audit Opinion.

I would like to take this opportunity to thank the staff at NHS Hartlepool and Stockton-on-Tees CCG for the co-operation and assistance provided to my team during the year.

Stuart Fallowfield

Senior Director of Internal Audit/Deputy Managing Director (interim)

AuditOne

22 May 2019

Appendix A

Summary of work undertaken

Audit area	Priority	Assurance			
		Substantial	Good	Reasonable	Limited
CORE AREAS					
Financial Planning & Budget Setting	High	√			
Governance & Risk Management Arrangements	High	√			
Financial Management and Performance Reporting	High	√			
Data Security & Protection Toolkit	Medium	Assurance level not provided			
Conflicts of Interest	High	√			
Primary Care Commissioning	Medium	√			
CYCLICAL AUDITS					
Serious Incidents *(to start)*	Medium				
Continuing Health Care & Funded Nurse Care *(Planning)*	High				
Totals		**5**	**0**	**0**	**0**

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

As part of the CCG's risk management processes, an Assurance Framework has been in place throughout the year which provides a simple yet comprehensive method for the effective and focused management of the principal risks and assurances to meeting and

delivering the CCG's objectives. The Assurance Framework reflects the principal risks associated with the delivery of the CCGs strategic objectives. This includes risks around the delivery of the CCGs strategic aims, financial stability including QIPP delivery, and development of effective corporate governance and risk management.

The Assurance Framework details with the key controls and assurances in place against each risk, together with any relevant action being taken to address gaps in controls and assurances where required. This is supplemented by detailed risk registers that record the full comprehensive list of all risks facing the CCG at an operational and strategic level across the five areas of delivery, development and transition, finance, performance and quality.

The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed.

As highlighted above, the Audit and Risk Committee plays a key role in providing assurance to the Governing body on the effectiveness of the systems of internal control and governance arrangements operated by the CCG. As part of this the work of both internal and external audit and other sources of assurance are considered. No significant internal control issues have been identified from the work of the Audit and Risk Committee.

Similarly, no significant governance or internal control issues have been identified through Governing Body, Executive Group or any other assurance process which impact upon my review of the effectiveness of the system of internal control.

As described within the third party assurances section above, external assurances have been obtained over all significant outsourced services, including commissioning support services from NECS. No significant issues have been identified which impact upon the CCG or this review.

The Head of Internal Audit opinion is set out above. This contributes to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the CCG's system of internal control. The Head of Internal Audit provides good assurance that there is a generally sound system of internal control.

I have been advised on the implications of the result of this review by:

- The Governing Body
- The Audit and Risk Committee
- The Quality, Performance & Finance Committee
- Internal audit.

The corporate management team also make a significant contribution to the overall effectiveness of the system.

My review for 2018/19 is also informed by:

- Regular executive reporting to my Executive Committee (senior executive meeting) and to the Governing Body and escalation processes through the Audit and Risk Committee.
- Third Party Assurance provided for the functions carried out on behalf of the CCG.
- NHS England Assurance processes

Conclusion

The system of internal control described in this report has been in place in the CCG for the year ended 31 March 2019 and up to the date of the approval of the annual report and accounts. No significant internal control issues have been identified.

My review confirms that NHS Hartlepool and Stockton-on-Tees CCG has a sound system of internal control that supports the achievement of its policies, aims and objectives.

Dr Neil O'Brien
Accountable Officer
28 May 2019

Remuneration and Staff report

Remuneration report

Remuneration Committee

The Remuneration Committee was established to advise the Governing Body about pay, other benefits and terms of employment for the Chief Officer and other senior staff. The Committee also advises/recommends to the Governing Body remuneration for the role of Chair, remuneration and terms of service of Governing Body clinical representatives and any independent lay members and reviews any business cases for early retirement and redundancy.

The Committee is established in accordance with the CCG's constitution, standing orders and scheme of delegation. The Committee is made up as follows:

H Thompson	Lay Member (Patient and Public Involvement) and Chair of Remuneration Committee (until 30 November 2018)
S Rose	Lay Member (Patient and Public Involvement) and Chair of Remuneration Committee (from 1 February 2019)
J Flook	Lay Member (Audit and Governance)
Dr B Posmyk	Chair of Governing Body
Dr C Stanley	Governing Body Secondary Care Doctor

The Remuneration Committee, which is accountable to the CCG's Governing Body makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the CCG and on determinations about allowances under any pension scheme that the CCG may establish as an alternative to the NHS pension scheme.

The Chief Officer, Chief Financial Officer and HR advisor have provided advice and guidance to the Committee in relation to pay rates and terms and conditions for relevant staff, although they were specifically excluded from any discussions in relation to their own pay rates and terms and conditions.

Policy on the remuneration of senior managers

The remuneration for senior managers for current and future financial years is determined in accordance with relevant guidance, best practice and national policy.

Continuation of employment for all senior managers is subject to satisfactory performance. Performance in post and progress in achieving set objectives is reviewed annually. There were no individual performance review payments made to any senior managers during the year and there are no plans to make such payments in future years. This is in accordance with standard NHS terms and conditions of service and guidance issued by the Department of Health.

Contracts of employment in relation to the majority of senior managers employed by the CCG are permanent in nature and subject to between three and six months' notice of

termination by either party. The GP Clinical Leads, practice manager and practice nurse representatives are employed on a fixed term of 24 months. Lay members and the Secondary Care Doctor are appointed for a period of two years (up to three years for the Secondary Care Doctor) and can serve for a maximum of two terms.

Termination payments are limited to those laid down in statute and those provided for within NHS terms and conditions of service and under the *NHS Pension Scheme Regulations* for those who are members of the scheme. No awards have been made during the year to past senior managers.

Remuneration of Senior Managers

For the purpose of this remuneration report, the CCG has considered the definition of 'senior managers' within the 2018/19 CCG Annual Reporting Guidance and the Government Financial Reporting Manual and considers that the Governing Body members represent the senior managers of the CCG.

Details of the relevant salaries and allowances for all of the senior managers of the CCG can be found in the tables below, both for 2018/19 and also relevant comparative figures for 2017/18.

The following disclosures within the Remuneration and Staff Report are subject to audit by the CCG's external auditors:

- the table of salaries and allowances of senior officers on page 138 and related narrative notes on pages 140 to 141;
- the table of pension benefits of senior managers on pages 143 to 144;
- the analysis of staff numbers on page 146; and
- the table of pay multiples and related narrative notes on page 142.

Important Note regarding 'All Pension Related Benefits' stated in the tables below:

Please note the amount included here is the annual increase in pension entitlement expected **over twenty years**. This value has been determined in accordance with the HMRC method of calculation, in accordance with guidance from NHS England. Employee pension contributions made in 2018/19 have been deducted from the total. Pension related benefits shown in the table above relate to the NHS pension scheme members only**. The figure shown is not intended to reflect annual remuneration received by the individual during the financial year.**

NHS Hartlepool and Stockton-on-Tees CCG senior officers' salaries and allowances - 2018/19:

Name	Title	2018/19					
		Salary (Bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100)	Performance pay and bonuses (Bands of £5,000)	Long-term performance pay and bonuses (Bands of £5,000)	All Pension related benefits (Bands of £2,500)	Total (Bands of £5,000)
		£000	£	£000	£000	£000	£000
Dr N O'Brien	Clinical Chief Officer (Accountable Officer) (from 1 October 2018)	15 - 20	600			2.5 - 5	20 - 25
N Bailey	Chief Officer (from 1 October 2018)	15 - 20	700			0	15 - 20
S Findlay	Chief Officer (from 1 October 2018)	15 - 20	700			0	15 - 20
A Wilson	Chief Officer (until 30 September 2018)	15 - 20				0	15 - 20
Dr B Posmyk	Chair of Governing Body	45 - 50				0	45 - 50
Dr C Stanley	Governing Body Member, Secondary Care Doctor	10 - 15				0	10 - 15
G Niven	Chief Finance Officer	45 - 50	3,700			52.5 - 55	100 - 105
H Thompson	Governing Body Lay Member (Patient and Public Involvement) (until 30 November 2018)	5 - 10				0	5 - 10
Dr N Timlin	GP Governing Body Member Hartlepool Locality Lead	25 - 30				10 – 12.5	40 - 45
Dr A Hassan	GP Governing Body Member Stockton-on-Tees Locality Lead	25 - 30				0	25 - 30
J Flook	Lay Member (Audit and Governance)	5 - 10				0	5 - 10
A Mackay	Lay Member	5 - 10				0	5 - 10
J Golightly	Director of Nursing and Quality	45 - 50				12.5 - 15	60 - 65
Dr J Donkin	Governing Body GP Member	0 - 5				0	0 - 5
Dr A Din	Governing Body GP Member	0 - 5				0	0 - 5
L Tempest	Director of Planning, Performance & Assurance	65 - 70				12.5 - 15	75 - 80
K Hawkins	Director of Commissioning & Transformation	65 - 70				10 – 12.5	75 - 80
Dr A Jones	Chief Clinical Officer (until 30 September 2018)	20 - 25				5 – 7.5	30 – 35
S Rose	Lay Member (Patient and Public Involvement) (from 1 February 2019)	0 - 5				0	0 - 5

NHS Hartlepool and Stockton-on-Tees CCG senior officers' salaries and allowances - 2017/18 comparative figures:

Name	Title	2017/18					
		Salary (Bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100)	Performance pay and bonuses (Bands of £5,000)	Long-term performance pay and bonuses (Bands of £5,000)	All Pension related benefits (Bands of £2,500)	Total (Bands of £5,000)
		£000	£	£000	£000	£000	£000
A Wilson	Chief Officer	50 - 55	800	-	-	-	50 - 55
Dr B Posmyk	Chair of Governing Body	45 - 50	-	-	-	-	45 - 50
Dr C Stanley	Governing Body Member, Secondary Care Doctor	10 - 15	-	-	-	-	10 - 15
G Niven	Chief Finance Officer	70 - 75	5,700	-	-	15 - 17.5	95 - 100
H Thompson	Governing Body Lay Member (Patient and Public Involvement)	10 - 15	-	-	-	-	10 - 15
Dr N Timlin	GP Governing Body Member Hartlepool Locality Lead	25 - 30	-	-	-	2.5 - 5	30 - 35
Dr A Hassan	GP Governing Body Member Stockton-on-Tees Locality Lead	25 - 30	-	-	-	-	25 - 30
J Flook	Lay Member (Audit and Governance)	5 - 10	-	-	-	-	5 - 10
A Mackay	Lay Member	5 - 10	-	-	-	-	5 - 10
J Golightly	Director of Nursing and Quality	45 - 50	-	-	-	32.5 - 35	75 - 80
Dr D Hodges	Governing Body GP Member	5 - 10	-	-	-	0 - 2.5	5 - 10
Dr S Patel	Governing Body GP Member	0 - 5	-	-	-	-	0 - 5
L Tempest	Director of Planning, Performance & Assurance	70 - 75	-	-	-	20 - 22.5	90 - 95
K Hawkins	Director of Commissioning & Transformation	70 - 75	-	-	-	62.5 - 65	135 - 140
Dr A Jones	Chief Clinical Officer	20 - 25	-	-	-	15 - 17.5	35 - 40
D Murphy	Director of Nursing and Quality	10 - 15	-	-	-	-	10 - 15

Notes:

The taxable benefits included in the tables above all relate to car allowance and lease car benefits.

No performance related benefits have been agreed for any senior officers.

All pension related benefits disclosed in this report relate to 'officer employment' only, i.e. for any general practitioners, the figures exclude any benefits derived from practitioner employment.

Following a review of off-payroll arrangements in previous years, all senior officer remuneration is now provided through the CCG's payroll, including all remuneration disclosed in the tables above for 2018/19 and 2017/18.

Shared Management Arrangements

With effect from 1 October 2018, Dr N O'Brien was appointed as Accountable Officer across five CCGs; Darlington CCG, Durham Dales, Easington and Sedgefield (DDES) CCG, Hartlepool and Stockton-on-Tees (HAST) CCG, North Durham CCG and South Tees CCG. N Bailey and S Findlay were also appointed as Chief Officers across those five CCGs with effect from 1 October 2018. The costs of those three individuals have been shared across the five CCGs based on relative CCG population sizes since that date.

The remuneration shown above for those posts represents only the share that relates to the HAST CCG role. The total remuneration earned by each individual for all work across the five CCGs in 2018/19 is shown below:

Name	Title	2018/19		
		Salary (Bands of £5,000) £000	Expense payments (taxable) (Rounded to the nearest £100) £	Total (Bands of £5,000) £000
Dr N O'Brien	Clinical Chief Officer (Accountable Officer)	140 - 145	4,800	145 - 150
N Bailey	Chief Officer	145 - 150	6,000	150 - 155
S Findlay	Chief Officer	160 - 165	5,900	165 - 170

The remuneration of these three posts was reviewed by the five CCGs at the time of appointment. The level of remuneration for all three posts from 1 October 2018 exceeds £150,000 which reflects that the roles are being performed across five CCGs. The actual cost to each organisation is significantly lower than £150,000.

The remuneration of the Accountable Officer / Clinical Chief Officer role also reflects the clinical nature of the role and has been benchmarked against other Clinical Chief Officer roles and equivalent general practice earnings.

In addition to the shared posts identified above, a number of other senior officers have worked in joint posts shared with other CCGs:

The following senior officer works across both HAST CCG and South Tees CCG as part of a 50/50 staff sharing arrangement:

J Golightly Director of Nursing and Quality

The following senior officers have worked across HAST CCG and Darlington CCG as part of a joint management structure:

A Wilson Chief Officer (until 30 September 2018)
Dr A Jones Chief Clinical Officer (until 30 September 2018)
L Tempest Director of Planning, Performance & Assurance
K Hawkins Director of Commissioning & Transformation
J Flook Lay Member (Audit and Governance)
A Mackay Lay Member
Dr B Posmyk Chair of Governing Body

Also, the following senior officer has worked across Darlington CCG, HAST CCG and South Tees CCG as part of a joint management structure:

G Niven Chief Finance Officer

The remuneration shown above for these posts represents only the share that relates to the HAST CCG role. The total remuneration earned by each individual for all work across the CCGs in 2018/19 is shown below:

Name	Title	2018/19		
		Salary (Bands of £5,000) £000	Expense payments (taxable) (Rounded to the nearest £100) £	Total (Bands of £5,000) £000
J Golightly	Director of Nursing and Quality	95 - 100	-	95 - 100
A Wilson	Chief Officer (until 30 September 2018)	75 - 80	-	75 - 80
Dr A Jones	Chief Clinical Officer (until 30 September 2018)	70 - 75	-	70 - 75
Dr B Posmyk	Chair of Governing Body	60 - 65	-	60 - 65
G Niven	Chief Finance Officer	110 - 115	8,700	120 - 125
L Tempest	Director of Planning, Performance & Assurance	90 - 95	-	90 - 95
K Hawkins	Director of Commissioning & Transformation	90 - 95	-	90 - 95
J Flook	Lay Member (Audit and Governance)	10 - 15	-	10 - 15
A Mackay	Lay Member	10 - 15	-	10 - 15

Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the CCG in the financial year 2018/19 was £65-70k (2017/18: £70-75k). This was 1.13 times (2017/18: 1.39 times) the median remuneration of the workforce, which was £59,964 (2017/18: £53,818).

In 2018/19, no employees (2017/18: none) received remuneration in excess of that of the highest paid director. Full time equivalent remuneration for employees ranged from £5,567 to £164,252 (2017/18: £5,567 to £179,633).

For the purposes of identifying the highest paid director for this disclosure, it is the cost to the CCG of an individual that is considered, rather than the total of that individual's remuneration.

The reduction in the banded remuneration of the highest paid director in the CCG during the year reflects the shared arrangements for Chief Officer posts agreed across multiple CCGs during the year, with the calculation of the highest paid director reflecting only the cost to the CCG.

The remuneration of £5,567 relates to the CCG's lay members who receive an annual remuneration for a time-commitment below the CCG's normal contractual hours. As this represents the annual remuneration for the full required time-commitment, this is considered to represent the full time equivalent remuneration for that role although it relates to a time-commitment significantly below the CCG's normal contractual hours.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Accordingly the total remuneration figures reflected here exclude the pension related benefits shown in the salaries and allowances table on page 136.

	2018/19	2017/18
Band of Highest Paid Director's Total Remuneration (£'000)	65 – 70	70 - 75
Median Total Remuneration (£)	59,964	53,818
Ratio	1.13	1.39

Due to the small number of staff employed by the CCG, the median remuneration can be impacted by relatively small changes. The movement in the current year reflects the impact of changes to the agenda for change pay framework and the implementation of shared arrangements across five CCGs for Chief Officer posts.

NHS Hartlepool and Stockton-on-Tees CCG senior officers' pension benefits 2018/19:

Name and Title	Real increase / (reduction) in pension at age 60 (bands of £2,500) £000	Real increase / (reduction) in Pension Lump Sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2019 (bands of £5,000) £000	Lump Sum at aged 60 related to accrued pension at 31 March 2019 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2018 £000	Real increase in cash equivalent transfer value £000	Cash Equivalent Transfer Value at 31 March 2019 £000	Employer's contribution to stakeholder pension £000
Dr N O'Brien Clinical Chief Officer (Accountable Officer) (from 1 October 2018)	0 – 2.5	0 – 2.5	15 - 20	15 - 20	161	29	219	0
N Bailey Chief Officer (from 1 October 2018)	0 - 2.5	0	90 – 95	0	1,185	26	1,342	0
G Niven Chief Finance Officer	5 – 7.5	12.5 - 15	50 - 55	130 - 135	819	215	1,034	0
Dr B Posmyk Chair of Governing Body	0	0	0	0	0	0	0	1
Dr N Timlin GP Governing Body Member Hartlepool Locality Lead	0 – 2.5	0 – 2.5	10 - 15	30 - 35	237	39	276	0
Dr A Hassan GP Governing Body Member Stockton Locality Lead	0	0	0	0	0	0	0	0

NHS Hartlepool and Stockton-on-Tees CCG senior officers' pension benefits 2018/19 (continued):

Name and Title	Real increase / (reduction) in pension at age 60 (bands of £2,500) £000	Real increase / (reduction) in Pension Lump Sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2019 (bands of £5,000) £000	Lump Sum at aged 60 related to accrued pension at 31 March 2019 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2018 £000	Real increase in cash equivalent transfer value £000	Cash Equivalent Transfer Value at 31 March 2019 £000	Employer's contribution to stakeholder pension £000
J Golightly Director of Nursing and Quality	0 – 2.5	5 – 7.5	20 - 25	60 - 65	402	82	485	0
Dr J Donkin Governing Body GP Member	0	0	0	0	0	0	0	0
Dr A Din Governing Body GP Member	(0 – 2.5)	0	0 - 5	0	12	1	14	0
L Tempest Director of Planning, Performance & Assurance	0 – 2.5	0	15 - 20	0	185	48	232	0
K Hawkins Director of Commissioning & Transformation	0 – 2.5	(0 – 2.5)	20 - 25	40 - 45	273	55	328	0
Dr A Jones Chief Clinical Officer (until 30 September 2018)	0 – 2.5	0 – 2.5	10 - 15	40 - 45	260	29	318	0

The table above includes only those senior managers who are members of the NHS pension scheme where the CCG made contributions to the scheme as an employer during the year.

The figures included above reflect total pension benefits accrued within the NHS Pension Scheme, not just those accrued from employment within the CCG. No lump sum is shown for employees who only have membership in the 2008 section of the NHS Pension Scheme.

The real increase figures shown above relate only to the period each individual was in post as a senior officer.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefit accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their membership of the pension scheme. This may be for more than just their service in a senior capacity to which disclosure applies (in which case this fact will be noted at the foot of the table). The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real increase in cash equivalent transfer values

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee, (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Staff report

Staff numbers

Details of staffing costs for the year and the average number of employees can be found in notes 3.1 and 3.2 of the financial statements respectively.

The CCG's senior officers are listed in the remuneration report. 3 of the senior officers are on very senior manager bandings, 1 senior officer is on agenda for change band 9 and the remaining senior officers are either paid on a sessional basis or are non-executive members and hence have no agenda for change banding.

Staff composition

The CCG staff gender profile is given in the table below. This reflects our gender representation on the Governing Body and total CCG staff.

	Female	Male
Governing Body	3	10
Employees	35	16

These figures are as at 31 March 2019 and reflect the number of employees rather than full time equivalent figures.

The CCG can demonstrate fair and equitable recruitment, workforce engagement and employment terms and conditions to ensure levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work, and work rated as of equal value, and being entitled to equal pay.

Staff sickness absence

The table below provides staff sickness absence data for the 12 months ended 31 December 2018 (with comparative figures for the 12 months to December 2017), showing the total number of full time equivalent (FTE) staff days lost to sickness absence and the total number of FTE years available, based on the total number of FTE staff members within the CCG. This equates to an average number of days' sickness per FTE member of staff of 5 (7 for the 12 months to 31 December 2017):

	2018 Number of days	2017 Number of days
Total number of days lost to sickness absence	192	210
Total staff years	36	30
Average number of working days lost to sickness absence	**5**	**7**

Staff policies

The CCG is committed to giving full and fair consideration to all applications for employment received including those received from disabled persons, having regard to their particular aptitudes and abilities.

To support the human resource function the CCG has a suite of HR policies, implementation of which is supported by Human Resource Team within North of England Commissioning Support. They cover the full range of HR issues including recruitment, training and career development.

All appropriate support would be provided to any employee who might become a disabled person during the period when they were employed by the CCG.

Other employee matters

Employee consultation

With a small team we are still able to meet with the entire CCG office staff on a regular basis to ensure awareness of issues and facilitate staff involvement in decisions directly impacting upon them. We also participate in the local HR Partnership Forum coordinated by our commissioning support unit. Trade Union representatives jointly chair the group where HR policies are agreed and general HR issues discussed.

Trade Union Facility Time

The Trade Union (Facility Time Publication Requirements) Regulations 2017 require relevant public sector organisations to report on trade union facility time in their organisations. Facility time is paid time off for union representatives to carry out trade union activities. As the CCG has less than 49 members of staff, we are not required to publish this information.

Disabled employees

Our Equality Report sets out details of our policy in relation to disabled employees, and the Remuneration and Staff Report details arrangements for managing staff policies and highlight the CCG's commitment to giving full and fair consideration to all applications for employment received including those received from disabled persons, having regard to their particular aptitudes and abilities.

Sickness absence data

Days lost to sickness are shown earlier in the Remuneration and Staff Report. Staff sickness absence is managed in line with our policy on absence management. We continue to benefit from low levels of sickness absence and are committed to promoting health and wellbeing for our staff.

Health and safety

The CCG has legal obligations under the Health and Safety at Work Act 1974 and subsequent regulations to ensure the health, safety and welfare of our employees and those visiting our premises.

To ensure compliance with health and safety, fire and security we have a Health, Safety and Wellbeing Strategy, which sets out our framework for health and safety within the organisation including annual health and safety audits to ensure compliance with all relevant legislation and policies and procedures that are in place and detail organisational and individual responsibilities.

The CCG is compliant with legal and statutory obligations under the Health and Safety at Work Act 1974 and subsequent regulations. Our Strategy also reflects our commitment to the overall wellbeing of our staff and how we intend to continue to be a caring and responsible employer.

Expenditure on consultancy

Details of expenditure on consultancy services can be found in note 4 of the financial statements, with expenditure on agency staff shown in note 3.1 of the financial statements.

Off-payroll engagements

Following a review of off-payroll engagements in previous years, all senior officers were transferred on to the CCG's payroll and all senior officer remuneration for the year has been transacted through payroll.

There have been no off-payroll engagements during the year of greater than £245 per day and lasting longer than 6 months.

Exit packages
No exit packages have been agreed during the year, and none were agreed in 2017/18.

Dr Neil O'Brien
Accountable Officer
28 May 2019

Parliamentary Accountability and Audit Report

Hartlepool and Stockton-on-Tees CCG is not required to produce a Parliamentary Accountability and Audit Report. Where relevant, disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report in pages 155 to 171.

An audit certificate and report is also included in this Annual Report at page 172.

Dr Neil O'Brien
Accountable Officer
28 May 2019

Financial statements

NHS Hartlepool & Stockton-on-Tees CCG Financial Statements for the year ended 31 March 2019

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Administration costs and programme expenditure			
Gross employee benefits	3.1	1,900	1,623
Other costs	4	462,317	448,406
Other operating revenue	2	(55)	(302)
Net operating costs		**464,162**	**449,727**
Investment revenue	7	-	-
Other (gains)/losses	8	-	-
Finance costs	9	-	-
Net operating costs for the financial year		**464,162**	**449,727**
Of which:			
Administration costs			
Gross employee benefits	3.1	1,604	1,480
Other costs	4	3,684	4,241
Other operating revenue	2	-	-
Net administration costs		**5,288**	**5,721**
Programme expenditure			
Gross employee benefits	3.1	296	143
Other costs	4	458,633	444,165
Other operating revenue	2	(55)	(302)
Net programme expenditure		**458,874**	**444,006**
Total comprehensive net expenditure for the year		**464,162**	**449,727**

Statement of Financial Position as at 31 March 2019

	Note	31 March 2019 £000	31 March 2018 £000
Current assets			
Trade and other receivables	11	1,356	1,650
Cash and cash equivalents	12	406	166
Total current assets		**1,762**	**1,816**
Total assets		**1,762**	**1,816**
Current liabilities			
Trade and other payables	13	(27,053)	(25,402)
Provisions	14	-	-
Total current liabilities		**(27,053)**	**(25,402)**
Total assets less total current liabilities		**(25,291)**	**(23,586)**
Financed by taxpayers' equity			
General fund		(25,291)	(23,586)
Total taxpayers' equity		**(25,291)**	**(23,586)**

The notes on pages 155 to 171 of the Annual Report form part of this statement.

The financial statements on pages 151 to 171 of the Annual Report were approved and authorised for issue by the Governing Body on 22 May 2019 and signed on its behalf by:

Dr Neil O'Brien
Accountable Officer
28 May 2019

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2019

	General fund £000	Total reserves £000
Changes in taxpayers' equity for 2018/19:		
Balance at 1 April 2018	(23,586)	(23,586)
Changes in CCG taxpayers' equity for 2018/19		
Net operating costs for the financial year	(464,162)	(464,162)
Net recognised CCG expenditure for the financial year	**(464,162)**	**(464,162)**
Net Parliamentary funding	462,457	462,457
Balance at 31 March 2019	**(25,291)**	**(25,291)**

	General fund £000	Total reserves £000
Changes in taxpayers' equity for 2017/18:		
Balance at 1 April 2017	(19,396)	(19,396)
Changes in CCG taxpayers' equity for 2017/18		
Net operating costs for the financial year	(449,727)	(449,727)
Net recognised CCG expenditure for the financial year	**(449,727)**	**(449,727)**
Net Parliamentary funding	445,537	445,537
Balance at 31 March 2018	**(23,586)**	**(23,586)**

Statement of Cash Flows for the year ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Net operating costs for the financial year		(464,162)	(449,727)
Decrease / (increase) in trade and other receivables	11	294	(52)
Increase in trade and other payables	13	1,651	4,040
Increase / (decrease) in provisions	14	-	(3)
Net cash outflow from operating activities		**(462,217)**	**(445,742)**
Net cash outflow before financing		**(462,217)**	**(445,742)**
Cash flows from financing activities			
Net funding received		462,457	445,537
Net cash inflow from financing activities		**462,457**	**445,537**
Net increase / (decrease) in cash and cash equivalents	12	**240**	**(205)**
Cash and cash equivalents at the beginning of the financial year		166	371
Cash and cash equivalents at the end of the financial year		**406**	**166**

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of CCGs shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to CCGs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Acquisitions & Discontinued Operations

Activities are considered to be ‘acquired’ only if they are taken on from outside the public sector. Activities are considered to be ‘discontinued’ only if they cease entirely. They are not considered to be ‘discontinued’ if they transfer from one public sector body to another.

1.4 Movement of Assets within the Department of Health and Social Care Group

Transfers as part of reorganisation are to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.5 Pooled Budgets

Where the CCG has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006, the CCG accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the CCG is in a "jointly controlled operation", the CCG recognises:

- the assets the CCG controls;
- the liabilities the CCG incurs;
- the expenses the CCG incurs; and,
- the CCG's share of the income from the pooled budget activities.

If the CCG is involved in a "jointly controlled assets" arrangement, in addition to the above, the CCG recognises:

- the CCG's share of the jointly controlled assets (classified according to the nature of the assets);
- the CCG's share of any liabilities incurred jointly; and,
- the CCG's share of the expenses jointly incurred.

1.6 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the CCG's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.6.1 *Critical Judgements in Applying Accounting Policies*

The following are the critical judgements, apart from those involving estimations (see below), that management has made in the process of applying the CCG's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- determining whether income and expenditure should be disclosed as either administrative or programme expenditure;
- determining whether a substantial transfer of risks and rewards has occurred in relation to leased assets; and
- determining whether a provision or contingent liability should be recognised in respect of certain potential future obligations, particularly in respect of continuing healthcare.

1.6.2 Key Sources of Estimation Uncertainty

The following are the key estimations that management has made in the process of applying the CCG's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- the assumptions applied in the estimation of activity not yet invoiced, including partially completed treatment spells as at the Statement of Financial Position date;
- the estimate of potential future liabilities in respect of continuing healthcare services; and
- the estimate of prescribing expenditure for the final two months of the year based on the ten months of actual charges received from the Prescription Pricing Division.

1.7 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.8 Employee Benefits

1.8.1 *Short-term Employee Benefits*

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 *Retirement Benefit Costs*

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the CCG of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the CCG commits itself to the retirement, regardless of the method of payment.

1.9 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenses and liabilities in respect of grants are recognised when the CCG has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.10 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.10.1 The CCG as Lessee

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

1.11 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the CCG's cash management.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.12 Provisions

Provisions are recognised when the CCG has a present legal or constructive obligation as a result of a past event, it is probable that the CCG will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

- Timing of cash flows (0 to 5 years inclusive): Minus 0.76% (2017/18: minus 2.42%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.14% (2017/18: minus 1.85%)
- Timing of cash flows (10 to 40 years inclusive): Minus 1.99% (2017/18: minus 1.56%)
- Timing of cash flows (over 40 years): Minus 1.99% (2017/18: minus 1.56%)

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the CCG has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.13 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the CCG pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the CCG.

1.14 Non-clinical Risk Pooling

The CCG participates in the Liabilities to Third Parties Scheme. This is a risk pooling scheme under which the CCG pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses as and when they become due.

1.15 Continuing healthcare risk pooling

In 2014/15, a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme CCGs contribute annually to a pooled fund, which is used to settle the claims. Any claims after the 31 March 2013 are managed as part of the CCG's normal business.

1.16 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the CCG, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the CCG. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.17 Financial Assets

Financial assets are recognised when the CCG becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

All CCG assets have been classified as financial assets at amortised cost.

1.17.1 *Financial Assets at Amortised cost*

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.17.2 *Impairment*

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the CCG recognises a loss allowance representing the expected credit losses on the financial asset.

The CCG adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The CCG therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the CCG does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.18 Financial Liabilities

Financial liabilities are recognised on the Statement of Financial Position when the CCG becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.18.1 *Other Financial Liabilities*

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from the Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Notes to the financial statements (continued)

1. Accounting policies (continued)

1.19 Value Added Tax

Most of the activities of the CCG are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the CCG not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.21 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Department of Health and Social Care Group Accounting Manual does not require the following Standards and Interpretations to be applied in 2018/19. These standards are still subject to HM Treasury FREM adoption, with IFRS 16 being for implementation in 2019/20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16: Leases (application from 1 January 2019), but not yet adopted by the FREM: early adoption is not therefore permitted;
- IFRS 17: Insurance Contracts (application from 1 January 2021) but not yet adopted by the FREM: early adoption is not therefore permitted;
- IFRIC 23: Uncertainty over Income Tax Treatments (application from 1 January 2019).

The application of the Standards as revised would not have a material impact on the accounts for 2018/19, were they applied in that year.

2. Other Operating Revenue

	2018/19 Admin £000	2018/19 Programme £000	2018/19 Total £000	2017/18 Total £000
Non-patient care services to other bodies	-	-	-	302
Other non contract revenue	-	55	55	-
Total other operating revenue	**-**	**55**	**55**	**302**

Programme revenue is revenue received that is directly attributable to the provision of healthcare or healthcare services.

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the General Fund.

Revenue is totally from the supply of services. The CCG receives no revenue from the sale of goods.

The impact of IFRS15 has been considered and has no material impact on the financial statements.

Notes to the financial statements (continued)

3. Employee benefits and staff numbers

3.1.1 Employee benefits

2018/19	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee benefits									
Salaries and wages	1,546	1,546	-	1,304	1,304	-	242	242	-
Social security costs	169	169	-	144	144	-	25	25	-
Employer contributions to NHS Pension scheme	185	185	-	156	156	-	29	29	-
Gross employee benefits expenditure	**1,900**	**1,900**	**-**	**1,604**	**1,604**	**-**	**296**	**296**	**-**

No amounts were recovered in respect of employee benefits and no employee benefits were capitalised during the year (2017/18: none).

3.1.1 Employee benefits prior year

2017/18	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee benefits									
Salaries and wages	1,313	1,313	-	1,196	1,196	-	117	117	-
Social security costs	142	142	-	130	130	-	12	12	-
Employer contributions to NHS Pension scheme	168	168	-	154	154	-	14	14	-
Gross employee benefits expenditure	**1,623**	**1,623**	**-**	**1,480**	**1,480**	**-**	**143**	**143**	**-**

3.2 Average number of people employed

	2018/19			2017/18
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**30**	**30**	**-**	34

None of the above people were engaged on capital projects (2017/18: none).

3.3 Staff sickness absence and ill health retirements

	2018/19 Number	2017/18 Number
Total Days Lost	192	210
Total Staff Years	31	30
Average working days lost	**6**	**7**

The staff sickness absence data for 2018/19 is based on the 12 months ended 31 December 2018 (2017/18: 12 months ended 31 December 2017).

No staff retired early on ill health grounds during the financial year (2017/18: none).

3.4 Exit packages agreed in the financial year

No exit packages have been agreed in the financial year (2017/18: none).

Notes to the financial statements (continued)

3. Employee benefits and staff numbers (continued)

3.5 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions.

Both Schemes are unfunded, defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health, in England and Wales. The Schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each Scheme is accounted for as if it were a defined contribution scheme: the cost to the CCG of participating in the Scheme is taken as equal to the contributions payable to that Scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

3.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data at 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

3.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The latest actuarial valuation undertaken for the Scheme was completed for the year ending 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgement from the Court of Appeal in December 2018, the Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Notes to the financial statements (continued)

4. Operating expenses

	2018/19 Admin £000	2018/19 Programme £000	2018/19 Total £000	Restated 2017/18 Total £000
Other costs				
Services from other CCGs and NHS England	2,910	2,011	4,921	11,722
Services from foundation trusts	-	287,556	287,556	275,983
Services from other NHS trusts	-	729	729	612
Purchase of healthcare from non-NHS bodies	-	79,124	79,124	71,132
Prescribing costs	-	46,147	46,147	47,963
General ophthalmic services	-	1	1	5
GPMS/APMS and PCTMS	-	40,967	40,967	38,808
Supplies and services – clinical	-	822	822	834
Supplies and services – general	164	34	198	210
Establishment	55	13	68	133
Transport	1	-	1	2
Premises	174	1,219	1,393	668
Audit fees	37	-	37	37
Other non statutory audit expenditure				
· Other services	3	-	3	-
Other professional fees	202	10	212	191
Legal fees	20	-	20	3
Education and training	21	-	21	3
Chair and Non Executive Members	95	-	95	96
Clinical negligence	2	-	2	4
Total other costs	**3,684**	**458,633**	**462,317**	**448,406**

Included within Other professional fees is £28,175 (Restated 2017/18: £27,599) paid for Internal Audit Services.

Limitation of auditor's liability:

The CCG's contract for external audit services provides for a limitation of the auditor's liability of £1,000,000 (2017/18: £1,000,000).

Notes to the financial statements (continued)

5.1 Better Payment Practice Code

Measure of compliance	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the year	16,395	111,805	13,880	108,272
Total Non-NHS Trade Invoices paid within target	16,206	110,686	13,743	107,560
Percentage of Non-NHS Trade invoices paid within target	**98.85%**	**99.00%**	**99.01%**	**99.34%**
NHS Payables				
Total NHS Trade invoices paid in the year	2,384	303,970	2,264	288,542
Total NHS Trade invoices paid within target	2,373	303,897	2,262	288,536
Percentage of NHS Trade invoices paid within target	**99.54%**	**99.98%**	**99.91%**	**100.00%**

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

5.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no payments made in respect of late payments of commercial debts in 2018/19 (2017/18: none).

6. Income Generation Activities

The CCG does not undertake any income generation activities (2017/18: none).

7. Investment revenue

There was no investment revenue in 2018/19 (2017/18: none).

8. Other (gains) and losses

There were no other (gains) and losses in 2018/19 (2017/18: none).

9. Finance costs

There were no finance costs in 2018/19 (2017/18: none).

Notes to the financial statements (continued)

10. Operating Leases

10.1 As lessee

The CCG has entered into a small number of formal operating lease arrangements, relating to leased cars, none of which are individually significant. Specific lease terms vary by individual arrangement but are based upon standard practice for the type of arrangement involved.

The CCG occupies property owned and managed by NHS Property Services Limited and Community Health Partnership's Limited. The charges shown in note 10.1.1 from NHS Property Services Limited are intended to reflect the cost of occupancy, or void space, attributable to the CCG, calculated based on market rents by NHS Property Services Limited.

While our arrangements with NHS Property Services Limited and Community Health Partnership's Limited fall within the definition of operating leases, the rental charge for future years has not yet been agreed. Consequently, this note does not include future minimum lease payments for these arrangements.

10.1.1 Payments recognised as an Expense

	2018/19 Buildings £000	2018/19 Other £000	2018/19 Total £000	2017/18 Total £000
Payments recognised as an expense				
Minimum lease payments	1,379	6	**1,385**	**666**
Total	**1,379**	**6**	**1,385**	**666**

10.1.2 Future minimum lease payments

	2018/19 Buildings £000	2018/19 Other £000	2018/19 Total £000	2017/18 Total £000
Payable:				
No later than one year	-	4	**4**	**-**
Total	**-**	**4**	**4**	**-**

Notes to the financial statements (continued)

11. Trade and other receivables

	Current 31 March 2019 £000	Non-current 31 March 2019 £000	Current 31 March 2018 £000	Non-current 31 March 2018 £000
NHS receivables: Revenue	681	-	355	-
NHS accrued income	45	-	-	-
Non-NHS and Other WGA receivables: Revenue	305	-	996	-
Non-NHS and Other WGA prepayments	294	-	300	-
Provision for the impairment of receivables	-	-	(1)	-
VAT	31	-	-	-
Total trade and other receivables	**1,356**	**-**	**1,650**	**-**
Total current and non current	**1,356**		**1,650**	

The great majority of trade is with other NHS bodies, including other CCGs as commissioners for NHS patient care services. As CCGs are funded by Government to commission NHS patient care services, no credit scoring of them is considered necessary.

11.1 Receivables past their due date but not impaired

	31 March 2019 £000	31 March 2018 £000
By up to three months	171	96
By three to six months	108	-
By more than six months	40	-
Total	**319**	**96**

£6k of the amount above has subsequently been recovered post the Statement of Financial Position date.

The CCG did not hold any collateral against receivables outstanding at 31 March 2019 (31 March 2018: none).

11.2 Expected credit losses on financial assets

	31 March 2019 £000	31 March 2018 £000
Balance at 1 April 2018	(1)	-
Amounts written off during the year	-	-
Decrease / (increase) in receivables impaired	1	(1)
Balance at 31 March 2019	**-**	**(1)**

The CCG has reviewed all receivables to determine whether an impairment value is required. In determining the recoverability of a receivable, the CCG considers any change in credit quality of the receivable from the date credit was initially granted up to the reporting date. The overall level of credit risk is considered to be relatively low due to the proportion of the customer base which is comprised of NHS bodies.

Notes to the financial statements (continued)

12. Cash and cash equivalents

	2018/19 £000	2017/18 £000
Balance at 1 April	166	371
Net change in year	240	(205)
Balance at 31 March	**406**	**166**
Made up of:		
Cash with the Government Banking Service	406	166
Cash and cash equivalents as in Statement of Financial Position	**406**	**166**
Balance at 31 March	**406**	**166**

The CCG held £nil cash and cash equivalents at 31 March 2019 on behalf of patients (31 March 2018: £nil).

13. Trade and other payables

	Current 31 March 2019 £000	Non-current 31 March 2019 £000	Current 31 March 2018 £000	Non-current 31 March 2018 £000
NHS payables: revenue	992	-	3,348	-
NHS accruals	2,541	-	1,820	-
Non-NHS and Other WGA payables: Revenue	617	-	1,257	-
Non-NHS and Other WGA accruals	22,431	-	18,270	-
Social security costs	28	-	27	-
Tax	32	-	28	-
Other payables	412	-	652	-
Total trade and other payables	**27,053**	**-**	**25,402**	**-**
Total current and non-current	**27,053**		**25,402**	

At 31 March 2019, the CCG had no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2018: none).

Other payables include £382k in respect of outstanding pension contributions at 31 March 2019 (31 March 2018: £309k).

14. Provisions

There were no provisions to recognise in the financial statements at 31 March 2019 (31 March 2018: none).

15. Contingencies

There were no contingent assets or liabilities at 31 March 2019 (31 March 2018: none).

Notes to the financial statements (continued)

16. Commitments

There were no contracted or non-cancellable contracts entered into by the CCG at 31 March 2019 which are not otherwise included in these financial statements (31 March 2018: none).

17. Financial instruments

17.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

As the CCG is financed through Parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The CCG has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the CCG in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the CCG's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the CCG's internal auditors.

17.1.1 Currency risk

The CCG is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The CCG has no overseas operations. The CCG therefore has low exposure to currency rate fluctuations.

17.1.2 Interest rate risk

The CCG has no borrowings and has only limited powers to borrow funds from government for capital expenditure, subject to affordability as confirmed by NHS England. The CCG therefore has low exposure to interest rate fluctuations.

17.1.3 Credit risk

Because the majority of the CCG's revenue comes from Parliamentary funding, the CCG has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

17.1.4 Liquidity risk

The CCG is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The CCG draws down cash to cover expenditure, as the need arises. The CCG is not, therefore, exposed to significant liquidity risks.

Notes to the financial statements (continued)

17. Financial instruments (continued)

17.2 Financial assets

	Financial Assets measured at amortised cost 31 March 2019 £000	Total 31 March 2019 £000	Financial Assets measured at amortised cost 31 March 2018 £000	Total 31 March 2018 £000
Trade and other receivables:				
· NHSE bodies	676	676	296	296
· Other DHSC group bodies	51	51	59	59
· External bodies	304	304	995	995
Cash at bank and in hand	406	406	166	166
Total at 31 March	**1,437**	**1,437**	**1,516**	**1,516**

17.3 Financial liabilities

	Other 31 March 2019 £000	Total 31 March 2019 £000	Other 31 March 2018 £000	Total 31 March 2018 £000
Trade and other payables:				
· NHSE bodies	45	45	239	239
· Other DHSC group bodies	13,270	13,270	16,156	16,156
· External bodies	13,266	13,266	8,300	8,300
Other financial liabilities	412	412	652	652
Total at 31 March	**26,993**	**26,993**	**25,347**	**25,347**

18. Operating segments

The CCG has considered the definition of an operating segment contained within IFRS 8 in determining its operating segments, in particular considering the internal reporting to the CCG's Governing Body, considered to be the 'chief operating decision maker' of the CCG, which was used for the purpose of resource allocation and assessment of performance.

All activity performed by the CCG relates to its role as a commissioner of healthcare for its relevant population. As a result, the CCG considers that it has only one operating segment, being the commissioning of healthcare services.

An analysis of both the income and expenditure and net assets relating to the segment can be found in the Statement of Comprehensive Net Expenditure and Statement of Financial Position respectively.

19. Pooled budgets

The CCG entered into a pooled budget in relation to the loan of community equipment with:

- Middlesbrough Council
- Stockton-on-Tees Borough Council
- Hartlepool Borough Council
- NHS South Tees CCG

The pool for Tees Community Equipment Services is hosted by Middlesbrough Council. Under the arrangement, funds are pooled under Section 75 of the NHS Act 2006 for the loan of community equipment. The memorandum account for the pooled budget is:

	2018/19 £000	2017/18 £000
Income	1,420	1,295
Expenditure	(1,402)	(1,282)
Net Underspend	**18**	**13**

The CCG entered into a pooled budget arrangement with Hartlepool Borough Council and Stockton-on-Tees Borough Council in respect of the Better Care Fund, with effect from 1 April 2015, through a section 75 agreement.

The CCG contribution to the pooled budget in 2018/19 was £19,124k which was used to commission a range of health and social care services in line with the agreed objectives of the Better Care Fund (2017/18: £18,808k). The Better Care Fund provides a vehicle for furthering integration between health and social care to support the transformation that is required to address the sustainability in the system. This contribution to the Better Care Fund is recognised within the financial statements as CCG expenditure.

- Hartlepool Borough Council (Better Care Fund)	2018/19 £000	2017/18 £000
Income	8,381	6,923
Expenditure	(8,381)	(6,923)
Net Underspend	**0**	**0**

- Stockton-on-Tees Borough Council (Better Care Fund)	2018/19 £000	2017/18 £000
Income	20,306	18,820
Expenditure	(18,906)	(17,486)
Net Underspend	**1,400**	**1,334**

Notes to the financial statements (continued)

20. Related party transactions

During the year the CCG has undertaken transactions with the following CCG Governing Body members or members of the key management staff, or parties related to any of them:

CCG Governing Body	Role	Dates	Related Party	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Dr Neil O'Brien	Clinical Chief Officer (Accountable Officer)	01/10/2018 - 31/03/2019	NHS Darlington CCG	195	114	-	53
Dr Neil O'Brien	Clinical Chief Officer (Accountable Officer)	01/10/2018 - 31/03/2019	NHS Durham Dales, Easington And Sedgefield CCG	42	206	-	-
Dr Neil O'Brien	Clinical Chief Officer (Accountable Officer)	01/10/2018 - 31/03/2019	NHS North Durham CCG	233	27	-	40
Dr Neil O'Brien	Clinical Chief Officer (Accountable Officer)	01/10/2018 - 31/03/2019	NHS South Tees CCG	6,092	934	-	58
Dr Neil O'Brien	Clinical Chief Officer (Accountable Officer)	01/10/2018 - 31/03/2019	Academic Health Science Network For The North East & North Cumbria Ltd	15	-	1	-
Dr Stewart Findlay	Chief Officer	01/10/2018 - 31/03/2019	NHS Darlington CCG	195	114	-	53
Dr Stewart Findlay	Chief Officer	01/10/2018 - 31/03/2019	NHS Durham Dales, Easington And Sedgefield CCG	42	206	-	-
Dr Stewart Findlay	Chief Officer	01/10/2018 - 31/03/2019	NHS North Durham CCG	233	27	-	40
Dr Stewart Findlay	Chief Officer	01/10/2018 - 31/03/2019	NHS South Tees CCG	6,092	934	-	58
Dr Stewart Findlay	Chief Officer	01/10/2018 - 31/03/2019	North of England Commissioning Support	5,063	-	20	-
Graeme Niven	Chief Finance Officer	01/04/2018 - 31/03/2019	NHS Darlington CCG	195	114	-	53
Graeme Niven	Chief Finance Officer	01/04/2018 - 31/03/2019	NHS South Tees CCG	6,092	934	-	58
Nicola Bailey	Chief Officer	01/10/2018 - 31/03/2019	NHS Darlington CCG	195	114	-	53
Nicola Bailey	Chief Officer	01/10/2018 - 31/03/2019	NHS Durham Dales, Easington And Sedgefield CCG	42	206	-	-
Nicola Bailey	Chief Officer	01/10/2018 - 31/03/2019	NHS North Durham CCG	233	27	-	40
Nicola Bailey	Chief Officer	01/10/2018 - 31/03/2019	NHS South Tees CCG	6,092	934	-	58
Karen Hawkins	Director of Commissioning & Transformation	01/04/2018 - 31/03/2019	NHS Darlington CCG	195	114	-	53
John Flook	Lay Member (Audit and Governance)	01/04/2018 - 31/03/2019	NHS Darlington CCG	195	114	-	53
Andie Mackay	Lay Member	01/04/2018 - 31/03/2019	Stockton-on-Tees Borough Council	18,528	111	248	-
Andie Mackay	Lay Member	01/04/2018 - 31/03/2019	NHS Darlington CCG	195	114	-	53
Jean Golightly	Director of Nursing and Quality	01/04/2018 - 31/03/2019	NHS South Tees CCG	6,092	934	-	58
Lisa Tempest	Director of Planning, Performance & Assurance	01/04/2018 - 31/03/2019	NHS Darlington CCG	195	114	-	53
Dr Boleslaw Posmyk	Chair of Governing Body	01/04/2018 - 31/03/2019	Havelock Grange Practice	1,829	-	-	-
Dr Boleslaw Posmyk	Chair of Governing Body	01/04/2018 - 31/03/2019	Hartlepool & Stockton Health LTD	2,286	-	-	-
Dr Boleslaw Posmyk	Chair of Governing Body	01/04/2018 - 31/03/2019	NHS Darlington CCG	195	114	-	53
Dr Adam Hassan	GP Governing Body Member	01/04/2018 - 31/03/2019	Woodlands Family Medical Centre	1,646	-	-	-
Dr Adam Hassan	GP Governing Body Member	01/04/2018 - 31/03/2019	Hartlepool & Stockton Health LTD	2,286	-	-	-
Dr Adam Hassan	GP Governing Body Member	01/04/2018 - 31/03/2019	Elm Tree practice	523	-	-	-
Dr Adam Din	GP Governing Body Member	01/04/2018 - 31/03/2019	Havelock Grange Practice	1,829	-	-	-
Dr Adam Din	GP Governing Body Member	01/04/2018 - 31/03/2019	Hartlepool & Stockton Health LTD	2,286	-	-	-
Dr Judith Donkin	GP Governing Body Member	01/04/2018 - 31/03/2019	Hartlepool & Stockton Health LTD	2,286	-	-	-
Dr Judith Donkin	GP Governing Body Member	01/04/2018 - 31/03/2019	Marsh House Medical Centre	997	-	-	-
Dr Nick Timlin	GP Governing Body Member	01/04/2018 - 31/03/2019	McKenzie House Surgery	3,279	-	-	-
Dr Nick Timlin	GP Governing Body Member	01/04/2018 - 31/03/2019	Hartlepool & Stockton Health LTD	2,286	-	-	-
Dr Nick Timlin	GP Governing Body Member	01/04/2018 - 31/03/2019	Alice House Care Agency	4	-	-	-
Steve Rose	Lay Member (Patient and Public Involvement)	01/02/2019 - 31/03/2019	Catalyst Stockton On Tees Ltd	529	320	-	-
Dr Andrea Jones	Chief Clinical Officer	01/04/2018 - 31/12/2018	NHS Darlington CCG	195	114	-	53
Ali Wilson	Chief Officer	01/04/2018 - 30/09/2018	NHS Darlington CCG	195	114	-	53

All of these transactions were undertaken under standard terms and conditions in the normal course of business.

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

- NHS England (including North of England Commissioning Support Unit);
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Resolution;
- NHS Business Services Authority; and,
- NHS Property Services.

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Stockton-on-Tees Borough Council and Hartlepool Borough Council.

The increase in related parties disclosed in the table above relate to the collaborative working arrangements from the 1st October 2018, where CCG Governing Members are jointly appointed across Hartlepool and Stockton-on-Tees CCG, Darlington CCG, Durham Dales, Easington and Sedgefield CCG, North Durham CCG and South Tees CCG.

2017/18 comparative figures:

During 2017/18 the CCG undertook transactions with the following Governing Body members or members of the key management staff, or parties related to any of them:

Governing Body member		Dates	Related Party	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Dr Andrea Jones	Chief Clinical Officer	01/10/2017 - 31/03/2018	NHS Darlington CCG	426	374	15	-
Ali Wilson	Chief Officer	01/04/2017 - 31/03/2018	NHS Darlington CCG	426	374	15	-
Ali Wilson	Chief Officer	01/04/2017 - 31/03/2018	County Durham & Darlington NHS FT (North East Leadership academy)	1,414	-	102	-
Ali Wilson	Chief Officer	01/04/2017 - 31/03/2018	North of England Commissioning Support	5,774	-	111	-
Dr Boleslaw Posmyk	Chair of Governing Body	01/04/2017 - 31/03/2018	Havelock Grange Practice	1,708	-	4	-
Dr Boleslaw Posmyk	Chair of Governing Body	01/04/2017 - 31/03/2018	Hartlepool & Stockton Health LTD	1,863	-	31	-
Graeme Niven	Chief Financial Officer	01/04/2017 - 31/03/2018	NHS Darlington CCG	426	374	15	-
Lisa Tempest	Director of Planning, Performance & Assurance	01/04/2017 - 31/03/2018	NHS Darlington CCG	426	374	15	-
Karen Hawkins	Director of Commissioning & Transformation	01/04/2017 - 31/03/2018	NHS Darlington CCG	426	374	15	-
Jean Golightly	Executive Nurse	01/04/2017 - 31/03/2018	NHS South Tees CCG	4,460	77	98	193
Dr Nick Timlin	GP Governing Body Member	01/04/2017 - 31/03/2018	McKenzie House Surgery	2,890	-	-	-
Dr Nick Timlin	GP Governing Body Member	01/04/2017 - 31/03/2018	Hartlepool & Stockton Health LTD	1,863	-	31	-
Dr David Hodges	Governing Body Member	01/04/2017 - 31/03/2018	Alma Medical Centre	1,173	-	2	-
Dr David Hodges	Governing Body Member	01/04/2017 - 31/03/2018	Hartlepool & Stockton Health LTD	1,863	-	31	-
Dr David Hodges	Governing Body Member	01/04/2017 - 31/03/2018	Queens Park Medical Centre	2,391	-	8	-
Hilary Thompson	Lay member for public and patient involvement	01/04/2017 - 31/03/2018	Hartlepool Families First	1	-	-	-
Dr Adam Hassan	GP Governing Body Member	01/04/2017 - 31/03/2018	Woodlands Family Medical Centre	1,582	-	4	-
Dr Adam Hassan	GP Governing Body Member	01/04/2017 - 31/03/2018	Hartlepool & Stockton Health LTD	1,863	-	31	-
Dr Adam Hassan	GP Governing Body Member	01/04/2017 - 31/03/2018	Elm Tree practice	616	-	1	-
Andie MacKay	Governing Body Lay Member	01/04/2017 - 31/03/2018	Stockton-on-Tees Borough Council	11,251	38	1,508	-
Andie MacKay	Governing Body Lay Member	01/04/2017 - 31/03/2018	NHS Darlington CCG	426	374	15	-
John Flook	Governing Body Lay Member	01/04/2017 - 31/03/2018	NHS Darlington CCG	426	374	15	-

All of these transactions were undertaken under standard terms and conditions in the normal course of business.

Notes to the financial statements (continued)

21. Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the CCG.

22. Losses and special payments

There have been no losses or special payments identified in 2018/19 (2017/18: £1k).

23. Financial performance targets

CCGs have a number of financial duties under the NHS Act 2006 (as amended).

The CCG's performance against those duties was as follows:

	2018/19 Target £000	2018/19 Performance £000	2017/18 Target £000	2017/18 Performance £000
Expenditure not to exceed income	464,217	464,217	452,298	449,727
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	464,162	464,162	452,298	449,727
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	40,561	40,199	39,960	38,640
Revenue administration resource use does not exceed the amount specified in Directions	6,397	5,288	6,552	5,721

CCG financial performance is now reported on an in-year basis. The figures within this note reflect only the in-year position, being the difference between the in-year allocation (plus any pre-approved surplus drawdown) and total expenditure.

The CCG received no capital resource during 2018/19 and incurred no capital expenditure (2017/18: none).

Performance against the revenue expenditure duties is further analysed below:

	2018/19 Programme Resource £000	2018/19 Administration Resource £000	2018/19 Total £000
Revenue resource	457,765	6,397	**464,162**
Net operating cost for the financial year	458,874	5,288	**464,162**
(Overspend) / Underspend against revenue resource	**(1,109)**	**1,109**	**-**

	2017/18 Programme £000	2017/18 Administration £000	2017/18 Total £000
Revenue resource	445,746	6,552	**452,298**
Net operating cost for the financial year	444,006	5,721	**449,727**
Underspend against revenue resource	**1,740**	**831**	**2,571**

The CCG has delivered an in-year breakeven position in 2018/19. The underspend within Administration (running costs) was used during the year to increase spend on Programme (direct healthcare).

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS HARTLEPOOL AND STOCKTON-ON-TEES CLINICAL COMMISSIONING GROUP

Opinion

We have audited the financial statements of NHS Hartlepool and Stockton-on-Tees CCG for the year ended 31 March 2019 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 23. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2018/19 HM Treasury's Financial Reporting Manual (the 2018/19 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2018/19 and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England (the Accounts Direction).

In our opinion, the financial statements:

- give a true and fair view of the financial position of NHS Hartlepool and Stockton-on-Tees CCG as at 31 March 2019 and of its net operating costs for the year then ended; and
- have been properly prepared in accordance with the Health and Social Care Act 2012 and the Accounts Directions issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the Clinical Commissioning Group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGN01, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Clinical Commissioning Group's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The other information comprises the information included in the annual report set out on pages 3 to 149 other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Health and Social Care Act 2012

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health and Social Care Act 2012 and the Accounts Directions issued thereunder.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the Governance Statement does not comply with the guidance issued by the NHS Commissioning Board; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Clinical Commissioning Group, or an officer of the Clinical Commissioning Group, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Clinical Commissioning Group under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the Clinical Commissioning Group has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We have nothing to report in these respects.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's Responsibilities set out on page 102, the Accountable Officer is responsible for the preparation of the financial

statements and for being satisfied that they give a true and fair view and is also responsible for ensuring the regularity of expenditure and income.

In preparing the financial statements, the Accountable Officer is responsible for assessing the Clinical Commissioning Group's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or have no realistic alternative but to do so.

As explained in the Governance Statement, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Clinical Commissioning Group's resources. We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the Clinical Commissioning Group has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether the Clinical Commissioning Group had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Clinical Commissioning Group put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Clinical Commissioning Group had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the Clinical Commissioning Group has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local

Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Clinical Commissioning Group's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Report on Other Legal and Regulatory Requirements

Regularity opinion

We are responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (the Code of Audit Practice).

We are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

In our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Certificate

We certify that we have completed the audit of the accounts of NHS Hartlepool and Stockton-on-Tees CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Governing Body of NHS Hartlepool and Stockton-on-Tees CCG in accordance with Part 5 of the Local Audit and Accountability Act 2014 and for no other purpose. Our audit work has been undertaken so that we might state to the members of the Governing Body of the Clinical Commissioning Group those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the members as a body, for our audit work, for this report, or for the opinions we have formed.

Nicola Wright (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Newcastle-upon-Tyne
28 May 2019

The maintenance and integrity of the NHS Hartlepool and Stockton-on-Tees CCG web site is the responsibility of the members; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

HEALTH AND WELLBEING BOARD

23rd September 2019

Report of: Director of Children's and Joint Commissioning Services and Stockton-on-Tees Clinical Commissioning Group

Subject: SEND (SPECIAL EDUCATIONAL NEEDS AND DISABILITIES) IMPROVEMENT PLAN PROGRESS

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1. PURPOSE OF REPORT

1.1 To share with members of the Health and Wellbeing Board progress on the local areas SEND Improvement Plan.

1.2 For members to be sighted on the progress in relation to SEND and offer challenge and support on areas that are not making sufficient progress.

2. BACKGROUND

2.1 The Special Educational Needs and Disability (SEND) provisions in the Children and Families Act 2014 were introduced on 1 September 2014. This act sets out duties for all partners with a particular focus on the local authority, CCG (Clinical Commissioning Group) and education providers. From September 2014, children or young people who are newly referred to a local authority for assessment are considered under the new Education, Health and Care (EHC) plan assessment process.

2.2 The SEND code of practice: 0 to 25 gives detailed information on the reforms. The Code of Practice provides guidance to help the Local Authority, schools, health services and social care more identify children with SEN.

2.3 Ofsted and CQC have been commissioned to undertake inspections of local areas in their implementation of the Code of Practice and Hartlepool was inspected in October 2016 and found to have four areas of weaknesses.

2.4 Subsequently the area was revisited in January 2019 to review progress in each of the areas of weakness. Inspectors felt that the area had not made sufficient progress in two of the areas:

a) Inconsistencies in the timeliness and effectiveness of the local area's arrangements for identifying and assessing children and young people's special educational needs and/or disabilities
b) Weaknesses in the strategic joint commissioning of services for children and young people who have special educational needs and/or disabilities

3. PROGRESS

3.1 The improvement plan has been submitted to the Department for Education and is attached as **Appendix A**. The plan has been updated up to reflect the position at the end of August 2019 and will be updated following the next SEND operational group against the end of September milestones. This will be reported to the SEND governance group meeting on 8th October and then to the next Health and Wellbeing Board.

3.2 Actions within the plan have been reviewed and it is important to report, by exception, to the Health and Wellbeing Board actions where milestones have not been met as follows:

- Balanced scorecard (page 2 of the improvement plan) - has been produced however the first completed iteration of this will provide a summary baseline of the current position for the academic year 2018/19. The scorecard will then be updated and reported to the governance group and board quarterly. This will provide performance comparison information against the baseline position where appropriate giving a clear picture of our performance progress.
- Audit activity (page 2 of the improvement plan) – A quality assurance tool has been developed and an audit planning session has taken place. This is the first stage of our multi-agency quality assurance process and with advice from our Department for Education SEND adviser it has been agreed the primary focus will be on ensuring that we are meeting minimum standards required within the Code of Practice. Once we have assurance that minimum standards have been achieved the audit process will establish a benchmark for "good". In the meantime we will determine whether the cases audited are satisfactory or not satisfactory against the minimum standards and this is will be reported to the governance group and Board.
- Development and use of an outcome star within children and young people's plans and reviews (page 6 of the improvement plan) - The work to achieve needs to be accelerated. Strategic leaders have identified this through the strategic group and a specific action plan has been established to ensure that this is implemented at the earliest opportunity. Progress of this will be overseen by the strategic group and reported in the next update to the Health and Wellbeing Board

4. RISK IMPLICATIONS

4.1 There is a risk that if leaders do not hold each other to account to ensure that the plan is implemented the Secretary of State will intervene.

4.2 There is a risk that if agencies do not work together that the system will be difficult to navigate for children with SEND and their families. This will prevent children and young people improving their outcomes and reaching their full potential.

5. FINANCIAL CONSIDERATIONS

5.1 There are no specific financial considerations within this report.

6. LEGAL CONSIDERATIONS

6.1 There are no specific legal considerations within this report, however all partners must ensure they are meeting their duties within the Children and Families Act 2014.

7. EQUALITY AND DIVERSITY CONSIDERATIONS (IMPACT ASSESSMENT FORM TO BE COMPLETED AS APPROPRIATE.)

7.1 The services discussed in this report support children with additional needs.

8. STAFF CONSIDERATIONS

8.1 There are no staff considerations within this report.

9. ASSET MANAGEMENT CONSIDERATIONS

9.1 There are no asset management considerations within this report.

10. RECOMMENDATIONS

10.1 That members of the Health and Wellbeing Board note the progress of SEND improvement plan and the remedial actions being taken where milestones have not been met/changed.

10.2 That members of the Health and Wellbeing Board reflect on their duties for children under the Children and Families Act 2014 to ensure that children with SEND are supported as appropriate.

11. REASONS FOR RECOMMENDATIONS

11.1 To ensure that children with SEND are appropriately supported.

12. BACKGROUND PAPERS

SEND Code of Practice
https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

13. CONTACT OFFICER

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Hartlepool SEND Improvement Plan Appendix A

April 2019 (Updated August 2019)

A joint local area inspection of Hartlepool's effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities (SEND) took place in October 2016. This inspection identified four areas of significant weakness which were detailed in a written statement of action (WSOA). The local area jointly submitted an action plan to tackle the areas of weakness which was declared fit for purpose by Ofsted on 24 April 2017.

The local area convened an Improvement Board that oversaw the implementation of the action plan which made some positive progress to deliver the required improvements. In January 2019, Ofsted and the Care Quality Commission revisited Hartlepool to assess whether the local area had made sufficient progress in addressing the areas of significant weakness detailed in the written statement of action. During the revisit, inspectors found that we had not made sufficient progress in two of the four areas included in the Written Statement of Action, although acknowledged that we had undertaken significant work in tackling these outstanding issues. During the revisit, the inspectors told us that our governance arrangements were not robust enough as our SEND Improvement Board, established in February 2017, had responsibility for delivering the improvements as well as holding ourselves to account on the effectiveness of this. This resulted in a lack of progress in the two areas:

- Inconsistencies in the timeliness and effectiveness of the local area's arrangements for identifying and assessing children and young people's special educational needs and/or disabilities; and
- Weaknesses in the joint commissioning of services for children and young people who have special educational needs and/or disabilities.

As a consequence of the insufficient progress made in the above detailed areas of weakness, a further, more rigorous improvement plan has been produced to accelerate the pace of change to tackle these two outstanding weaknesses.

The Hartlepool local area is committed to delivering this plan to improve the quality of services provided to children and young people with special educational needs and disabilities, ensuring their needs are identified and assessed in a timely way and the arrangements for joint commissioning are substantially improved resulting in a more responsive service.

The timescales detailed within this action plan will be monitored by a newly formed Strategic Group of accountable officers who will receive six weekly reports from the Operational Group and in turn be accountable to the Hartlepool Health and Wellbeing Board. Within 12 months, the Health and Wellbeing Board will have received the report of a Local Government Association Peer Review which will demonstrate that the improvement plan has been delivered and the local area has implemented the necessary improvements to the quality of services to children and young people with Special Educational Needs and / or Disabilities.

Hartlepool SEND Improvement Plan

Appendix A

April 2019 (Updated August 2019)

Weakness to be addressed: System governance for delivery of SEND services for the children and young people of Hartlepool. **We will know this is working well when**: The effectiveness of the local system is held to account by itself and internal and external scrutiny									
Objective	Actions	Intended Outcomes/ Impact Measures	Responsible Person(s) / Post	**Milestones**					
				By 31/05/19	Status	By 30/09/19	Status	By 31/03/20	Status

Hartlepool SEND Improvement Plan

Appendix A

April 2019 (Updated August 2019)

The governance arrangements provide effective strategic and operational accountability. Clearly identified action plan to deliver improvements with robust accountability and reporting arrangements. Local area leaders are sighted on delivery of this improvement plan and hold those working within the system to account to achieve the required improvements. Local leaders take swift action to address barriers, delays or systemic issues that impact on progress. Strategic leaders are individually responsible for the implementation of this improvement plan within their own organisation and escalate risk to their own internal governance. Collectively HWB board will hold strategic leaders to account for the delivery of this plan.	Implement revised governance arrangements for local area SEND ensuring there is clear understanding of accountability and governance across all stakeholders. Workstreams produce 6 weekly reports which track progress, milestones, issues and risks for strategic group. Strategic group will be responsible for tracking progress against milestones within this action plan and taking remedial action where these are not achieve.	Local governance arrangements hold all organisations to account for the delivery of the SEND Strategy and the improvement of performance including related outcomes for children and young people with SEND. **Evidence by: Minutes of meetings and action logs demonstrating timely discussions and monitoring of the plan** Children, young people, parents, family members and carers will understand how the system is working to deliver SEND services and improvements. Children, young people, parents and carers will feel that the system works for them and shape and design the development of services. Children, young people and parents/ carers will provide feedback on the effectiveness of the local arrangements leading to evaluation and continuous improvement. **Evidence by: Parents and Carer representation attend strategic/decision making meetings. Minutes of governance meetings.**	Director of Children's and Joint Commissioning Services HAST CCG Director for Childrens Services Chair of Health and Wellbeing Board Chair of One Hart, One Mind, One Future (PCF) HeadTeacher representative	New governance arrangements in place: 1. Separation of current Improvement Board into distinct Operational and Strategic functions. 2. Revised Terms of Reference in place outlining lines of accountability including to Health and Wellbeing Board. First Progress Report presented to strategic group. All organisations understand the challenges and need for accelerated progress and understand their role in delivering this action plan. Local balanced scorecard produced which details performance measures of compliance, impact and effectiveness.	Complete Complete Complete Complete	Health and Wellbeing Board holds challenge session to review the effectiveness of new governance arrangements in ensuring all partners are fulfilling their responsibilities to deliver this improvement plan and system change. Second Progress Report presented to Health and Wellbeing Board, CCG Exec/Governing Body and LA committees. Any risks escalated to Audit and Governance Committee. Balance scorecard shows improvements in performance. Findings from audits of EHC Plans received by strategic group identifying areas of strength and areas for improvement and actions required to tackle these.	Complete To present on 23rd Sept. Balance score card has been produced with baseline information populated – to be updated quarterly Audit session to take place beginning of Sept Findings being presented to Strategic group on 8/10/2019	One year on report presented to Health and Wellbeing Board demonstrates areas of weakness fully addressed and significantly improved performance in compliance, impact and outcomes. Peer review completed and findings presented to Health and Wellbeing Board confirming Improvement Plan delivered. Systems improvement embedded business as usual in good performing local area.	

Hartlepool SEND Improvement Plan

Appendix A

April 2019 (Updated August 2019)

Weakness to be addressed: Limited and inconsistent assurance around the timeliness, quality and effectiveness of the local area's arrangements for identifying and assessing children and young people's special educational needs and/or disabilities

We will know this is working well when: Local area effectively identifies and assesses children and young people with SEND through timely high quality and effective plans that lead to improved outcomes

Objective	Actions	Intended Outcomes/ Impact Measures	Responsible Person(s) / Post	Milestones					
				By 31/05/19	Status	By 30/09/19	Status	By 31/03/20	Status
80% of EHC Plans completed within 20 week timescale. For those not completed within timescales this is Identified at the earliest possible opportunity and based on the best interests of the child and family. Performance in relation to timeliness of assessments is rigorously monitored by strategic group and reported to the HWB and action taken where the above two actions have not been met.	Strategic group to receive report on the baseline position and 6 weekly thereafter in relation to timeliness and compliance. These reports will also include an analysis of reasons for non-compliance and remedial action being undertaken. Performance report to be shared with all partners and a system action plan developed to address barriers impacting on compliance. A review of the SEND training offer to be completed and updated to address any workforce development needs based identified areas for improvement. Workforce development plan with named lead facilitators to be published on Local Offer with strategic partners identifying key staff within their organisations to attend.	An increase in the completion in high quality effective EHC plans within statutory timescales Strategic group has accurate and real time performance information to address areas for improvement within individual organisations and across system Well trained and skilled workforce that understands its role within the EHC Plan process and consistently provide high quality information in a timely manner that leads to good plans being developed within timescales that meet need. **Evidence by: Balance scorecard including parental satisfaction**	Head of SEND, HBC Director of Nursing North Tees and Hartlepool NHS Foundation Trust School reps - SENDCO from each school cluster Locality Manager (CAMHS) Tees Esk and Wear Valley NHS Foundation Trust Local area operational group	Baseline report and action plan on timeliness and compliance outlining performance on an individual agency basis considered by strategic group. SEND training offer reviewed and dates set throughout the year for the roll out of the revised workforce development plan. Workforce development plan identifies targeted staff who need to participate in training.	Complete Complete Complete	70% of EHC plans completed within 20 week timescale 6 weekly reports received by strategic group 40% of identified practitioners have engaged in SEND workforce development programme. Workforce development offer evaluated based on feedback from participants and improvements identified. Parental satisfaction survey undertaken	75% completed within timescale (SEN2) Have achieved 75% therefore have amended action: *Balance scorecard populated and reported to strategic group quarterly* Complete Complete To be completed by 23rd Sept	80% of EHC Plans completed within 20 week timescale. 100% of identified practitioners participated in SEND workforce development programme. Workforce development programme continuously updated as per feedback from participants and established as within core workforce development offer to staff.	

Hartlepool SEND Improvement Plan

Appendix A

April 2019 (Updated August 2019)

EHC plans are of high quality and are effective leading to improved outcomes for children and young people with SEND	Undertake a piece of work to identify best practice regionally and nationally in EHC plans using PCF and their networks to identify excellence. Define and develop a quality audit tool against which to understand baseline of local performance and improvements required. Implement quarterly audit activity which will be reported within balanced scorecard to strategic group and HWB. Delivery of audit improvement plan to meet identified areas of concern to drive continuous improvement in the quality of EHC plans.	All Hartlepool EHC Plans are legally compliant. EHC plans are consistently of a high quality individualised and meet needs the child / young person. All EHC Plans are outcome focused with SMART objectives to enable impact to be measured. SMART objectives are based upon stretch targets for the individual child / young person. Language used within the plan enables clarity of understanding by child / young person / family / carer / professionals. Ensuring that specialist advice and guidance within plans are of high quality and accessible to families. **Evidence by: Balance scorecard audit activity which shows improving picture.**	Head of SEND, HBC Assistant Director, Education, HBC Director of Nursing North Tees and Hartlepool NHS Foundation Trust Locality Manager (CAMHS) Tees Esk and Wear Valley NHS Foundation Trust Local area operational group	Best practice identified and benchmark set Quality assurance tool devised and date set for first audit. Multi-agency quality assurance cycle established, date set for first audit and audit team identified including representatives from PCF.	Complete Complete Complete	Two audit days completed. Report of audit findings prepared including plan to address of areas for improvement. Report presented to Strategic Group and HWB Audit activity evidences improvement in quality of plans. Target: > 60 %judged good or better DfE SEND Professional adviser to moderate audit findings and reports and advice local area to add value. Parental satisfaction survey in partnership through PCF	Two dates set up: 10th Sept 2019 1st October 2019 To be completed by 20th Sept 2019 8/10/19 Strategic Group 18/11/19 HWB board Amended action: *Audit sets baseline for plans meetings minimum standards of CoP* Will moderate audit from 10th Sept To be completed by 23rd Sept	LGA Peer Review completed of the local area SEND arrangements including a case review of the timeliness, quality and effectiveness of EHC plans. LGA Peer Review report presented to HWB Audit activity evidences improvement in quality of plans. Target: > 80 % judged good or better	

Hartlepool SEND Improvement Plan

Appendix A

April 2019 (Updated August 2019)

Weakness to be addressed: Weaknesses in the joint commissioning of services for children and young people who have SEND.

We will know this is working well when: We have a detailed and comprehensive understanding of the needs of children and young people with SEND and their families. Services are commissioned in a more integrated way and working together effectively to meet need.

Objective	Actions	Intended Outcomes/ Impact Measures	Responsible Person(s) / Post	**Milestones**					
				By 31/05/19	Status	By 31/09/19	Status	By 31/03/19	Status
To understand current and projected need of children and young people with SEND.	A systematic review of all available data which will include prevalence data, analysis and forward projection of needs of the SEND population. Joint Strategic Needs Analysis will detail an evidence based robust needs analysis of the local area's SEND population A sufficiency assessment will be prepared based on refreshed JSNA. This will identify gaps in service provision and areas where services need to be developed, wherever possible, through a joint commissioning approach.	The JSNA and sufficiency assessment will provide local leaders with an understanding of need and the gaps in service provision to allow for the effective joint planning and commissioning of services. The sufficiency assessment will identify specific service areas that require review and/or re-commissioning and /or decommissioning. These areas will be addressed within the joint commissioning strategy. **Evidenced by:** **Sufficiency assessment published** **JSNA refreshed** **Joint commissioning plan that is SMART** Local area will jointly commission services for children and young people with SEND that have high levels of user satisfaction. **Evidenced by:** **CYP families report they are satisfied with services provided.**	Assistant Director, Joint Commissioning, HBC Head of Commissioning and Strategy, CCG Director of Public Health Schools Parent Carer Forum	Consultation to inform needs assessment and potential joint commissioning opportunities with all schools Accurate local Information provided, collated and analysed and shared with strategic group Updated qualitative JSNA completed which reflects joint priorities and targets across education, health and care.	Complete Complete Complete	Needs assessment, sufficiency assessment and draft joint commissioning strategy presented to Strategic Group and Health and Wellbeing Board	Needs assessment and strategy in draft – to be finalised by end of Sept To go to: Strategic Group 8/10/19 HWB 18/11/19	Year 1 priorities services jointly commissioning and commenced delivery First quarter contract information presented to Health and Wellbeing Board Health and Wellbeing board receives a progress report against the joint commissioning plan	

Hartlepool SEND Improvement Plan

Appendix A

April 2019 (Updated August 2019)

To jointly commission services that meet the needs for children and young people with SEND and their families	Review TOR for joint commissioning workstream Develop and implement local area Joint commissioning Strategy and three year plan which identifies agreed priorities between education, health and Local Authority. Develop and implement system wide reviews of service provision across health, education and social care.	Partners are jointly commissioning services based on needs and priorities. **Evidenced by:** **Commissioning Strategy approved and published** **Commissioning plan approved and published** There is a mechanism for addressing the commissioning requirements needed to deliver the Joint Commissioning strategy and action plan. **Evidenced by:** **Action logs of operational group** The joint commissioning strategy and plan is co-produced by Children, young people and their families **Evidenced by:** **Commissioning process paperwork** **PCF minutes** **Operational strategic group minutes**	Assistant Director, Joint Commissioning, HBC Head of Commissioning and Strategy, CCG Head of Strategic Commissioning, (Childrens), HBC Director of Public Health	Revised Terms of Reference for joint commissioning workstream in place Joint Commissioning workstream has met and developed timeline for development and implementation of strategy	Complete Complete	Draft joint commissioning strategy approved by Health and Wellbeing Board System wide review of service provision has commenced.	Draft needs assessment and strategy in place to be finalised end of September. To be presented to HWB 18/11/19 (due to availability of meetings) This has commenced	Year 1 priorities services jointly commissioning and commenced delivery First quarter contract information presented to Health and Wellbeing Board Health and Wellbeing board receives a progress report against the joint commissioning plan. System wide review of service provision has been completed and presented to HWB. All redesigned and or commissioned services for children and young people with SEND will have a positive impact on outcomes	
Measure the impact of the effectiveness of services in improving outcomes for children and young people with SEND.	Refine and conclude the implementation of our approach to evaluating and measuring outcomes. Strengthen the review process in measuring the impact of the plan in improving outcomes for children and young people.	Children experience improved outcomes from the implementation of effective EHC plans Local leaders know if services are making a positive impact on the lives of children, young people with SEND and their families. If children are not making expected progress local leaders understand why and work together to address system issues. All services for children and young people with SEND will have a positive impact on outcomes. **Evidenced by:**	Operational group Strategic group	Pilot within SLT and Education completed and outcomes framework refined from findings of pilot. Develop an outcomes star to show progress of children and young people with SEND.	Completed and shared with Ops group NOT COMPLETED	Implement outcomes star Commence roll out of outcomes framework starting with Physio, OT and social care with review processes in place (SLT and education to continue) Reporting template developed and impact and outcomes reported to strategy group	NOT COMPLETED NOT COMPLETED NOT COMPLETED	Outcomes star and outcomes framework fully implemented across all services and report of impact presented to HWB Outcomes framework embedded within balanced scorecard.	

		Balanced scorecard reports to strategic group and HWB.							