A Clear and Credible Plan for Commissioning Health Services
2012 - 2017
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Foreword

Making a difference to the community we live and work in is the most important aspect of the new way of working that we will be talking about in this plan. This new Clinical Commissioning Group is being set up to do just this.

We want to see a health service that provides high quality and safe care to all local people that meet our 21st century requirements and help us reduce the inequality that exists across our communities and looks to keep improving.

We want to see everyone get healthier, but we want the health of the most vulnerable around us to be as good as that of the most fortunate.

Clinical commissioning is about serving our local communities and patients better by allowing GP Practices to make the important decisions as to how money is used and how NHS services can be improved. We have a real opportunity to improve local healthcare and reduce health inequalities.

We will be creating a truly clinically led organisation that embraces the skills, experience and knowledge of health professionals from different providers and from different backgrounds. We all talk a common language and get particularly passionate when we are engaged together planning how to get better clinical services.

Based on feedback from patients, the community and GP Practices three aspects stand out where we will need to show improvement:

- Quality of care and of the patient experience
- More timely access to care and care closer to home
- Equality of access and fairness in treatment

These important points are at the heart of our strategic outcomes. These are difficult to achieve. A finite budget and increasing demand will need us to make choices about the services we commission. Initially this will be focused on reducing unnecessary demand and reducing waste and inefficiency. These are the challenges we must face up to. “We” being the GP practices, the patients, the community, the providers of services and other partner organisations we work with. “Good health is everyone’s business”.

We must have the confidence to take the difficult decisions. We must do the right things, in the right way, to meet the needs of the people. We will do this by basing our decisions on clinical evidence and financial reality, by listening to patients and by co-ordinating what we do with other services.

As health professionals being given the responsibility to make these decisions we are in a privileged position of trust. We must balance the decisions we make between improving the health of the community and addressing individual needs. We must work well as a team with NHS managers and other partner organisations.

Having been honest about the challenges we face, as clinicians, we are also optimistic about the future. There are real opportunities we can take. For example:

- Making services more responsive to patient needs and expectations whilst improving quality and maximising efficiency
- Reducing the level of management cost and ensuring maximum investment in frontline care
- Working much more closely with partners such as the local council and health providers to streamline pathways of care and achieve better value.

This document sets out our objectives and our plan to achieve these over the next five years. We hope you find this inspiring and would welcome your comments, ideas and support. You can contact us on: 01642 745000 or www.hartlepoolandstocktonccg.nhs.uk.

And finally, thank you to everyone who has worked hard through considerable uncertainty to get us to where we are today. We are only at the start of a long journey, but one that we are confident will prove rewarding and successful. Please continue to give us your time, commitment and feedback on how we are doing – it is greatly appreciated.

Dr Boleslaw Posmyk
Chair, NHS Hartlepool and Stockton-on-Tees CCG
Introduction

Who is this written for?
This plan is written for the public, patients, clinicians, stakeholders and those affected by healthcare in Hartlepool and Stockton-on-Tees. Approximately 192,400 people live in Stockton-on-Tees and 91,300 in Hartlepool.

What is this plan about?
This high level plan explains:
1) What the main healthcare issues are for Hartlepool and Stockton-on-Tees; and
2) How the new Clinical Commissioning Group (CCG) plans to improve these over the next five years.

Who are we?
The CCG is the organisation responsible for planning and paying for the services that the public and patients of Hartlepool and Stockton-on-Tees need. It will be led by those GPs who look after the resident population. A few GPs have been elected to represent the views of all the member practices in their endeavours to be the voice of their patients. The services they are responsible for planning and commissioning are:

- Mothers and newborns
- People with need for support with mental health
- People with learning disabilities
- People who need emergency and urgent care
- People who need routine operations
- People with long term conditions
- People at the end of life
- People with continuing healthcare needs

The CCG is a membership organisation of all the GP practices in the Hartlepool and Stockton-on-Tees area. The GP Practices each have a vote and collectively appoint a governing body to oversee the running of the CCG. The CCG employs a senior leadership team to run the CCG from day to day. Further details are included in the ‘Our Organisation’ section below.

Why has this come about?
Parliament passed new legislation called the Health and Social Care Act in March 2012. This transfers the responsibility for decisions about buying health services to GP Practices. The GP Practices in each area have to form an organisation to do this called a Clinical Commissioning Group (CCG). The CCG will be responsible for:

- Listening to patients needs
- Understanding the health issues
- Buying the services which offer the best value
- Promoting the involvement of patients in their care
- Improving healthcare effectiveness, safety and quality of experience
- Enabling patients to make healthcare choices
- Reducing the inequalities between patients of access to care and outcomes of care
- Integrating healthcare with other public services
How will we behave?

To be successful, the CCG needs to win and maintain the trust of the public, its staff and the organisations it works with. To do this the CCG signs up to these principles:

- **Being open** about its plans and consulting on them before making key decisions. The publication of this plan is the beginning of this process. We will regularly update our website to keep you informed and seek your views.
- **Acting with integrity and honesty.** We will work in the public interest and not to gain financial or other material benefits for ourselves, family, or friends. We will maintain a public register of our interests.
- **Acting objectively** making decisions on clinical and economic evidence
- **Having courage** to lead by taking difficult decisions when necessary and avoiding unnecessary delay. In particular, we will need to make plans that are realistic and affordable that discriminates between “needs” and “wants”.
- **We will be accountable** for our decisions and actions to the public and must submit ourselves to whatever scrutiny is appropriate. Our Governing Body will meet in public and we will report the results of our work regularly against the targets we have set.

Our Values

- be **patient focussed** – the needs of our patients will inform all that we do
- build **engagement** – we will engage with our communities, our members and our partners and apply what we learn when commissioning services for local people
- focus on **quality** – we will be driven by our commitment to continuously improving the quality and safety of services
- deliver **value** – we will ensure the services we commission represent best value
- maximise **efficiency** – we will be ensure we are responsive and efficient in our approach to commissioning
- improve **affordability** - we will ensure we commission wisely to maximise use of NHS resources discriminating between “needs” and “wants” to ensure our plans are realistic and affordable

- work with **transparency** – we will share the rational underpinning our commissioning decisions with our communities, our members and our partners

We will follow best practice in everything we do. We will follow the requirements of the NHS Constitution and our own CCG constitution. We will act in accordance with the seven Nolan Principles of Public Life. We also champion the seven principles enshrined in the NHS Constitution which are:

- The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief
- Access to NHS services is based on clinical need, not an individual’s ability to pay
- The NHS aspires to the highest standards of excellence and professionalism
- NHS services must reflect the needs and preferences of patients, their families and their carers
- The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
- The NHS is committed to providing best value for taxpayers’ money and the most effective, fair and sustainable use of finite resources
- The NHS is accountable to the public, communities and patients it serves

Further information:
The Nolan Principles are available at: [http://www.public-standards.gov.uk/Library/Seven_principles.doc](http://www.public-standards.gov.uk/Library/Seven_principles.doc)

How can patients and the community have a say in decisions?

A key aspect of the Health and Social Care Act 2012 is a commitment that patients and the public must be at the heart of everything health and social care services do. The CCG will encourage feedback and involvement wherever possible as follows:
The CCG is organised into two ‘localities’ to reflect the needs of the two communities of Stockton-on-Tees and Hartlepool. The practice representatives from each locality have a responsibility to represent their patients’ needs. Two of the GP representatives from each locality are part of the governing body of the CCG which makes the CCG’s decisions as well as a GP chair from the CCG area as a whole. An independent member of the governing body will have specific responsibility for patient and public involvement across the CCG.

The CCG works as part of the Health and Wellbeing Board for each locality. 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 in collaboration with other local agencies.

The CCG will work with the new local HealthWatch organisations which champion the views and experiences of patients, people using these services, carers and the wider public. HealthWatch will continue the functions currently provided by Local Involvement Networks (LINks)

The CCG will hold specific consultation and engagement events for big proposals and we welcome your feedback via your local GP and to the Chair via our website at: http://www.hartlepoolandstocktonccg.nhs.uk

The CCG will hold some of its governing body meetings in public and will include the public in the decisions as to how best to involve them in these meetings

The CCG will seek assurance from providers as to the steps they are taking to record and improve the patient experience. This will include monitoring collection of data and actions taken to address identified areas for improvement.

Direct patient feedback will be part of the way we work. All our member practices will have a representation through the Council of Members and through Locality leads. Localities are designed to ensure that very local intelligence is gathered and used to monitor service quality and make improvements.

We are encouraging each practice to have a patient participation group which directly engages with practice level patient issues – these are very active in, for example, the arena of reducing waste in medication.

Case study: Public engagement events
The CCG held public engagement events (Hartlepool 28 February 2012, and Stockton-on-Tees 2 May 2012) to discuss the establishment of the CCG and seek views on our plans. The feedback has been incorporated into this plan.

Further information:
Notes of Hartlepool engagement event:
http://www.hartlepool.nhs.uk/content/page.aspx?page=423
Notes of Stockton-on-Tees engagement event:
http://www.stockton-on-tees.nhs.uk/content/page.aspx?page=446
Our vision

What is our vision?

To build 21st century health services for and with the Stockton-on-Tees and Hartlepool communities so that health inequalities reduce and wellbeing continuously improves.

Our vision, values and aims have been developed in localities with input from clinicians, managers, partners, providers and patients. We describe below how we reached this vision.

Health Inequalities and Health Improvement

Improving peoples’ health goes beyond the NHS. Factors such as employment prospects and housing are equally as important. The 2010 report produced from the Marmot review ‘Fair Society, Healthy Lives’ emphasises the link between an individual’s socioeconomic position and good health. Analysis of the wider health challenges that face the people of Stockton-on-Tees and Hartlepool shows we must work with our partner organisations to address our major health inequalities and help people live healthier lives.

The Joint Strategic Needs Assessments (JSNAs) highlight the main health and wellbeing priorities for our residents taking account of data and information on inequalities within and between communities.

The JSNAs identify those health conditions that most affect people in Stockton-on-Tees and Hartlepool as:

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

The CCG has specific populations consisting of two localities; Stockton-on-Tees and Hartlepool. The burden of risks to population health is high across both localities including higher than national (England) average levels of behavioural risks to health such as smoking, excess alcohol consumption and lack of exercise. Some of the wider determinants of health, such as low educational attainment and unemployment are also crucial to seeing long-term improvements in health. As a result of these risks we see higher than average death rates and more ill-health. Health Inequalities are spread across the CCG and within localities e.g. smoking prevalence varying from 16% to 48%, and emergency admissions for heart disease are two and a half times more likely in the most deprived wards than in the least deprived.

We see from the analysis above that the poorest outcomes – in particular heart disease, stroke and cancer as well as those in poor health are significant – and particularly in Hartlepool. Death rates are lower in Stockton-on-Tees but remain higher than the England average. Tackling these big killers, the behaviours that contribute to them and the resulting health inequalities are key to our plans.

Prevalence predictions have been produced for some of the long term conditions that our residents suffer. We have produced predictions for chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), diabetes mellitus, hypertension and stroke. So we have ambitions to set clear targets to tackle the effects of these priority health conditions.
In 2010, a high-profile engagement campaign was undertaken with members of the public, one of the aims of which was to increase understanding of the local community’s views on key priorities for investment. Overall, the views of 1883 people were recorded via telephone, street and campervan interviews.

Respondents identified the priority topics most likely to affect them and their families as being:
- Cancer (24%),
- Healthy heart (23%)
- Smoking (17%),

Further information:
Further information on the health profiles for Stockton-on-Tees and Hartlepool can be found at: http://www.teespublichealth.nhs.uk/
2011 health profile for Hartlepool and Stockton-on-Tees
Joint Health and Well-being Strategies for Hartlepool and Stockton-on-Tees

We have an ageing population. We expect our over 65 year population to increase from 17% (44,400) to 22% (59,500) over the next 16 years. As larger numbers of older people live longer, more people are likely to develop diabetes, asthma and chronic airways disease while some people have more than one long term condition. This ageing population will see an increasing degree of dementia and therefore the associated demand for increased health and social care provision.

The CCG has built on the work already carried out by NHS Tees in developing the Integrated Cluster Plan and have consulted with key stakeholders including Patients, Health & Wellbeing Partnership and Local Authority Scrutiny Committees on how the CCG will take forward and complement current strategies in particular how we work through the Health and Wellbeing Boards to implement the Joint Health and Wellbeing strategies.

In October and November 2011, views were sought from patients, carers, members of the public and stakeholders across Teesside in order to ensure that this plan reflects the views of local people. There was significant consensus from patients on a few key themes or topics, with the most cited being:
- Quality of care and of the patient experience;
- Ensuring services represent value for money and reducing waste;
- Focusing on timely access to care and on care closer to home;
- Listening to patients / carers, effective communication and supporting choice;
- Staying true to the core values of the NHS, including care available to all, free at the point of delivery;
- Equality of access and fairness in treatment;
- Meeting the needs of the local community and supporting health improvement initiatives.

One of the main issues that the CCG has identified relates to patient experience. Patients are consistently highlighting issues on the complexity of what services to access and when to access them particularly Urgent Care. Linked to this, we need to tackle variation of health and treatment outcomes by ensuring all services follow agreed pathways determined by the most up to date evidence available – improving Quality in Primary Care is central to this. Our aims, values and strategic outcomes have been developed using this information to ensure our patients views are at the heart of our plans for improvement.

21st century healthcare delivering continuous improvement

Access to the right care, at the right time and in the right place is central to being able to provide services that are continually improving and which ultimately improve the well-being of our patients and public.

We work very closely with our major hospital provider Trusts – North Tees and Hartlepool NHS Foundation Trust, South Tees Hospitals NHS Foundation Trust and Tees, Esk and Wear Valley NHS Foundation Trust. (South Tees provides some of our general acute services but also a number of our specialist services).

North Tees and Hartlepool NHS Foundation Trust provides acute and community services to our population and the basis for their FT application was the vision to transform secondary care services as part of a whole system change. We share this vision. Our predecessor PCTs recognised that the need to improve access to high quality services was a necessary development driven by the need to ensure high quality services, effectively and efficiently. Working with our main providers and supporting a business case for the reconfiguration of services will be a major plank of our future strategy.
The diagram below illustrates how we want our services to integrate. Service transformation and the implementation of evidence based practice and technologies characterize our vision.

Key features of the new system will include:

- A continued focus on prevention and self-care
- A strengthened and comprehensive primary care system
- Increased provision of locally based care, assessment, diagnostics, treatment and care management closer to people’s homes
- A high quality, safe, well equipped and comprehensive urgent care service
- Community-based children and family services
- Flexible and increased choices of service provision, including maternity care
- Comprehensive and proactive management of long term conditions
- Responsive and wider range of options for the provision of Step Up and Step Down care
- Rapid response diagnostic services central to the healthcare system
- Transparent and easily accessible information, alongside ongoing communication between all areas and people within the health and social care system
- More integrated health and social care management and service provision
- Reduced waste, improved access and increased efficiency of service provision.

Out of Hospital Care

Community services and primary care tend to be fragmented and result in avoidable admissions. Services tend to be organised around professional domains rather than pathways which is inefficient. There are significant opportunities to improve productivity.

There is a wide variation in how primary care operates - ranging from how services are accessed and referral routes, to treatment decisions, such as prescribing choices. Some variation is required to reflect individual patient needs. Eliminating unexplained variation is critical to improving value for money as well as improving clinical outcome.

The CCG recognises the importance of an effective community service to deliver patient outcomes. Outcomes have been developed in relation to service delivery with our community services provider. This will shape services to better enable General Practices to co-ordinate patient care particularly those with long term conditions.

It is critical that care is moved from acute to community settings to improve the patient experience and maximise efficiency. Resources can then be used to fund new initiatives and areas of increasing demand. Progress is already under way to achieve these goals, but this will need to accelerate in order to deliver the required efficiency savings in the financial plan. We need to improve the way people access services, ensuring equality of access for all – regardless of age or other factors.

Acute in-hospital care and reducing admissions

There has been a national trend of growing admissions and attendance at Accident and Emergency. In many cases patients can be treated closer to home. The demand for Urgent Care should be minimised where possible by identifying health conditions early and handling them in a measured way. Urgent care is also very expensive as it is delivered in
hospital settings. When our patients need urgent care we need to ensure that access is as simple as possible.

Our workstream programmes contribute to moving this agenda forward as the outline business case - part of our Momentum:Pathways to Healthcare programme – progresses.

Mental health and learning disabilities

It is estimated that around 17.7% of adults aged 18 and older meet the diagnostic criteria for at least one common mental health disorder. Reducing the prevalence of common mental health disorders such as anxiety and depressive disorders is a major public health concern.

Hartlepool has a greater unadjusted prevalence of learning disabilities than nationally. People with learning disabilities have greater health needs than the rest of the population exacerbated by difficulties accessing the right services. In Hartlepool there are approximately 580 people over the age of 14 years with a learning disability. In Stockton-on-Tees there are about 440 people identified over the age of 18 with learning disabilities. People with learning disabilities often find it hard to access mainstream health services, despite often having greater general needs. They also often have to live away from their local area to access services to meet their needs. Adults with Autistic Spectrum conditions have limited access to diagnosis and appropriate support.

Military veterans aged over 65 years tend to report better health than the general population, but in the 25-65 age group poor general health is twice as common as in the general population. Particular issues identified with poor health in 25-65 year-old veterans include musculo-skeletal, cardiovascular and respiratory conditions. Suicide is more common in former service personnel aged under 24 than in their non-service counterparts. Mental health problems are more common in this community, including depression, anxiety, alcohol misuse and post-traumatic stress disorder.

Dementia

People with dementia experience worse outcomes in acute settings and remain in hospital a third longer than average. Currently, people with dementia have limited access to reablement, intermediate care and specialist behaviour management services. With our increasingly elderly population (22% by 2029) we face a major challenge to getting our services fit for the increase in demand and able to provide the range of services required, alongside our partners.

Medicines Optimisation

Medicines account for 12% of NHS spend and 70% of this is spent in primary care. Nationally it is estimated that £300m of medicine is wasted annually and £90m of medication is unused in peoples’ homes. The quality of prescribing is generally high in our CCG although there remains variation in the use of medicines across different practices. There remain benefits to be realised from the elimination of waste. By freeing up resources we will be able to redirect this money towards the increasing use of drugs in the treatment and prevention of ill health. For example, high use of antibiotics and some stomach medicines can increase the risk of developing MRSA or Clostridium difficile.
What are our aims?

Our aims for achieving our vision are what drive the way we plan to work. To improve health together we will aim to:

- 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
- 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 patients home as possible
- Plan and respond to the identified needs, at a locality level, of the residents of Stockton-on-Tees and Hartlepool

To:

- Ensure services are safe, high quality and cost effective
Strategic outcomes

How is the CCG going to fulfil its vision and what is it going to change?

We have looked at the most up to date information available from a range of sources from patient views to national clinical publications to local health and wellbeing data as you can see in our case for change above. Based on this we have set out what we see as our strategic outcomes. We describe the outcomes and where we want to get to for each of these.

In order to practically implement actions to address these strategic outcomes we have 5 transformational workstreams (our clinical workstreams). The following sections then break down the clinical ‘workstreams’ and explain some of our plans in more detail. The diagram below shows the relationship between the strategic outcomes and the workstreams. Each workstream is led by a clinical lead and supported by a senior manager, and project team drawn from the CCG, member practices, partners and the North East Commissioning Support Service. Our strategic outcomes are set out in the diagram below.
Strategic outcome: Bringing care closer to home

Being in hospital should only happen when it is clinically indicated and when it is the right medical decision. When a person needs planned or unplanned care in a hospital setting we need to ensure that this happens in a timely manner.

Too many avoidable admissions happen though. This is a result of a variety of issues, for example, lack of alternatives, lack of crisis support, need for help at home or just telephone advice or a lack of understanding of what services would suit people best in their situation.

Too many people have no choice at the end of their lives, too many people are admitted as a result of complications in their long term conditions unnecessarily and too many people stay too long in hospital because of a lack of support on discharge.

We aim to reduce the number of people being admitted to hospital when an alternative arrangement would be in their best interests.

We aim to ensure that when you need care it is in the right place – either in your home or in a community setting. Services may not be geographical closer but will be within the community and not in hospital if its not needed

Urgent care services will be simple to navigate with an increasingly better understanding for all about how to access care out of hours or in an emergency. We aim to provide care at locations which make it easier for people to look after themselves and have the necessary education to support them to do so.

Our redesigned services will be more integrated, streamlined and efficient. When procedures can be undertaken as a day case or outpatients instead of an inpatient stay we will commission accordingly.

Follow up will be undertaken in the most appropriate place and we will see fewer secondary care review appointments and more primary care management.

Our primary care services will become the hub for patient management.

Strategic outcome: Tackling health inequalities

The CCG covers two distinct populations. Out of 354 local authorities in England, Hartlepool is the 23rd most deprived and Stockton-on-Tees is 98th. This creates inequalities in health outcomes. For example, In Hartlepool life expectancy is lower than the national average by 2.6 years for men and 3.0 years for women. There are also wide differences in life expectancy within the area. For example, men in the most deprived areas of Stockton-on-Tees will live on average 15 years less than the least deprived (12 years difference in Hartlepool). There is an 11 year difference for women (8 years in Hartlepool).

In Stockton-on-Tees, smoking prevalence varies by ward from 16% to 48%, and emergency admissions for heart disease are two and a half times more likely in the most deprived wards than in the least deprived. Particular issues highlighted in the JSNA include:

- There are around 200 smoking attributable deaths per year in Hartlepool. People from the most disadvantaged areas, with the highest smoking prevalence have the least success in 4-week quit rates. There are high rates of smoking during pregnancy.

Building on the national work around health inequalities instigated by the Department of Health National Support Team, health inequalities will be addressed by the CCG at a population, personal and community level. In addition, some of the wider determinants of health such as low educational attainment and unemployment (both higher than average) are also important for securing long-term improvements in health. Inequalities relating to deprivation have to be tackled through concerted action across public sector services. We will work closely with other public sector service providers through the following:

- Joint Strategic Needs Assessments (JSNA)
- Joint Health & Wellbeing Strategies
- Demand management strategy
- Communication and engagement strategy
- Financial and QIPP Plans

The CCG is already working closely with Public Health to support initiatives to address areas of particular concern such as:

- Making healthy lifestyle choices easier, including stopping smoking, promoting safe, sensible drinking and increasing physical activity.
- Improve access to community based preventative services in particular vulnerable/hard to reach groups (e.g. BME/ Mental Health/ Routine and Manual Workers and Young People) supported by more effective information and advice, signposting of services, transport arrangements etc.
- Rates of obese and overweight children are above the national average – the National Child Measurement Programme (NCMP) findings suggest a large increase in childhood obesity prevalence between the ages of 5 and 11.
- Binge drinking levels (estimated at 29.2%) and alcohol specific hospital admission rates are amongst the highest in the country and they are increasing. Females with alcohol specific admissions are within the worst 10% and alcohol attributable admissions are in the worst 5% nationally.

The ability to understand, embrace and operate in diverse communities is critical to the ability to promote social inclusion and reduce health inequalities.

<table>
<thead>
<tr>
<th>Strategic outcome: Caring for an ageing population</th>
<th>Where we want to get to</th>
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<tr>
<td>According to the Office for National statistics the population is likely to grow by about 9% in the next thirty years. However the number of those aged over 65 will increase by 34%. This is consistent in both Hartlepool and Stockton-on-Tees. This will place increasing demands on the healthcare system and resources as a result of conditions such as stroke and dementia. Not only does an ageing population present increasing demands on health care but also on housing and social care needs and the need to provide services in a different way to support people in their own homes, living as independently as possible for as long as they and their carers would like. Dementia presents a huge challenge to society, both now and increasingly in the future. There are currently 700,000 people in the UK with dementia, of whom approximately 570,000 live in England. Dementia costs the UK economy £17 billion a year and, in the next 30 years, the number of people with dementia in the UK will double to 1.4 million, with the costs trebling to over £50 billion a year. Where people have reached the end of their lives however, we need to ensure they are able to be in the location of their choice. Too many deaths occur in hospital which is not always necessary.</td>
<td>Helping people identify sooner if they are at risk of cardiovascular disease, cancer, and other illnesses so they can get the right care and treatment quickly to prevent them getting ill. Improve the uptake of these screening programmes. Improving access to, and quality of, care and treatment for people if they do get ill. Supporting people in old age and with long-term health conditions to live independent, good quality lives. Ensure that services are commissioned which focus on prevention, early intervention and reablement, such as the healthy heart check and cancer early intervention and prevention programmes. The CCG is committed to ensuring patients, carers, the public and our staff are not discriminated against on the grounds of age, disability, gender, race, religious beliefs or sexual orientation. We plan to be working in an integrated manner with our key partners to ensure that the actions we take as commissioners contribute to the wider determinants of health and that the advice we can contribute to the health impact of actions of our partners will result in us making an impact together on the health of our residents. All workstreams will tackle this outcome through: Moving services closer to home into the community where care is more accessible and can provide a better patient experience. Minimising urgent care by identifying the healthcare issues associated with the elderly and managing these more effectively. Directly tackling the challenges faced by individuals, families and carers with dementia in a dedicated workstream. Reduced avoidable admissions Working effectively with adult social care services through the Health and Wellbeing Board and aligning reablement and social care support. Services that are flexible and responsive to the changing locations presented by caring for people in their own place of residence. Carers feeling supported to continue the work that is so invaluable to helping people live independent lives. End of life care will be available increasingly in a location of choice rather than unavoidable in hospital.</td>
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### Strategic outcomes: Priority health conditions

In 2010, members of the public were asked for their views on key priorities for investment. Respondents identified the priority conditions most likely to affect them and their families as being:

- Cancer (24%)
- Healthy heart (23%)
- Smoking (17%)

These themes are consistent with the Joint Strategic Needs Assessment (JSNA) – this is a review of the main health and wellbeing priorities for the residents of Stockton-on-Tees and Hartlepool. The JSNA describes the health conditions that most affect people in Stockton-on-Tees and Hartlepool as:

- Cardiovascular disease
- Cancer
- Smoking-related illness
- Alcohol related illness
- Mental health problems including dementia

Other long term conditions such as diabetes are often avoidable and the quality of advice and treatment to prevent and help self-management will go a long way to reducing unnecessary cost and ill-health.

We aim to reduce deaths and morbidity as a result of these conditions.

### Where we want to get to

We have used sophisticated mathematical models to understand what the main issues will be in future years - the ‘predictive health outcome model’ developed by the Association of Public Health Observatories. These consider trends in data and also risk factors for specific diseases and predicted changes in population structure. Knowledge from these is then applied to population projections to estimate likely levels of disease into the future.

Prevalence predictions have been produced for chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), diabetes mellitus, hypertension and stroke.

We have used these predictions to set ambitious targets to tackle the priority health risks. In particular, we want to:

- Increase the number of people surviving cancer at 5 and 10 years after diagnosis
- Reduce the number of people who develop a chronic respiratory disease.
- Increase the number of people who are screened for cancers and cardiovascular diseases through targeted campaigns and expansion of existing programmes.

Early detection and treatment will be crucial to achieving these targets. We will offer all adults aged 40-74 a vascular risk assessment every 5 years. Helping people to stop smoking, reducing the impact of alcohol consumption and improving access to advice and treatment with keeping mentally well will be continuous activities across our services.

We shall also work with other public services to support people with chronic respiratory diseases and other long term conditions to live healthier lives, manage their condition and retain their independence.

We will continue to improve access to and the quality of GP and primary care services including providing more services closer to people's homes and help in self-care of chronic and long term conditions utilising where possible new technologies available to us.

### Strategic outcome: Improving quality in primary care

For many patients the beginning of their care starts with general practice – a visit to the doctor or nurse. The decisions taken at this point directly affects the type and quality of service that is received.

Not all referrals are necessarily going to the right place, person or service. Ensuring that the right referral is made at the right time is

### Where we want to get to

Involving as many GPs and health professionals as we can from primary care in looking at pathways and helping to design them will become the norm.

Involving patients in that design will be a key activity of our member practices.

Seeking feedback through a smooth and clear process which helps us monitor our success and publishing data about our performance will be an accepted way of practice.
key to reducing unnecessary admission, excellent diagnostics and efficient management of patient care.

Providing the right services in primary care also affects the uptake of other services – urgent care for example. Unnecessary usage of A&E and other urgent care provision makes care inefficient and costly. More coordinated arrangements that are simple to navigate and help people access more local services 24 hours a day when they need them affects primary care as much as secondary care.

Practices are experiencing greater demand on their time and resources and will require support to reduce waste and develop increasing efficiencies whilst balancing the need to increase primary care in a sustainable and manageable manner.

<table>
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<tr>
<th>Strategic outcome: Quality and safety</th>
<th>Where we want to get to</th>
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<tr>
<td>We all expect a high quality and safe health service.</td>
<td>Improving the quality and safety of all our services is a theme that will run throughout our detailed plans. By involving clinicians in key decisions, we ensure that the work of national best practice, through to clinical networks and our local initiatives is taken into account.</td>
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<td>This is emphasised in the NHS Operating Outcomes Framework which sets out the planning, performance and financial requirements for NHS organisations in 2012/13.</td>
<td>We will use Clinical Quality Review Groups to ensure that robust clinical challenge occurs between providers and commissioners as we strive to commission safe, effective quality services.</td>
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<td>Quality and safety underpin the reputation of the CCG and the wider NHS.</td>
<td>We will learn from the times when things go wrong, robustly investigating serious incidents and monitoring the implementation of recommendations.</td>
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<td>Safeguarding our vulnerable children and adults is an important aspect of our duties and our joint working efforts to keep our children from harm and our vulnerable adults safe and well.</td>
<td>The CCG will ensure that contracts with health providers will be centred on improving outcomes for patients. We will continue to build on the systems in place such as the NHS Safety Thermometer. The CCG will use the Commissioning for Quality and Innovation (CQUIN) scheme to drive up quality. CQUIN rewards excellence, by linking a proportion of healthcare providers’ income to achieving quality improvement targets set by the CCG. Evidence Based Practice has been incorporated into the development of the CQUIN work and Quality Outcome Schedule for 2012/13.</td>
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<td>Further information: Details of CQUIN: <a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443">http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443</a></td>
<td>The CCG will develop a quality dashboard. We will work collaboratively with all of our provider organisations in driving forward national, regional and local initiatives to improve patient safety.</td>
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Whilst significant progress has been made, the CCG will continue to focus on controlling healthcare acquired infections such as MRSA and C.Difficile. Our determination to move care closer to home will also make it less likely that patients are exposed to these infections.

We shall use the summary care record (SCR) so that all health care providers can access good electronic patient records. Many avoidable hospital adverse events are medication related. Use of SCR should make patient care safer by improving communication. Two thirds of practices use the system and we are working hard to assist the remainder to develop the systems. We are prioritising use of the SCR in secondary care, especially for urgent care, end of life and diabetes.

The CCG is acutely sighted on the importance of patient safety. We are passionate in working proactively and collaboratively with our providers in ensuring that all requirements are met under the umbrella of the national initiative *Energising for Excellence*. We will ensure that our providers implement the requirements of the Safety Thermometer data collection and in addition to this, drive forward required improvements in the 4 targeted harms:

- Venous thromboembolism
- Catheter associated urinary tract infections
- Falls
- Pressure sores

The CCG recognises the importance of continuing to reduce healthcare associated infections (HCAI) in acute and community settings. Our priority will be MRSA and Clostridium difficile. We recognise the important of collaborative working in this area and we will ensure this continues with root cause analysis and lessons learned and shared for each case.

**Safeguarding**

Systems and processes will be continually reviewed and refined to support quality improvement and to evidence outcomes. We will ensure that we discharge our statutory functions accordingly and build upon improvements to date in this area for both adults and children. We will be working closely with the Local Safeguarding Children’s Boards, Safeguarding Adults Boards and with our partners across the area including local authorities, schools and police services.
**Strategic outcome: Improving the patient experience**

The patient experience is what drives our endeavours for improvement. The overwhelming view is that we have a high quality NHS service. But we know that the patients experience is the ultimate measure of the quality of our care and whether our services are operating efficiently.

Improving the overall experience – be that clinical outcome or the way people have accessed services – is our challenge.

In October and November 2011, views were sought from patients, carers, members of the public and stakeholders across Teesside in order to ensure that this plan reflects the views of local people. There was significant consensus from patients on a number of key topics, with the most popular being:

- Quality of care and of the patient experience;
- Ensuring services represent value for money and reducing waste;
- Focusing on timely access to care and on care closer to home;
- Listening to patients / carers, effective communication and supporting choice;
- Staying true to the core values of the NHS, including care available to all, free at the point of delivery;
- Equality of access and fairness in treatment;
- Meeting the needs of the local community and supporting health improvement initiatives.

GP’s have fed back that patients are consistently highlighting the issues on the complexity of what services to access and when to access them particularly Urgent Care.

**Where we want to get to**

Our work will focus on improving the efficiency of the path patients take when receiving care. We strongly believe that by better coordination of services and treating patients closer to home we can significantly reduce costs whilst improving patients’ experience.

Clinical led commissioning provides primary care with the opportunity to ensure the most effective pathway is implemented at each patient contact. Our organisation does this by:

- Being run by a governing body elected by clinicians and with a majority of clinicians
- Splitting our work into workstreams to improve the pathways, each led by a clinician
- Regularly reviewing progress and issues at the locality level amongst all health care clinicians

Personal Health Budgets (PHBs)
The development of PHBs has the support of the Coalition Government and is cited as having potential for increasing personalisation and putting patients in control. The CCG is committed to continuing the pilot and following completion of the evaluation in October 2012, implementing the identified recommendations.

We will pay attention to patients experience throughout all our work. In particular we will gather information through:

- Local HealthWatch
- Patient and Liaison Service (PALS)
- Patient experience surveys
- Reporting on formal complaints
- Monitoring informal concerns and queries
- Contract requirements for providers to report on patient experience

GP Practice Patient Participation Groups will be in place in every practice and be able to provide a smooth process for seeking views, getting involved in service design and specific activities, such as medicines management. We will be able to ensure that there are ways in which comments and experiences raised in personal consultations can be drawn upon to improve services – whilst also respecting the patient’s wishes and confidences.

The CCG will seek assurance from providers as to the steps they are taking to record and improve the patient experience. This will include monitoring collection of data and actions taken to address areas for improvement. We recognise that sometimes things go wrong and complaints are one way of learning how to improve the services we commission. We have a clear complaints handling process which aims to deal with complaints quickly and promptly.

In addition, patients’ experiences of services, will be used by the CCG to inform decision-making processes, such as that from LInKs/Healthwatch, GP Practice Patient Participation Groups and MY NHS, both as direct sources of information about the patient experience and as a tool for capturing the views of the wider Practice population. See communication and engagement framework.
<table>
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<tr>
<th>Strategic outcome: Seeking best value for money in budget</th>
<th>Where we want to get to</th>
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<tr>
<td>The NHS faces an unprecedented financial challenge as a result of continuously rising demand, expensive new treatments and an ambitious national reform programme. At the same time funding is becoming much tighter. There is only a 3% increase in 2011/12 across Hartlepool and Stockton-on-Tees, compared with 5.5% in preceding years. In 2012/13 the CCG will need to make £17.6m savings which represents 4.8% of its total budget for the year. Similar levels of savings will be required in future years. The CCG will become increasingly reliant on efficiency savings as a means of generating resource to fund future growth and investment. Current planned commitments including inflation increase in CQUIN payments, as well as demand and demographic growth will commit £28.7m for 2012/13.</td>
<td>The CCG recognises the challenge and will need to take decisive action to address the finances in order to ensure the contracts which it can influence are in recurrent affordable balance by 31st March 2013. We will need to make plans that are realistic and affordable and that we discriminate between “needs” and “wants”. The CCG has implemented initiatives with our major providers, in the 2012/13 financial year, which helps us achieve our budget targets. The next steps are to further progress these initiatives with our service providers. The key themes around delivering the QIPP challenge for the next three years are set out in the finance and QIPP workstream section below. The financial impact of all the CCG’s initiatives is built into the workstream programmes. The CCG governing body ensures that both the clinical and financial business cases make sense for all initiatives. The reconfiguration of our acute and community services will see us deliver higher quality services with streamlined access which sees the right patients at the right time in the right place – ultimately securing better value for money.</td>
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Workstreams
How will we implement our plans?

We have 5 key clinical workstreams. These are long term workstreams within which projects and activities will vary from year to year as we work through our plans to achieve our strategic outcomes. So the way we will engage clinicians and the amount of commissioning support we will need will vary. Our aims to include patients, our partners and clinical professionals run through all our workstreams. At different times we will engage different people, based on the skills we need and the capacity required to implement changes. We consider that these workstreams will have sufficient longevity so as to ensure a stable environment for our planning, partnerships and development.
**Health and Wellbeing**

**Our Plan**

Improving people's health goes beyond the NHS. Factors such as employment prospects and housing are equally important. The 2010 report from the Marmot review ‘Fair Society, Healthy Lives’ emphasises the link between an individual’s socio-economic position and good health. We will **work together with other public services and local action teams** to tackle the wider health challenges that face the people of Stockton and Hartlepool.

The NHS Operating Outcomes Framework sets out the planning, performance and financial requirements for NHS organisations in 2012/13 and the basis on which they will be held to account. Further information can be found at [www.dh.gov.uk](http://www.dh.gov.uk). We will **ensure that we deliver and report on our statutory responsibilities**. Those that do not fall under the other workstreams will be monitored as part of this workstream. We will use QOF indicators to improve quality in primary care.

We intend to significantly **improve screening to identify those who have undiagnosed conditions**, namely for:

- Chronic obstructive pulmonary disease - “missing thousands”
- CVD – “healthy heart”
- Bowel cancer
- HPV (within cervical screening programme)

We will increase the level of support for mums for pre and postnatal periods to **reduce smoking in pregnancy and improve breastfeeding rates**. We also have a plan to reduce smoking rates amongst children.

The CCG is well underway with establishing the arrangements for working with Public Health post transfer to local authorities in 2013. The Clinical Commissioning Group is focusing on **defining the “core public health offer”**. The JSNAs will be finalised in the summer 2012 and the completion of Joint Health and Wellbeing Strategies (JHWS) will follow in September 2012. The development of a performance framework is scheduled for September 2012 - February 2013, HealthWatch will be established by October 2012.

The CCG has recognised the need to **develop a joint carers strategy** with the local authorities by September 2012. Consultation has begun and it will at a minimum reflect:

- Supporting those with caring responsibilities (Young People and Adults) to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages (short breaks)
- Enabling those with caring responsibilities to fulfil their educational and employment potential
- Personalised support both for carers and those they support, enabling them to have a family and community life
- Supporting carers to remain mentally and physically well

The CCG will work in partnership with nearby CCG’s and Health and Wellbeing Board’s to ensure the development of **effective local health visiting services**, with sufficient capacity to deliver the new service model set out in “Health Visitor Implementation Plan 2011 – 2015 – A Call to Action” : to deliver the Healthy Child Programme. The Family Nurse Partnership is currently being implemented across Stockton-on-Tees and Hartlepool.

**Success measures and outcomes**

- Reduction in the % of patients with COPD diagnosis on emergency admission
- Improved identification of CVD, HPV and bowel cancer
- Smoking cessation target hit
- Breast feeding rates rising
- Practice achievement of QOF points
- An increase in the number of health visitors
- Delivery of healthy child programme
- Improved screening rates for cancer and increased atrial fibrillation screens

**How it was:** Mrs A works full-time, has a family of her own but also provides carer support for both her parents who have health problems. She is suffering from a number of stress related illnesses including depression. She needs a break but is unsure how to go about this. A friend tells her to contact social services. Three weeks later the social worker completes a financial assessment concluding that the family are not eligible for support and need to fund their own respite care, Mrs A is given a list of care homes to contact herself. Six weeks later, the carer finally finds a care home that she has confidence in and has availability. She books a last minute holiday

**How it will be:** When Mrs A is identified as a carer by her GP surgery she will be provided with a carers information pack which includes: information about support available, how to arrange a carers assessment, how to obtain respite if needed, general guidance on finance and eligibility, how to find information about care homes providing respite and the process involved. Provision of information and support will reduce the risk of depression in carers. The need for respite is identified and arranged before the carer becomes ill.
Out of Hospital Care

Our plan

We will work hard to **reduce variation in primary care** which will result in increased productivity and improved care for patients. Some variation is required to reflect individual patient needs. Eliminating unexplained variation is critical to improving value for money.

We are targeting areas ranging from how services are accessed and referral routes, to treatment decisions, such as prescribing choices. We will ensure methodical peer review is performed to identify best practices and minimise unexplained variation.

The CCG recognises the importance of an effective community service to deliver patient outcomes. Services have been redesigned and outcomes have been developed in relation to improved service delivery with the community services provider. This will better enable General Practices to co-ordinate patient care and will improve patient experience and outcomes - particularly those with long term conditions.

We will **move care from acute to community settings** to improve the patient experience and maximise efficiency that can be used to fund new initiatives and areas of increasing demand. We will improve access to primary care to achieve this. Two initiatives include:

- Dr First – a demand management technique to reduce A&E attendance
- Increasing the use of telephone consultations

To improve efficiency and productivity, community services and primary care will be organised around pathways rather than professional domains whilst improving the team work between practice and community staff through the Teams around the Practices’ (TaPs) initiative. We will encourage improvements in pathways by publishing commissioning intentions and incentivising using CQUIN. By taking a systematic approach to reviewing care pathways, the CCG will manage the demand for hospital treatment by using effective services and facilitating a more timely discharge back to services provided in the community, key schemes include:

- Reducing face to face follow-ups
- Shift from daycase to outpatient procedures
- Agree better plans with social and healthcare providers for post discharge services to prevent avoidable readmissions

Our community estate proposals centre on **developing integrated health care facilities** in Stockton, Billingham, Hartlepool and Yarm. The facilities in Hartlepool and Yarm are already in operation. These are significant steps towards our vision of providing care closer to home and a range of services within the community. Plans to develop integrated centres within Stockton and Billingham are underway. These centres will provide for example diagnostics, minor procedure surgery and outpatient facilities in the community closer to where people live and work. They also provide a wide range of health and care services delivered by integrated teams for the local community. The potential efficiencies of this approach are illustrated in the case study below which demonstrates the level of improvement in the patient experience.

We will complete an **impact analysis assessment for every change of service** that impacts on both primary care and other service providers. This will enable the CCG to identify and support the shift of resource between services and pathways and improve both access and quality of primary care.

The CCG will work with primary care and social care to **create a single point of access** so patients can ring one phone number (111) and be directed to the most appropriate service.
The CCG is focussing on reducing hospital admissions relating to alcohol. We will enable staff who work within the Drug and Alcohol Teams based within the hospital to identify and target multiple admissions resulting from alcohol misuse. Practices will identify patients with alcohol dependence by September 2012 with a targeted screening programme commencing from November.

The CCG is working with neighbouring commissioning groups to identify best practice in care home management and develop an approach that:
- Reduces inappropriate unplanned admissions and use of A&E
- Reduces the number of people admitted and then dying shortly afterwards
- Improves the health care and safeguarding of care home residents
- Improves educational support and training for staff working within care homes
- Establishes more integrated working across partner organisations

Success measures and outcomes
- Increase in alcohol brief interventions within the community
- Increase in utilisation of alcohol screening tool
- Usage of 111 and accessing the right service at the right time
- 10% increase in number of patients in residential/nursing home dying in their preferred place of death
- 90% of patients in residential/nursing care homes with a care plan in place
- 5% reduction in emergency admissions/re-admissions from care/nursing homes
- Reduction in hospital readmissions

A further range of community services measures:
- Patient satisfaction surveys for GP access
- Reduced GP Variation and Spend (GVIS)
- Reduced variation in outcomes, including on-going work to develop a GP quality dashboard
- Increase in Palliative Care Register
- Increased capacity within primary care through improved productivity
- Reduction in consultant to consultant referral rates.
- Working with practices to initiate a number of schemes based upon the Productive Practice
- Introducing telephone triage, assessment and follow up in General Practice

- 90% of patients in nursing/care homes to have a primary care plan in place with an advanced healthcare directive

Acute in hospital care and reduce admissions

Our plan

We will minimise admissions for urgent care and at A&E by identifying health conditions early and handling them in a measured way. The CCG is using recent examples of best practice to improve Urgent Care Services that are coherent and make sense to patients. As part of effective demand-management, it is essential that patients have access to information about accessing local services to enable them to choose the appropriate service for their need.

We are taking several initiatives to improve services and productivity. For example, the CCG is monitoring the number of review appointments that are generated by each new referral (“New to Review Activity”). The acute trusts have targets to move to within the top 10% of activity when compared to national rates. We will also taking measures to reduce length of stay and shift day case activity to outpatient.

Clinicians from primary and secondary care will continue to collaborate across specialties to identify initiatives that will improve the patient pathway. In particular we are engaging with the clinical networks for CHD, stroke, diabetes and neurology.

We will use the Any Qualified Provider approach to increase the choice of provider and improve quality across several services including audiology, IAPT and lymphoedma.

We will provide more treatment for patients closer to home where possible. In particular the following initiatives are being taken forward:

- Developing closer working between Out Of Hours and Minor injury service providers and hospital services
- Promoting and support self-management for a range of Long Term conditions e.g. COPD
- Developing case management across both health & social care with specific focus on Long Term Conditions, care homes and end of life care
- Using the ‘Urgent Care Clinical Dashboard’ to monitor unscheduled care activity including A&E attendances, emergency admissions and GP Out of Hours attendances.
- Supporting patients to make informed choices about which NHS service is most suitable for their illness or injury, and also promote self-care where this is most appropriate. We are targeting introduction of the NHS 111 service and the Capacity directory of services by April 2013.

- Creating a virtual ward for long term condition management
- Refining ambulatory care to minimise admissions

Success measures and outcomes

- Achievement of targeted New to Review ratios
- All people on an end of life pathway able to die in their own home if they wish
- Reduce the number of patients who are admitted to hospital only to be discharged very soon afterwards
- Achieve top decile performance for moving daycase to outpatient procedures
- Reduction in emergency admissions
- Reduced attendances at Urgent Care Centres ‘in hours’
- Reduced minor ailment attendances at A&E departments

Further information:
Best practice guidance for commissioning integrated Urgent and Emergency Care: A ‘whole system’ approach”, Dr Agnelo Fernandes, August 2011, The Royal College of General Practitioners

How it will be: Mr Smith a keen sportsman was seen by an orthopaedic surgeon for follow-up for a broken arm. When the plaster was taken off the surgeon noticed a rash on Mr Smith’s elbow, which Mr Smith said was itchy and also on his knees and back. The surgeon was going to follow his usual policy of referring Mr Smith to a colleague the dermatologist at the hospital, but remembered that under a new policy agreed with the CCG, he should direct Mr Smith to his GP. Mr Smith saw his GP and avoided having to wait for a dermatology appointment. His GP diagnosed psoriasis which cold be treated away from a hospital setting. Mr Smith was treated quickly and efficiently close to home. This saved waiting for and the cost of an outpatient appointment.
Mental health and learning disabilities

Our plan

We will **work with our partners to reduce the causes of common mental health disorders** such as anxiety and depressive disorders. Up to half the people on Teesside claiming incapacity benefit do so as a result of anxiety and/or depression. There is a recognised link between high levels of deprivation, characteristic of Teesside, and common MH problems. The CCG will target:

- Improved Access to Psychological Therapies
- Ensure all those with learning disabilities have annual health check and a health action plan if they wish
- Map and benchmark existing services against best practice
- Developing services and effective pathways for access to diagnosis and support for people with autism

We will **improve access to mainstream health services for people with learning disabilities**. We will work to minimise living away from the local area to access services to meet their needs. We will perform a review of all high cost and risk share placements.

We will also move services as locally as possible where they are provided out of area – starting with female low secure services and specialist packages.

Our plans will **meet the requirements of the Autism Act and the National Autism Strategy** and promote equity of health outcomes for people with a learning disability. We will improve access to diagnosis and appropriate support for adults with autistic spectrum conditions.

We will continue the **personal health budget** pilot and implement the recommendations following the evaluation in October 2012.

We will work with mental health providers to develop mental health care models that **prioritise early detection and intervention** to maximise recovery.

We will continue to focus on improving **access and choice to psychological therapies** using tendering under Any Qualified Provider. This process qualifies a range of high quality providers to offer services and ultimately improve access which reduces waiting times.

The CCG will continue to be actively involved in **Tees Armed Forces local network** group to ensure the principles of the Armed Forces Network Covenant are met for the armed forces and that the NHS plays an active part in this locally.

**Success measures and outcomes**

- **50% reduction in out-of-area learning disability placements**
- **Reduced waiting times for assessment of ASD**
- Increase the number of patients with mental health conditions retained in employment
- Improved equality of access to healthcare for those with learning disabilities
- 100% of those with learning disabilities to be offered an annual health check and health action plan
- Delivery of psychological therapies under Any Qualified Provider (AQP).
- Increase in those completing treatment (50% target in 2013)

**Work with partners to contribute to:**

- Reducing the number of people with common mental health problems claiming sickness-related benefits
- Increasing the number of patients with mental health conditions retained in employment

**Further information:**
Department of Health “Any Qualified Provider guidance” available here:
http://healthandcare.dh.gov.uk/any-qualified-provider-2/
Dementia

Our plan
We are aiming to improve access to reablement, intermediate care and specialist behaviour management services for people with dementia.

We are working to deliver ‘Living Well with Dementia: A National Dementia Strategy’ (Feb 2009). This is a five-year plan for improving health and social care services for everyone with dementia and their carers. The aim of the Strategy is to ensure that significant improvements are made to dementia services across three key areas:
- Improved awareness;
- Earlier diagnosis and intervention;
- Higher quality of care.

We are seeking to implement “The Darlington Experience”. Specifically, in 2009 the Darlington Dementia Collaborative was launched. This involved four organisations who committed to a joint venture of delivering large scale change. The project was led by a full range of professionals, service users, carers and clinical staff who, by sharing, learning and working together sought to make a significant and sustained contribution to the delivery of high quality services. We intend to adopt this approach.

We are already underway with a range of initiatives to enhance services through early identification of dementia and training for health and social care staff (including within the care home sector).

In accordance with the recent national report on the prescribing of drugs to those with dementia, we will look for opportunities to offer better care by reducing the use of antipsychotic drugs for people with dementia.

Success measures and outcomes
- Increased access to memory clinic services
- 10% reduction in unplanned hospital admission and readmission rates for people with dementia
- 25% reduction in the number of bed days for people with dementia in acute and mental health settings
- More people accessing screening for dementia

How it will be: A 78 year old man living at home with his 80 year old wife has been increasingly forgetful over the last two years and has become more irritable with his wife. The GP sees the couple at an appointment at his surgery and, following blood screening and a mini mental state examination, a referral is made to the memory clinic. Within two weeks of the GP referral, the man and his wife attend a joint appointment at the memory clinic for assessment. That same day he attends the neuro-radiology department for a CT scan. Within four weeks he attends the memory clinic for a diagnostic appointment where he receives information about his diagnosis and future care plan which includes anti-dementia medication. Two weeks later he attends the memory clinic for a post diagnosis meeting where he and his wife are offered further support, education and counselling. The man then goes on to receive ongoing support from the memory clinic, the integrated mental health trust and GP.

Further information:
The National Dementia strategy can be accessed here:
Medicines Optimisation

Our plan

We will reduce inappropriate variation in the use of medicines across the practices. There remain benefits to be realised from the elimination of waste such as unnecessary prescriptions. By freeing up resources we will be able to redirect this money towards the increasing use of drugs in the treatment and prevention of ill health. We will try to reduce over-use of antibiotics and some stomach medicines which can increase the risk of developing MRSA or C. difficile.

The CCG will have arrangements in place to ensure the optimal use of medicines. This will include having:

- Effective medicines optimisation strategy in place
- Effective medication review and reconciliation of medicines
- Effective systems for ensuring cost effective, clinically effective and safe use of medicines.
- Effective arrangements in place for local decision making on new medicines
- Effective support and advice to ensure statutory responsibilities in relation to medicines are met
- Governance and assurance processes including local intelligence network and preparation of assurance reports
- Close performance management of provider contracts to meet our QIPP and CQUIN targets

We will maintain an up to date medicines management commissioning toolkit to support safe, effective use of medicines within contracts

We will provide a range of prescribing analysis reports in order to plan for, monitor, audit and manage medicines usage and expenditure

Success measures and outcomes

- 10% increase in repeat dispensing rates
- 20% reduction in cost
- Reduction in volume of PPIs antibiotics by 10% or 75th percentile value

- Performance against a range of indicators measuring cost effectiveness and quality of prescribing has improved
- Over 1000 patients had a comprehensive medication review
- A total saving of £1.82 million on primary care medicines expenditure

How it was: A man with depression was prescribed Venlafaxine Modified Release (MR) 150mg one to be taken in the morning by a psychiatrist in the mental health trust in 2009. Once the patient’s condition was stable his GP agreed to take over prescribing and monitoring of the antidepressant. The cost of this one medication to the NHS is £479 per year

How it will be: Medicines Management identified potential savings if Venlafaxine MR was prescribed as standard Venlafaxine. A strategy to change medication in appropriate patients was agreed with the Mental Health Trust, GP prescribing leads and was endorsed by the Medicines Management Committee and Local Pharmaceutical committee. The patient’s medication was reviewed in the GP practice by the pharmacist from the MM team. As he met the agreed criteria the medication review was forwarded to the GP for agreement. The man was contacted by telephone by the practice pharmacist to explain the change. This phone call was followed up by letter and information leaflet. The man’s community pharmacist also discussed the change with him when he first got his tablets dispensed and the treatment continued to be effective. The total cost of the standard venlafaxine is £46 per year.

Further information:
JSNA for Stockton-on-Tees and Hartlepool can be accessed at:
http://www.teespublichealth.nhs.uk/

Marmot Review ‘Fair Society, Healthy Lives’:
http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

“Caring for our future:reforming care and support” whitepaper (DH, July 2012) available at:
http://www.dh.gov.uk/health/2012/07/careandsupportwhitepaper/
Finance and QIPP

(Quality Innovation Productivity and Prevention)

Covered in this section

This section describes the financial position of the CCG and the QIPP savings that will need to be made to remain within financial balance and achieve our statutory duties.

Context

The financial outlook for our area is significantly more challenging than in recent years, with average growth in 2011/12 of 3.0%, compared with uplifts of c.5.5% in the preceding years. In the context of continuously rising demand and an ambitious national reform programme, the CCG will become increasingly reliant on efficiency savings to fund future growth and the investment required to deliver this clear and credible plan. How we currently spend our budget is shown below:

Requirement for funding in 2012/13

Expenditure commitments across the CCG for 2012/13 total £28.7m. Growth for 2012/13, allocated through the Comprehensive Spending Review, totals £11.1m (3.0%). This will require efficiency savings in the region of £17.6m to be delivered recurrently, to ensure financial balance is maintained and contingency funds are protected in line with DH requirements. This represents an efficiency requirement of c.4.8%.

Increased Expenditure Commitments:

<table>
<thead>
<tr>
<th>Description</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inflation requirements</td>
<td>2.17%</td>
</tr>
<tr>
<td>CQUIN uplift (on provider contracts)</td>
<td>0.91%</td>
</tr>
<tr>
<td>Demographic and demand growth</td>
<td>2.71%</td>
</tr>
<tr>
<td>QIPP over achievement</td>
<td>-0.19%</td>
</tr>
<tr>
<td>Pre-commitments</td>
<td>0.00%</td>
</tr>
<tr>
<td>National policy developments</td>
<td>0.90%</td>
</tr>
<tr>
<td>Local Developments</td>
<td>1.33%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7.83%</strong></td>
</tr>
</tbody>
</table>

Funded By:

<table>
<thead>
<tr>
<th>Description</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Growth (inc. reablement)</td>
<td>3.03%</td>
</tr>
<tr>
<td>Efficiency programme</td>
<td>4.80%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7.83%</strong></td>
</tr>
</tbody>
</table>

Expenditure commitments

**Inflation requirements £7.9m** - Inflation uplifts for healthcare providers are set through national tariff arrangements. Local discretion is applied to other areas of spend.

**CQUIN increase £3.4m** - An increase of 1% on the provider contracts equates to c 0.9% uplift on the baseline budget. This has funded increase quality in all of our providers.

**Demographic and demand growth £9.9m** - Growth on acute contracts is estimated at c2.8% on contract baselines equating to £5.5m. In addition to this, substantial demand growth in continuing healthcare and prescribing has also been reflected.

**National priority developments £3.2m** - The annual operating framework identifies a range of policy initiatives, including reablement funding, cancer developments, a previous commitment to fund carers support is also required.
Commissioning Intentions - Local developments £4.8 - The clear and credible plan identifies a number of areas where there is a requirement to invest in services, identified in our clear and credible plan under ‘plans to improve’, for example our transformational programme to improve community services.

Funding for these commitments is clearly reliant upon delivery of efficiency savings. Given the inherent risk within this strategy, investment funding can only be released on delivery of the QIPP programme.

Funding Sources

Growth - Growth at £11.1m, will fund approximately one third of the total requirement for resource across Hartlepool and Stockton-on-Tees CCG, leaving the balance of £17.6m to be generated through efficiency savings.

Efficiency savings identified within Quality, Innovation, Productivity and Prevention (QIPP) Programme - The requirement for efficiency savings has been assessed at 4.8% equating to £17.6m. Contributing to this are price efficiencies generated through the application of the nationally set tariff uplift for all NHS and Foundation Trust contracts, estimated at c£10.3m.

In order to address the remaining balance of £7.3m, a range of efficiency schemes have been identified as follows:

<table>
<thead>
<tr>
<th>Programme</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute - Unplanned care</td>
<td>3.1</td>
</tr>
<tr>
<td>Acute - Planned care</td>
<td>0.8</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2.4</td>
</tr>
<tr>
<td>Joint Commissioning</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>7.3</strong></td>
</tr>
<tr>
<td>Price Efficiencies</td>
<td>10.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17.6</strong></td>
</tr>
</tbody>
</table>

Contract negotiations will understandably focus on the detail of PCT/CCG plans to deliver the savings required. Whilst the level of savings required from acute providers is significant, this must be seen in the context of substantial investment in contract growth and over performance in recent years.

However, delivering savings of this magnitude is a challenge and requires real acceptance from all parties that current levels of growth cannot be sustained. Expenditure must be reduced across all parts of the economy to deliver a sustainable solution and healthcare providers on Tees have expressed a genuine desire to work with commissioners to streamline pathways in order to reduce costs.

Negotiation of savings at this level however will be extremely challenging for both commissioners and providers. In recognition of the need to ensure that all parts of the health economy remain viable, we are working on a collaborative basis with local providers, involving clinician to clinician discussion on the detail of individual scheme proposals and the impact on specialty level activity and costs.

It is key that changes in pathways and reduction in cost is managed in a sustainable way and that the inherent risks for both providers and commissioners are mitigated appropriately. All parties must be inextricably linked and jointly responsible for delivery of this programme and contract offers have been structured in such a way as to recognise the need to share the management of risk through this uncertain period. Risks in relation to in year over performance will be mitigated through contractual frameworks.

Plans for 2013/14 and beyond

Plans for 2013/14 and beyond are based on the assumption that the measures taken as part of the QIPP programme will serve to prevent the acute contract pressures which have become an issue in recent years and provide a stable platform on which to determine how resources should be deployed in future to achieve maximum health benefit.

Key assumptions in future year plans are as follows:

- Growth reduces to 2011/12 levels c2.23%
- Inflation uplifts are static for two years and then begin to rise
- Acute contract growth is provided for at 3%
- Tariff efficiencies deliver 4% in real terms from 2013/14 onwards at local level
- QIPP efficiencies are generated in full on a recurrent basis
### Risk Modelling

The revised financial plan for 2012/13 has been updated with the planning assumptions as announced in the operating framework. The risks for 2012/13 are around the delivery of the plan and demand increasing above plan. The following demonstrates the scenarios of risk for the key areas of expenditure and demonstrates how the CCG would mitigate this financial risk. It is highly unlikely that the high risk scenario would happen but we can demonstrate how we would manage this scenario.

As we move forward to future years the risks around some of the planning assumptions increase i.e. inflation increasing, efficiency requirements increase, growth funding decreases. We have been cautious in our estimates in assuming lower growth, increasing inflation, increased demand and similar technical efficiencies and our QIPP programme is based around this, similar mitigating factors to 2012/13 will be used.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td>£4,327</td>
<td>£8,654</td>
<td>£12,980</td>
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<tr>
<td>Prescribing</td>
<td>£1,338</td>
<td>£1,784</td>
<td>£2,230</td>
</tr>
<tr>
<td>Joint Commissioning</td>
<td>£991</td>
<td>£1,651</td>
<td>£2,642</td>
</tr>
<tr>
<td>Walk-in/OOH</td>
<td>£246</td>
<td>£328</td>
<td>£410</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>6,901</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>12,417</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>18,262</strong></td>
</tr>
</tbody>
</table>

#### Mitigation

<table>
<thead>
<tr>
<th>Mitigation</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Commissioning Contingency</td>
<td>£991</td>
<td>£1,651</td>
<td>£2,860</td>
</tr>
<tr>
<td>Contingency 2% non recurrent</td>
<td>£5,911</td>
<td>£7,541</td>
<td>£7,541</td>
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<tr>
<td>delayed local investment</td>
<td>£0</td>
<td>£3,224</td>
<td>£4,880</td>
</tr>
<tr>
<td>delayed national framework investment</td>
<td>£0</td>
<td>£0</td>
<td>£2,494</td>
</tr>
<tr>
<td>demand management programme</td>
<td>£0</td>
<td>£487</td>
<td>£1,819</td>
</tr>
<tr>
<td></td>
<td><strong>6,901</strong></td>
<td><strong>12,417</strong></td>
<td><strong>18,262</strong></td>
</tr>
</tbody>
</table>

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**QIPP Savings by Workstream**

- **Other Commissioning**
- **Mental health, learning disabilities & dementia**
- **Medicines optimisation**
- **Acute in hospital care**
- **Out of hospital care**

Note: Out of Hospital care includes “Acute - unplanned care”, and “community”. Mental health includes joint commissioning. Detailed financial plans are included in separate document.
Our organisation:
Covered in this section
This part of the plan sets out the internal actions required to develop the CCG and its staff in the run-up to April 2013.

What will our Governance arrangements look like?
Since 1st April 2012 a single shadow CCG Governing Body has been in place supporting on the localities in preparation for full authorisation.

The CCG is a membership organisation and will be run by a governing body. The structure of the organisation is set out below showing the relationship between the member practices, localities and the governing body and the delivery team.

We have worked hard to understand any potential conflicts that may arise as a result of this new commissioning infrastructure and will be keeping a clear separation between commissioning and providing activities. This will be apparent at both CCG and locality level and our role outlines seek to make very clear the commissioning responsibilities of post holders from practice representatives through to the governing body so that no personal business interest can be seen to be driving commissioning decisions.

The CCG is establishing robust governance arrangements with the purpose of enabling it to deliver its strategic objectives and remain a safe organisation. This includes:
- Governance training and workshops for senior clinicians and practice staff
- A CCG constitution, standing orders and prime financial policies and a clear scheme of delegation clarifying the delegated responsibilities of the CCG Governing Body’s sub-committees who will support the Governing Body in discharging its duties.
- Terms of Reference for the Governing Body in line with published best practice and the statutory duties
- Processes to ensure probity in the conduct of business including managing conflicts of interest.

Our governance structure seeks to ensure that member practices are fully engaged in driving a clinically led organisation. Roles are clearly defined to maximise added value from the clinical knowledge of health professionals where it is most needed. Clinical engagement will be secured best when clinicians consider that their skills are used and their voices are heard in making a difference to the way services are provided for their patients. Our model therefore seeks to use that skill in the most appropriate way. We will ensure that there is clinical oversight from the governing body and its committees and that we minimise the chance of any conflicts.

Our Quality, Performance and Finance committee has a role to monitor the performance of the CCG. Our view is that an integrated committee linking quality, performance and finance together is the best way of ensuring that all elements of our strategy are monitored together. The Clinical workstream leads will have a standing place to report into this committee, as requested, on progress and challenges to delivery. This group will be chaired by a clinical Lead.

Our delivery team will have a day to day role in implementing the strategy, supporting clinical workstream leads and overseeing operational management. It will be chaired by the Accountable Officer.
How will we manage our risks?

The governing body will be responsible for the management of key risks as defined within an Assurance Framework and corporate risk register. The governance infrastructure (Risk and Governance committee) and scheme of delegation further embed risk management responsibilities throughout the organisation to ensure management of risk is appropriately delegated to CCG leads, clinicians, and chief officers. All staff and commissioning support will be aware they have a responsibility for the management of risk.

Oversight of the register of interests and monitoring of potential conflicts will be taken here. The risk and governance committee will also have oversight of information governance.

The CCG has established an internal and external risk register and risk assessment process whereby risks are graded according to their level of severity and all risks submitted are allocated to a responsible officer and have an action plan to support the risk. The risk register will be accessible to all staff employed and contracted (support) and will be supported by a risk assessment process. This will enable operational risks to be identified, escalated and managed at a local level and will be complemented by an Assurance Framework which identifies and articulates the organisation’s strategic risks. Risks will be escalated to the Governing Body where appropriate.

In accordance with statutory requirements, the CCG will publish an Annual Statement on Internal Control informed by the Head of Internal Audit Opinion.

What Commissioning Support will we need?

We plan to be a lean, clinically-led organisation. We recognise that there are skills that we will need to secure, either through direct employment or by securing this from outside organisations.

North East Commissioning Support (NECS) is developing as a commissioning support organisation to provide a range of skills and expertise to support CCGs in effective commissioning. We intend to secure the necessary support primarily through NECS. This may change over the longer term as we recognise this is a developing relationship. NECS has been successful to date in securing the necessary permission to continue to develop and we consider that it is in the best interests of the CCG and its population to work with NECS to embed the new arrangements. We have signed a Memorandum of Understanding with NECS and are now developing more detailed arrangements for working together.

There are some guiding principles by which we will be securing the necessary support.

- Support that works with our local approach including our Clinical Workstreams
- Developing relationships with staff within NECS to secure a long-term knowledge of our needs
- Securing support in conjunction with other CCGs (primarily South Tees) where this makes sense
- Support to manage our role as lead commissioners alongside other North East CCGs
- Working within our allocated budget for running our organisation (currently £25/head).

We will be securing our IT needs through NECS, in particular, and will be building on the work undertaken across NHS Tees up to now. See Integrated Cluster Plan section 10 for the relevant information.

Further information:
Latest information about NECS:
http://www.stockton-on-tees.nhs.uk/content/page.aspx?page=429

How will we secure public health advice and expertise?

Developing a detailed understanding of the needs of the patients in each member practice will be important to us to develop a targeted approach to commissioning the right services in the right places. Over time we will plan our services according to more granular understanding of smaller populations.

We will be working closely with the Directors of Public Health and organisations that can provide us with detailed information to support a practice population analysis of need that supports our commissioning intentions through a shared service approach.
How will we ensure we develop successfully?

We recognise this is a new organisation and the importance of setting up in a sustainable manner. We will include the right people at the right time with the right skills to help us. Where there are gaps in knowledge or a need to learn to work better together we have developed an Organisational Development plan to aid:

- our transition,
- the pathway to authorisation and
- our on-going succession planning and development.

Who will we collaborate with in our commissioning work?

We will be working very closely, when necessary with our neighbouring CCG, NHS South Tees CCG. We will work closely with other CCG’s as appropriate, particularly around collaborative commissioning. Good relationships are already established with regular meeting of all CCGs in the North East coming together to share common agendas. Working relationships are developing with Durham Dales, Easington and Sedgefield CCG around joint commissioning for acute services. (as part of the Momentum programme)

Stronger links are being established across Durham and Tees Valley where service strategy is being developed jointly. A Tees Valley strategic partnership forum has been developed to ensure joint working across health and social care partners and to develop the evidence base for longer term strategic plans.

The CCG has established particularly close links with NHS South Tees CCG. Due to its history of close working as a former Tees PCT Cluster, the relationship with the main providers in South Tees, Tees, Esk and Wear Valley and North Tees and Hartlepool and existing commissioning support staff are strong. Regular meetings take place between lead officers and clinicians and joint working arrangements and posts are in development, particularly aimed at ensuring continuity and robustness around safeguarding and patient safety. The two CCG’s plan to work closely together around medicines management, prescribing committees, funding panels and public health developing further joint working as appropriate to meet the needs of our respective populations.

The CCG needs to ensure that there is a strong and diverse range of local health providers to buy services from. The CCG currently has 42 major contracts across the Hartlepool and Stockton-on-Tees. The majority of contracts are now covered by the nationally mandated standard contracts, they include:

- Acute services from providers such as North Tees & Hartlepool NHS Foundation Trust (NTHFT), South Tees Hospitals NHS Foundation Trust (STHFT), Nuffield, Ramsay etc.
- NHS Standard Community Contract; covering providers such as the North Tees Community Provider, Hospices etc.
- NHS Standard Mental Health Contract; covering providers such as Tees, Esk and Wear Valley NHSFT, Alliance, MIND etc.

As the strategic direction of the CCG is to ensure patients are only treated in a hospital setting if clinically appropriate than we need to ensure through commissioning intentions and contract management that funding flows reflect these changes.

Our success in driving our strategic outcomes will be considerably improved by working closely with our local authority partners – Hartlepool and Stockton-on-Tees councils. Throughout this plan we have referenced a wide number of ways in which we will need to do this from planning through to delivery.

We are members of both Health and Wellbeing boards at a locality level which will ensure that local issues and solutions can be found where possible. Developing our strategies in conjunction with and alongside the JHWS is a key part of our first years’ work.
Appendices

General Duties of Clinical Commissioning Groups

14P Duty to promote NHS Constitution
(1) Each clinical commissioning group must, in the exercise of its functions—
   (a) act with a view to securing that health services are provided in a way which promotes the NHS Constitution, and
   (b) promote awareness of the NHS Constitution among patients, staff and members of the public.
(2) In this section, “patients” and “staff” have the same meaning as in Chapter 1 of Part 1 of the Health Act 2009 (see section 3(7) of that Act). Health and Social Care Act 2012 (c. 7) Part 1 — The health service in England 39

14Q Duty as to effectiveness, efficiency etc.
Each clinical commissioning group must exercise its functions effectively, efficiently and economically.

14R Duty as to improvement in quality of services
(1) Each clinical commissioning group must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness.
(2) In discharging its duty under subsection (1), a clinical commissioning group must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services.
(3) The outcomes relevant for the purposes of subsection (2) include, in particular, outcomes which show—
   (a) the effectiveness of the services,
   (b) the safety of the services, and
   (c) the quality of the experience undergone by patients.
(4) In discharging its duty under subsection (1), a clinical commissioning group must have regard to any guidance published under section 14Z8.

14S Duty in relation to quality of primary medical services
Each clinical commissioning group must assist and support the Board in discharging its duty under section 13E so far as relating to securing continuous improvement in the quality of primary medical services.

14T Duties as to reducing inequalities
Each clinical commissioning group must, in the exercise of its functions, have regard to the need to—
   (a) reduce inequalities between patients with respect to their ability to access health services, and
   (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

14U Duty to promote involvement of each patient
(1) Each clinical commissioning group must, in the exercise of its functions, promote the involvement of patients, and the carers and representatives (if any), in decisions which relate to—
   (a) the prevention or diagnosis of illness in the patients, or
   (b) their care or treatment.
(2) The Board must publish guidance for clinical commissioning groups on the discharge of their duties under this section.
(3) A clinical commissioning group must have regard to any guidance published by the Board under subsection (2). Health and Social Care Act 2012 (c. 7) Part 1 — The health service in England 40

14V Duty as to patient choice
Each clinical commissioning group must, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them.

14W Duty to obtain appropriate advice
(1) Each clinical commissioning group must obtain advice appropriate for enabling it effectively to discharge its functions from persons who (taken together) have a broad range of professional expertise in—
   (a) the prevention, diagnosis or treatment of illness, and
   (b) the protection or improvement of public health.
(2) The Board may publish guidance for clinical commissioning groups on the discharge of their duties under subsection (1).
(3) A clinical commissioning group must have regard to any guidance published by the Board under subsection (2).

14X Duty to promote innovation
Each clinical commissioning group must, in the exercise of its functions, promote innovation in the provision of health services (including innovation in the arrangements made for their provision).

14Y Duty in respect of research
Each clinical commissioning group must, in the exercise of its functions, promote—
(a) research on matters relevant to the health service, and
(b) the use in the health service of evidence obtained from research.

14Z Duty as to promoting education and training
Each clinical commissioning group must, in exercising its functions, have regard to the need to promote education and training for the persons mentioned in section 1F(1) so as to assist the Secretary of State in the discharge of the duty under that section.

14Z1 Duty as to promoting integration
(1) Each clinical commissioning group must exercise its functions with a view to securing that health services are provided in an integrated way where it considers that this would—
(a) improve the quality of those services (including the outcomes that are achieved from their provision),
(b) reduce inequalities between persons with respect to their ability to access those services, or
(c) reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.
(2) Each clinical commissioning group must exercise its functions with a view to securing that the provision of health services is integrated with the provision of health-related services or social care services where it considers that this would— Health and Social Care Act 2012 (c. 7) Part 1 — The health service in England
(a) improve the quality of the health services (including the outcomes that are achieved from the provision of those services),
(b) reduce inequalities between persons with respect to their ability to access those services, or
(c) reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

(3) In this section—
“health-related services” means services that may have an effect on the health of individuals but are not health services or social care services;
“social care services” means services that are provided in pursuance of the social services functions of local authorities (within the meaning of the Local Authority Social Services Act 1970).