NHS

Hartlepool and Stockton-on-Tees
Clinical Commissioning Group

Assurance Framework 2013/14

Contents

Introduction

Everyone Counts – Planning for patients 2013/14

This document is developed as a base template to support both CCG and Direct Commissioning narrative plans. It has two main objectives:

1. To provide the space for CCGs and the Area Team (in respect of its direct Commissioning responsibilities) to supplement the basic requirements of the template submissions in a form which will assist them in marshalling their efforts towards their priorities and informing their requirements of Commissioning Support organisations; and

2. To encourage the submission of plans in a common format to support effective assurance by the Area Team.

The proposed chapter and section structure responds to the range of planning requirements confirmed in Everyone Counts. Those sections, therefore, provide the specification for commissioners' content in a way which immediately confirms fidelity of the plan against the guidance.

This document should be read in conjunction with **Everyone Counts: Planning for Patients 2013/14 Technical Definitions -** First published: 21 December 2012.

The vision for the NHS in England is to secure better outcomes for patients as defined by the 5 domains of the NHS Outcomes Framework and uphold the rights and pledges in the NHS Constitution.

This plan will describe how Hartlepool & Stockton Clinical Commissioning Group (HAST CCG) will deliver the outcomes for its population in conjunction with a range of stakeholders from the health economy as defined through the delivery of system reform, quality, performance and financial metrics as defined in:

- The Mandate for the NHS in England – the strategic framework for the discharge of NHS responsibilities, requiring the NHS to deliver improvements against the NHS Outcomes Framework; ensure patients' rights and pledges under the NHS Constitution are maintained within allocated resources and meet the QIPP challenge.

- The NHS Outcomes Framework – the standards for the NHS to achieve to secure better outcomes

- The NHS Constitution – the rights of and pledges to patients to be upheld.

Through the delivery of the mandate, the NHS Constitution and the NHS Outcomes Framework HAST CCG will guarantee that no community is left behind or disadvantaged; will focus on reducing health inequalities and advancing equality to improve outcomes for patients.

We aim to treat patients as respectfully as customers and put their interests first; transform the NHS service offer to enable patients to take more control and make informed choices, if they want to.

The CCG will continue to work with and **lead the Momentum: Pathways to Healthcare Programme**. This involves a whole system re-design of care pathways supported by a number of community facilities and the development of a single site hospital. Our Commissioning Plans are enablers to delivery of this programme.

In order to develop this plan a number of stakeholders within our local health economy and across a wider conurbation/sub-regional footprint (where appropriate) were consulted in order to triangulate our planning processes and deliver the outcomes we want to see for our population.

Section 1 – Improving Outcomes, Reducing Inequalities

This section outlines how the CCG intend to use the planning process to deliver the outcomes as described in the 5 domains of the NHS Outcomes Framework.

The CCG aims and objectives will be achieved through setting our commissioning intentions and delivering these through a series of workstreams. All aims and objectives run as themes through our 5 clinical workstreams. These workstreams are clinically driven and centred on the priorities for healthcare and patient need. The workstreams are held to account and report into the Quality, Performance and Finance committee, this committee ensures plans are in place and tracks performance of each project within the workstream to ensure delivery of outcomes.

Each of the workstreams have been summarised to provide an understanding of the approaches taken and expected outcomes (see appendix 1)

The commissioning intentions for 13/14 (see appendix 2 plan on a page) were developed and identified from;

- A stocktake and intelligence from the 12/13 contracting intentions and workstream projects
- The CCG Clear and Credible Plan and Delivery Plan
- The Everyone Counts Planning Framework
- Local stakeholder engagement
- JSNA/Health & Wellbeing Strategy

The tables below make reference to how our plan on a page at appendix 2 has been informed by the Outcome Framework Indicator measures. These measures will be used to assess our delivery *(alignment of initiative to measures is indicated using numbering i.e. **1**).* A more in-depth analysis of our commissioning intent is set out at appendix 3 as an outcome map. Within the Plan on a Page we have identified key risks and mitigation plans to reduce the impact of these at appendix 4.

1.1 Preventing people from dying prematurely

We will work with direct commissioners, Public Health England, Health & Wellbeing Boards (HWBoards) and Local Authorities to:

- develop and provide integrated health and social care approaches through better use of health checks to ensure earlier diagnosis;
- improve early management in community settings;
- improve acute services and treatment, and
- prevent recurrence after an acute event.
- Reduction in number of women smoking at time of delivery

Indicator

- Potential years of life lost from causes amendable to healthcare: **1**
- Under 75 mortality rate from CVD; Respiratory and liver disease and cancer: **2**

Initiatives aligned to measures within NHS Outcome Domain 1: Preventing People from Dying Prematurely	
Commission sufficient capacity to meet the demand of the screening programmes **1, 2**	Work with Primary Care Providers to increase uptake of bowel screening **1, 2**
Reduce Hospital Admissions in relation to alcohol by signposting to support services offered to patients identified **1, 2**	Reduce Hospital Admissions in relation to alcohol through collaboration with Public Health in relation to delivery of the alcohol strategy and determine future requirements for commissioned services **1, 2**
Reduce smoking prevalence through collaboration with Public Health to develop a joint strategy in relation to smoking cessation services to improve access and attendance and focus on improving the quit rate of women smoking at time of delivery **1, 2**	Reduce smoking prevalence by ensuring the smoking cessation services are linked to the Community Renaissance Teams **1, 2**
Reduce COPD Admissions by carrying out a review of acute and community respiratory services **1, 2**	Reduce COPD Admissions by commissioning a range of preventative initiatives such self-care packs and patient education **1, 2**
Implement management plans for all patients identified by the LACE tool as being at high risk of readmission **1, 2**	Review and audit of the new community services model **1, 2**

To improve the quality and capacity in Primary Care and continue to support Primary Care in reducing variation in General Practice, both in terms of quality and financial spend **1, 2**	Robust and accurate registers of patients with Dementia **1**
Ensure CAMHS services meet NICE requirements and improves assessment to diagnosis waiting times **1**	

1.2 Enhancing the quality of life for people with long-term conditions

We will work with direct commissioners through HWBoards to outline as a minimum how they plan to:

Provide person-centred integrated care for people with long-term conditions through improvements in primary care and through the social care and reablement funding;

- put patients in charge and having ownership of their care through personalised care plans and budgets and ensure coordination and continuity of their care.
- work with providers to invest savings in better re-ablement and post-discharge support.

Indicator

- Health-related quality of life for people with LTC **1**
- Proportion of people feeling supported to manage their condition **2**
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) **3**
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19's **4**
- Estimated diagnosis rate for people with dementia **5**

Initiatives aligned to measures within NHS Outcome Domain 2: Enhancing the quality of life for people with long-term conditions	
Commission sufficient capacity to meet the demand of the screening programmes **3**	Reduce smoking prevalence through collaboration with Public Health to develop a joint strategy in relation to smoking cessation services to improve access and attendance and focus on improving the quit rate of women smoking at time of delivery **4**
Reduce smoking prevalence by ensuring	Reduce COPD Admissions by carrying

Initiatives aligned to measures within NHS Outcome Domain 2: Enhancing the quality of life for people with long-term conditions	
the smoking cessation services are linked to the Community Renaissance Teams **4**	out a review of acute and community respiratory services **1, 2, 3**
Reduce COPD Admissions by commissioning a range of preventative initiatives such self-care packs and patient education **1, 2, 3**	Improve the Quality of Care within Residential and Nursing Homes and ensure all residential/ nursing home patients will have a regularly reviewed Health Care Plan (HCP) **5**
Implement management plans for all patients identified by the LACE tool as being at high risk of readmission **1, 2, 3, 4**	Review and audit of the new community services model **1, 2, 3, 4**
To improve the quality and capacity in Primary Care by better understanding capacity and demand within Primary Care to determine future commissioning intent **1, 2, 3, 4**	To improve the quality and capacity in Primary Care and continue to support Primary Care in reducing variation in General Practice, both in terms of quality and financial spend **1, 2, 3, 4, 5**
Implement revised MSK pathway to include direct access to core Physiotherapy and direct access to MSK **1, 2**	Implement revised MSK pathway to ensure where referral is sent to incorrect, referral will automatically refer on to appropriate service without sending back to GP or requesting a re-referral **1, 2**
Work with providers to reduce the number of delayed discharges **1**	Work with Provider to ensure that routine services are offered 7 days a week **1, 2, 3, 4**
Development of a pilot memory clinic within a primary care setting **1, 2, 5**	Ensure CAMHS services meet NICE requirements and improves assessment to diagnosis waiting times **1, 2**
Development of alternative rehabilitation and recovery services to support complex individual residents **1, 2**	Review current commissioning arrangements for specialist sensory assessments and develop local pathway **1, 2**
Implementation of e-discharge solution which transfers information directly into clinical system (inpatient and outpatients) **1, 5**	Implementation of Choose and Book, including advice and guidance **1, 5**

1.3 Helping people to recover from episodes of ill health or following injury

Direct commissioners and CCGs will:

- reduce avoidable admissions to hospitals;
- keep people out of hospitals if better care can be delivered in a different setting;
- ensure effective joined-up working between primary and secondary care;
- deliver high quality and efficient hospital care and coordinate care and support post discharge;
- work with providers to invest savings in better re-ablement and post-discharge support.
- work with commissioners and providers to identify gaps in provision of rehabilitation services

Indicators

- Emergency admissions for acute conditions that should not usually require hospital admission **1**
- Emergency readmissions within 30 days of discharge from hospitalisation **2**
- Total health gain assessed by patients – Hip replacement; Knee replacement; Groin hernia and Varicose veins **3**
- Emergency admissions for children with Lower Respiratory Tract Infections (LRTI) **4**

Initiatives aligned to measures within NHS Outcome Domain 3: Helping people to recover from episodes of ill health or following injury	
Commission sufficient capacity to meet the demand of the screening programmes **1, 2**	Reduce Hospital Admissions in relation to alcohol by signposting to support services offered to patients identified **1, 2**
Reduce Hospital Admissions in relation to alcohol through collaboration with Public Health in relation to delivery of the alcohol strategy and determine future requirements for commissioned services **1, 2**	Reduce COPD Admissions by commissioning a range of preventative initiatives such self-care packs and patient education **1, 2**
Improve the Quality of Care within	Triage and signpost patients who are not

Initiatives aligned to measures within NHS Outcome Domain 3: Helping people to recover from episodes of ill health or following injury	
Residential and Nursing Homes and ensure all residential/ nursing home patients will have a regularly reviewed Health Care Plan (HCP) **1, 2**	appropriate to be seen in A&E to the relevant care provider in order to support the re-education programme **1**
Implement management plans for all patients identified by the LACE tool as being at high risk of readmission **1, 2, 4**	Review and audit of the new community services model **1, 2, 4**
To improve the quality and capacity in Primary Care by better understanding capacity and demand within Primary Care to determine future commissioning intent **1, 2, 4**	To improve the quality and capacity in Primary Care and continue to support Primary Care in reducing variation in General Practice, both in terms of quality and financial spend **1, 2, 3, 4**
Reduction in readmissions **2**	Implement revised MSK pathway to include direct access to core Physiotherapy and direct access to MSK **3**
Implement revised MSK pathway to ensure where referral is sent to incorrect, referral will automatically refer on to appropriate service without sending back to GP or requesting a re-referral **3**	Work with providers to reduce the number of delayed discharges **2**
Work with Provider to ensure that routine services are offered 7 days a week **1, 2, 4**	Robust and accurate registers of patients with Dementia **1**
Development of a pilot memory clinic within a primary care setting **1, 2**	Ensure CAMHS services meet NICE requirements and improves assessment to diagnosis waiting times **3**
Implementation of e-discharge solution which transfers information directly into clinical system (inpatient and outpatients) **2**	To improve the quality of discharge information and medication supply by ensuring patients will be provided with at least 28 day's supply of long-term medicines, appliances and nutritional supplements on discharge **2**
To improve the quality of discharge information and medication supply and ensure patients will be supplied a "monitored dosage system" where this was in use prior to admission, or has	To improve the quality of discharge information and medication supply and ensure patients will be supplied full treatment course for all drugs where a defined treatment course is indicated e.g.

Initiatives aligned to measures within NHS Outcome Domain 3: Helping people to recover from episodes of ill health or following injury	
been deemed necessary by valid assessment during the in-patient stay **2**	antibiotics, steroids **2**
Self-administration of medication in secondary care **2**	

1.4 Ensuring people have a positive experience of care

Direct commissioners and the CCG will:

- deliver rapid comparable feedback on the experience of patients and carers;
- build capacity and capability in providers and commissioners to act on patient feedback;
- assess the experience of people who receive care and treatment from a range of providers in a coordinated package.

Indicators

- Patient experience of primary care – GP services and GP Out of Hours services **1**
- Patient experience of hospital care **2**
- Friends and Family test **3**

Initiatives aligned to measures within NHS Outcome Domain 4: Ensuring people have a positive experience of care	
Reduce COPD Admissions by carrying out a review of acute and community respiratory services **1, 2**	Reduce COPD Admissions by commissioning a range of preventative initiatives such self-care packs and patient education **1, 2**
Improve the Quality of Care within Residential and Nursing Homes and ensure all residential/ nursing home patients will have a regularly reviewed Health Care Plan (HCP) **1, 2**	Implement management plans for all patients identified by the LACE tool as being at high risk of readmission **1**
Review and audit of the new community services model **1**	Developing integrated health care services in Stockton, Billingham, Hartlepool and Yarm **1, 2**
To improve the quality and capacity in Primary Care by better understanding	To improve the quality and capacity in Primary Care and continue to support

Initiatives aligned to measures within NHS Outcome Domain 4: Ensuring people have a positive experience of care	
capacity and demand within Primary Care to determine future commissioning intent **1, 2**	Primary Care in reducing variation in General Practice, both in terms of quality and financial spend **1, 2**
Reduction in readmissions **2**	Continued Reduction in C2C Referrals **2**
Reduction in N:R ratio and review of Nurse delivered clinics **2**	Extend the Hartlepool plastics service to include access for Stockton patients **2**
Choose & Book by ensuring letters are reviewed prior to clinics to ensure patients are attending correct clinics **2**	Choose & Book by ensure patients are redirected to most appropriate clinics where wrong referral has been made **2**
Choose & Book by ensure advice and guidance is available via Choose and Book **2**	Implement revised MSK pathway to include direct access to core Physiotherapy and direct access to MSK **2**
Implement revised MSK pathway to ensure where referral is sent to incorrect, referral will automatically refer on to appropriate service without sending back to GP or requesting a re-referral **2**	Work with providers to reduce the number of delayed discharges **2**
Work with Provider to ensure that routine services are offered 7 days a week **2**	Development of a pilot memory clinic within a primary care setting **2**
Triage and signpost patients who are not appropriate to be seen in A&E to the relevant care provider in order to support the re-education programme **2**	Perinatal Mental Health – to ensure compliance with NICE guidance including potential for specialist community service **2**
Ensure CAMHS services meet NICE requirements and improves assessment to diagnosis waiting times **2**	Development of alternative rehabilitation and recovery services to support complex individual residents **2**
Review current commissioning arrangements for specialist sensory assessments and develop local pathway **2**	Implementation of e-discharge solution which transfers information directly into clinical system (inpatient and outpatients) **1, 2**
Implementation of Choose and Book, including advice and guidance **1, 2**	To improve the quality of discharge information and medication supply by ensuring patients will be provided with at least 28 day's supply of long-term medicines, appliances and nutritional supplements on discharge **2**

Initiatives aligned to measures within NHS Outcome Domain 4: Ensuring people have a positive experience of care	
To improve the quality of discharge information and medication supply and ensure patients will be supplied a "monitored dosage system" where this was in use prior to admission, or has been deemed necessary by valid assessment during the in-patient stay **2**	To improve the quality of discharge information and medication supply and ensure patients will be supplied full treatment course for all drugs where a defined treatment course is indicated e.g. antibiotics, steroids **2**
Self-administration of medication in secondary care **2**	

1.5 Treating and caring for people in a safe environment and protecting them from avoidable harm

The CCG aims to:

- significantly reduce C-Difficile in all providers in the health economy
- use the National Quality Dashboard to identify potential safety failures in providers.
- deliver zero tolerance to MRSA infection and conduct Post Infection Review
- Develop a patient safety culture across the NHS to strengthen the existing overarching indicators.
    - Patient Safety Incidents reported
    - Patient safety incidents involving severe harm or death
    - Hospital deaths attributable to problems in care
- Develop and utilise the use of the new placeholder indicator to measure 'Hospital deaths attributable to problems in care', this will provide a robust baseline and methodology for assessing national mortality attributable to problems in car and ensure that level of burden of harm from problems in care is fully reflected across the domain.

Indicator

- Incidence of healthcare associated infection (HCAI) – MRSA and C-Difficile **1**

Initiatives aligned to measures within NHS Outcome Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	
Improve the Quality of Care within Residential and Nursing Homes and ensure all residential/ nursing home patients will have a regularly reviewed Health Care Plan (HCP) **1**	
The CCG will use the NE Quality dashboard and safety measures and will monitor this through CQRG	

1.6 The 3 local priorities

The CCG has three locally identified measures agreed with HWBoards and key stakeholders, which will address local issues and priorities especially where outcomes are poor compared to others and where improvement in these areas will contribute to reduced health inequalities.

Plans describe the rationale for selecting the local priorities and describe the level of ambition given thought to clinical relevance, statistical significance and absolute improvement. As mandated in the 'Everyone Counts Planning for Patients 13/14' and as set out in the Quality Premium: 2013/14 guidance for CCGs Draft – December 2012' HAST CCG has worked collaboratively with the Directors of Public Health (DPH's) and their colleagues across Hartlepool and Stockton. The selected indicators are aligned to both the Health and Well Being strategies of the two local authorities and the CCGs own clear and Credible Plan.

In identifying the indicators for selection considerable work has been undertaken with the DPH's and colleagues. A review of the Joint Strategic Needs Assessment, the overarching Health and Well Being Strategies and the CCGs Clear and Credible Plan, along with the Outcomes Framework and CCG Outcomes Indicator Set informed the identification of a short list of indicators for possible selection.

Smoking in Pregnancy - Increase in the number of women achieving quitting smoking at time of delivery

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 which includes smoking.

Health Inequalities are spread across the CCG and within localities smoking prevalence varies from 16% to 48%. 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 smoking was an area selected as being a priority.. There are high rates of smoking during pregnancy therefore it was determined in line with all of strategies this area should be selected as a local priority.

This indicator will attribute towards the delivery of the NHS Outcomes Framework – Preventing People from Dying Prematurely and the CCG Outcomes Indicator Set – Reducing Deaths in babies and Young Children. Both Health and Wellbeing Strategies have identified 'Giving every child the best start in life' as a key priority.

Smoking in Pregnancy Baseline:

11/12: HAST CCG 19.3% - 12/13 Q3 - 17.9% (469/2614)

13/14 Expected Outcome: CCG 16.4% of pregnant women still smoking at time of delivery (573/3485) 3485 is the 12/13 FOT maternities

Emergency Readmissions within 30 days of discharge from hospital

The CCG will agree plans with health and social care providers for post discharge services to prevent avoidable readmissions. The CCG is working with neighbouring commissioning groups to identify best practice in care home management. The CCG have included within the commissioning intentions for 13/14 an intention to develop an approach that reduces inappropriate unplanned admissions and use of A&E. This indicator will attribute towards the delivery of the NHS Outcomes Framework – Helping people to recover from episodes of ill health or following injury. The indicator links clearly to the Health and Wellbeing Strategy priorities, in reducing long-term conditions; and reducing readmissions e.g. attributable to alcohol, where increasing screening and brief interventions and referral on to appropriate treatment services would help reduce readmissions. The CCG have commissioned an integrated Health Opportunity Assessment to be carried out with partner organisations to identify how to integrated services in order to deliver within this area, this is further supported through the reablement schemes.

13/14 Expected Outcome: Halt annual increase or increase in line with national % growth Target of 12.29% using standardised %. 4709/38313

The proportion of readmissions is rising locally and nationally therefore we aim to halt the increase

Estimated diagnosis rate for people with dementia

We have an ageing population. We expect our over 65 year population to increase from 17% to 22% over the next 16 years. As larger numbers of older people live longer, more people are likely to develop or 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. It is recognised people with dementia experience worse outcomes in acute settings and remains in hospital a third longer than average. We will work with our partners as we face a major challenge to getting our services fit for the increase in demand and able to provide the range of services required by selection of this indicator we will have robust data to inform future commissioning intent to meet the needs of this group of our population. We

are working with Primary Care and our Secondary Care providers to cross check practice registers to ensure that all new diagnosis are recorded accurately. This indicator will attribute towards the delivery of the NHS Outcomes Framework - Enhancing quality of life for people with long term conditions, the CCG outcomes indicator set – Enhancing quality of life for people with Dementia and the Health and Wellbeing Strategy.

This is a priority for Health and Wellbeing Board, which recognise the need to identify people needing support, to enable them to live independently for longer.

Baseline 11/12: 46.5% 1527/3283

13/14 Expected Outcome: 52.5% 1809/3446

Appendix 5 sets out the rationale in assessing ambition for selection of the local indicators as discussed and agreed with our partners and epidemiologists in Public Health and also details the working documents used by the CCG in producing the proposed improvement indicators.

1.7 Trajectory Setting

Appendix 6 outlines the technical process undertaken to develop Activity trajectories in relation to Outpatient, Inpatient, Non Elective and A&E Activity for the 13/14 contract year. The CCG would also propose the additional supporting narrative in relation to the following nationally required activity trajectories;

Improving Access to Psychological Therapies 'The proportion of the people that enter treatment against the level of need in the general population' – The CCG has proposed an annual target of 13.5% against this indicator. In light of current performance and recent changes to the provision of this service following procurement via the Any Qualified Provider process, the CCG would propose that attainment of this key requirement is based on Quarter 4 13/14 attainment as a percentage of the annual target i.e. the expectation is that there will be continued improvement against this indicator culminating in at least attainment of 3.375% in Quarter 4 13/14 to ensure the CCG are able to attain a recurrent target of 13.5%

Dementia Diagnosis Rates – The CCG has utilised the department of health dementia prevalence calculator and, in line with recommendations, applied the anticipated growth rates forward across both the first (13/14) and second (14/15) financial year. The CCG anticipates that the level of ambition demonstrated will be begin to close the gap in terms of prevalence and diagnosis, although recognises that this requires a long term approach.

Section 2 – The Basics of Care

This section outlines how the CCG will drive quality improvement in the delivery of care from all providers and how clinical leaders of the CCG will be assured that following cost improvement programmes, services are safe for patients with no reduction in quality and do not contravene NICE guidance.

Cost Improvement Programmes (CIP's) for all commissioned services will be signed off by the Medical/Nursing Director of the commissioned Providers. The process outlined below promotes a systematic exploration of quantitative and qualitative intelligence and encourages the orderly triangulation of information to help assess the quality impact of CIP's. The role of clinicians, including the Executive Nurse of the CCG is central to making this happen.

Establishing Confidence

In the first instance the CCG will consider the following:

1. A Quality Impact Assessment (QIA) has been completed and approved by Provider Boards.
2. Confirmation that the involvement of Provider Medical and Nurse Directors in agreeing and signing off CIPs has been undertaken. (2012/13 Operating Framework)
3. Providers can evidence compliance with NQB publication, Good Governance for Quality: a guide for provider Boards. (March 2011). Included in this document is reference to Monitor who describe a best practice approach to quality assurance through CIP processes.

Process – Undertaking the assessment

The Star Chamber approach based on the recommendations of the NQB will be formally adopted by the CCG. The Star Chamber will comprise of the following membership:

- Executive Nurse – Chair (CCG)
- Clinical representative in CCG – vice chair (CCG)
- Director of Finance (CCG and Provider)
- Head of Quality & Safeguarding (CCG)
- Head of Quality/Patient Safety (Provider)
- Commissioning Development Delivery Manager (CCG)

- Secretariat

The Star Chamber offers a useful method of completing various aspects of the quality impact assessment. It relies on collaboration between staff to identify critical indicators to inform the overall assessment. Such triangulation of information and perspectives also helps promote process reliability and validity. It also serves as a robust forum to enable constructive challenge. It equally serves as an opportunity to consider soft intelligence in the context of hard data as part of the overall assurance process. Finally, it provides an audit trail for future reference.

The Star Chamber will operate to the standards set in the NHS Early Warning Systems publication (February 2010).The Star Chamber will meet at least twice during the financial year, or more frequently if determined by the Governing Body. The Star Chamber will review each provider CIP and provide two RAG ratings based on the following:

- The level of detail and accuracy of the plans.
- The standard of evidence supporting the quality impact assessment.

The Chair will ensure that providers receive the outcome of the assessment and RAG rating in writing, including any specific requests for aspects of the CIP not to be implemented to protect quality pending further discussion/review.

The Star Chamber will consider receiving a presentation by the Medical/Nurse Director of the provider Trust in addition to a report in relation to CIPs to be shared prior to the first meeting. The values of openness and honesty will prevail between the CCG and Provider operating a principle of 'no surprises'.

The role of the Star Chamber in relation to QIA is described below:
The QIA is an on-going process explained in two stages.

- Stage 1: The Commissioner will examine at the commencement of the financial year all relevant data/information presented and submitted at Clinical Quality Review Group's (CQRGs) on a quarterly basis, (SIs, complaints, patient activity, etc) source data from national, regional quality dashboards, CQC QRPs, contract performance information on a monthly basis etc . Qualitative data sources will also be considered including patient stories, staff feedback. The Commissioner may also undertake a site visit to the provider to ascertain more facts and to check the reality of the situation at the point of service impact. This allows for a baseline assessment of the

quality of services provided. (i.e. the Provider's Quality Profile) against which the CIP can be judged as plans unfold in year. This information will be communicated/shared with the provider and agreement where possible reached.

- Stage 2: Surveillance and intervention – Routine monitoring of performance against plan will be undertaken by the Commissioner via CQRG (quarterly meetings) and contract/performance management processes (monthly). Intervention will be undertaken by the Commissioner where the situation warrants it. The Provider Medical and Nurse Director will be required to confirm on-going quality impact assessment of plans.

Section 3 – Patients' Rights: The NHS Constitution

This section outlines how the CCG will use the planning process to deliver on the rights and pledges from the NHS Constitution 2013/14. Identifying areas of poor performance during 2012/13 and actions plans to address to ensure performance is improved and sustained through 2013/14

Constitutional Pledge	2012/13 Performance	2013/14 Delivery Plan
Referral To Treatment waiting times for non-urgent consultant-led treatment	Both Hartlepool and Stockton PCT and therefore H&S CCG are currently achieving the 90% Admitted, 95% Non-Admitted and 92% Incomplete RTT targets. However, at a specialty level the CCG is not achieving the Admitted (both Hartlepool & Stockton localities), Non Admitted (only Hartlepool locality) and Incomplete (both Hartlepool & Stockton localities) targets. The main specialties of concern are Oral Surgery & Plastic Surgery. Contract Managers have raised issues with the Trust and action plans have been developed to address	Oral Surgery & Plastic Surgery activity during 13/14 will be commissioned directly within STHFT. Oral Surgery activity will no longer be commissioned by the CCG and the LAT will assume responsibility. Significant effort has been undertaken to further reduce waiting times backlogs in these areas during 2012/13, however the impact of winter pressures has hampered this to a degree. As part of the 2013/14 contract negotiations significant emphasis has been placed on the national quality requirements in relation to specialty level attainment of the RTT targets, and a risk assessment in relation to the delivery of these key quality requirements has identified that this may continue to be an area of challenge throughout quarter 1 of 2013/14. CCG & Area Team activity will have been formulated to ensure compliance with the RTT quality standards, commissioners are now progressing these with providers to ensure that there is contractual buy-in to these plans.
Diagnostic test waiting times	Currently no performance issues	These measures are included as a requirement within the Provider 13/14 contract therefore will continue to be

		monitored on a monthly basis implementing contracting levers where necessary should any performance issues arise.
A&E waits	Currently no performance issues	These measures are included as a requirement within the Provider 13/14 contract therefore will continue to be monitored on a monthly basis implementing contracting levers where necessary should any performance issues arise.
Cancer waits – 2 week wait Cancer waits – 31 days Cancer waits – 62 days	Although current performance is in line with national expectations these quality requirements continue to present a significant challenge to providers across Teesside. 2 week waits, specifically for breast patients, continue to suffer from the impact of seasonal effect primarily as a direct consequence of patient choice. In order to combat this significant work has been undertaken by the CCGs with member practices to ensure that patients are given appropriate information at the time a referral is made, a message reiterated by colleagues from within secondary care. The greatest area of challenge however remains the 62-day target. Both local Foundation Trusts have demonstrated significant improvement in terms of pathway management for those patients whose pathway is contained within a Tees-based provider of care. HAST CCG, along with the Northern Cancer Network are continuing to support local Foundation Trusts in ensuring that pathways across provider organisations are effective.	

Category A ambulance calls	Performance at a HAST CCG level along with that of the provider (NEAS) is above the national requirement of 75%. However this should be viewed in the context that local performance (at a Local Authority level) is reported below 75% for the Stockton locality (74.39% as at the January YTD position). The service is currently undertaking an A&E review to reconfigure ambulance crews which is expected to have an impact. NEAS are currently exploring sites in and around Ingleby Barwick to address the under performance and as an interim measure siting crews at emergency standby points in the vicinity. The CCG has continued to work with the provider throughout 2012/13 in order to improve performance. Although the CCG continues to press the provider, along with CCGs from across the North East of England, the new national standard contract for providers of Ambulance Services does not support CCGs in ensuring that all patients in all localities are able to receive an urgent response (i.e. Cat A) within 8 minutes as the nationally mandated quality requirements are reported at a Provider level. Commissioners are seeking to secure local quality requirements around the delivery of these standards at a locality level.	
Mixed Sex Accommodation Breaches	Currently no performance issues	These measures are included as a requirement within the Provider 13/14 contract therefore will continue to be monitored on a monthly basis implementing contracting levers where

		necessary should any performance issues arise.
Cancelled Operations	This measure has not been collected during 2012/13	These measures are included as a requirement within the Provider 13/14 contract therefore will continue to be monitored on a monthly basis implementing contracting levers where necessary should any performance issues arise.
Mental health	Currently no performance issues	

Section 4 – Patient Centred, Customer Focussed

This section outlines how the CCG will work with stakeholders to reform the health and social care system to deliver the five offers of the National Commissioning Board: The CCG will ensure that requirements are delivered through the alignment to workstreams and incorporated into delivery plans to develop in year.

4.1 NHS services, 7 days a week

The CCG will respond to the Medical Director's report to ensure primary and community services deliver high quality, responsive service in / out of hours and ensure better access to routine services 7 days a week in urgent and emergency care and diagnostic services.

Self-certification (Yes – the CCG will respond to the Medical Directors report expected in the Autumn and in preparation for this we have included within Provider contracts for 13/14 a requirement for Providers to carry out a baseline assessment of diagnostic and urgent and emergency care and an impact assessment to move to a seven day a week service where this is not already provided)

4.2 More transparency, more choice

The CCG will detail how and when they will ensure each of its providers for the services they commission, publishes its own information on these specialties on its website in the HQIP format in preparation for inclusion in the standard contract 2014/15.

Self-certification (Yes - the CCG has included within Provider contracts for 13/14 a requirement for Providers to publish activity, clinical quality measures and survival rates from national clinical audits for every consultant practising for those specialties as outlined in the Everyone Counts Planning for Patients Guidance 13/14 and in accordance with the HQIP format when guidance is available)

The CCG will detail a rationale for why and how they intend to increase choice in 2013/14 at all points of the pathway and how, where and in what services / pathways choice and competition will make the most difference.

Self-certification (Yes – the CCG will review the best evidence of how, where and what circumstances choice and competition has the potential to make the biggest positive difference and will utilise the NHS Commissioning Board and Monitor practical, evidence-based guidance and tools to assist in us delivering our commissioning plans ensuring choice is delivered to our population)

4.3 Listening to Patients and Increasing Their Participation

The CCG will identify how they are working with providers to establish processes to gather local public insight into local health services.

Self-certification (Yes – the CCG is committed to ensure that all NHS funded patients have the opportunity to leave feedback in real time by 2015. In preparation for this the CCG through CQUIN 13/14 are incentivising and working with Providers in improving the timeliness of patient and carer feedback to ensure transparency. The Friends and Family Test is also included as a National CQUIN indicator in 13/14). The local Patient Experience Programme agreed with Providers will drive forward real time patient feedback.

The CCG will detail how all NHS funded patients will be able to leave feedback in real time on any service by 2015 through the use of tools such as the Friends and Family test (acute inpatients and A&E patients from April 2013 and maternity services from October 2013.

Self-certification (Yes – see response above. The CCG will be working with Primary Care and the patient participation groups to ensure that feedback is gathered and acted upon)

Acting on feedback

The CCG will indicate how they will demonstrate the action taken as a consequence of feedback from Friends and Family test and plans to work with providers on further roll out from 2014/15.

Self-certification (Yes – the CCG has in place Clinical Quality Review Groups and a sub group of this is patient experience programme groups (PEPG). These groups monitor the Providers plans to drive forward continuous quality improvements in relation to patient experience)

Informing patients

The CCG to detail how they will:

- work with local HWBoards to assess population need and
- work with Healthwatch to ensure public involvement plans match local expectations for engagement at individual and collective level
- develop metrics to evaluate socio economic return on investment and other impacts of patient and public involvement activities.

Self-certification (Yes – the CCG has a communication and engagement strategy that sets out how we will engage with our partners and we are in the process of developing a plan that will detail how we will deliver our strategy in 13/14)

4.4 Better data, informed commissioning, driving improved outcomes

The CCG will be developing further detailed plans in year to enable delivery of the indicators, this will be integrated as part of the work plan that each workstream will be responsible for.

The CCG to detail how they will deliver the universal adoption of the NHS number as the primary identifier by all providers in 2013/14.

Self-certification (Yes – This will be delivered in accordance with the 2013/14 contract)

The CCG to detail how use NHS Standard Contract sanctions in 2013/14 if not satisfied with completeness and quality of provider data on SUS.

Self-certification (Yes – the CCG will through the North of England Commissioning Support service(NECS) implement sanctions in accordance with the NHS Standard Contract Terms and Conditions should we not be satisfied with the quality of data on SUS)

The CCG to detail how secondary care providers will account for patient outcomes and how they will ensure the adoption of safe, modern standards of electronic record keeping by 2014/15.

Self-certification (Yes – Patient outcome measures will be measured in year and monitored through discussion at the Clinical Quality Review Group)

In 2013/14 – secondary care providers will be expected to comply with data collections

The CCG will outline their strategies to ensure secondary care providers comply with data collections based on Information Standards Board and NCB advice by 30/09/13.

Self-certification (Yes – This is a requirement for Providers set out within their contract, Providers are required to provide a ¼ report detailing how they have implemented and monitoring is carried out within Data Quality Improvement Group meetings)

The CCG will detail how to move to a paperless referral system by 2015 to enable easy access to appointments in primary and secondary care.

Self-certification (Yes – The CCG will through contract management ensure Providers continue to roll out and implement Choose and Book in accordance with contractual requirements. The CCG will work closely with the Area Teams in the development of Primary Care to enable access to appointments easily.)

The CCG will outline in a plan how they will commission the appropriate GP information services to provide clinical assurance and safety.

Self-certification (Yes – The CCG has commissioned GP information services from the North of England Commissioning Support Service and formalised this arrangement through a Service Level Agreement)

4.5 Higher standards, safer care

Plans will outline the CCG and HWBoards will work together with providers to ensure the recommendations in Transforming Care: A National response to Winterbourne View Hospital and Francis report are implemented and ensure a dramatic reduction in hospital placements for people with learning disabilities or autism in NHS funded care who have a mental health condition or challenging behaviour.

Self-certification (Yes – Recommendations are included as local quality requirements set out in Provider contracts. The CCG have implemented plans for monitoring Providers to ensure compliance through the Clinical Quality Review Group meetings. Plans are in place and all placements in autism or inpatient assessment and treatment are being reviewed and plans will be developed to ensure that everyone in hospital inappropriately will move to community-based support as quickly as possible. Joint plans will be developed with Local Authorities to ensure high quality care and support services for all people with learning disabilities or autism and mental health conditions or behaviour described as challenging.

The CCG will detail how they plan to ensure the Compassion in Practice standards and application of the 6 C's are implemented across all the services provided for their population.

Self-certification (Yes - Standards are included as local quality requirements set out in Provider contracts. The CCG have implemented plans for monitoring Providers to ensure compliance through the Clinical Quality Review Group meetings)

The CCG will outline how their Responsible officers will ensure quality of appraisal and clinical governance systems in their organisations (including reference to the revalidation process).

Self-certification (Yes – The CCG will ensure quality of appraisal across the organisation by ensuring standard appraisal documentation and HR support from the commissioned support service. The CCG will ensure it has robust clinical governance processes/systems in place to contribute to the revalidation process by having regular appraisals with their clinical GP employees that are based on our core guidance for doctors, Good medical practice)

The CCG will demonstrate a commitment to implementation of the Comply or Explain regime and ensure compliance through the NHS Standard Contract.

Self-certification (Yes – Duty of Candour is included as a quality requirement set out in Provider contracts. The CCG have implemented plans for monitoring Providers to ensure compliance through the Clinical Quality Review Group meetings)

Innovation

The CCG will:

- detail that there will be automatic inclusion of positive NICE Technology Appraisals in local formularies planned and supporting safe and clinically appropriate practice.
- outline plans to publish local formularies and how they will track adoption of NICE TA's through Innovation Scorecard.

Self-certification (Yes –The CCG have a workstream Medicines Optimisation that will be responsible to oversee and undertake action to ensure that we are monitoring and supporting safe and appropriate practice. This will be part of the work plan for this workstream.)

The CCG will confirm their membership of an Academic Health Science Network (AHSN) and how they will use it to spread innovation and use at pace.

Self-certification (Yes – The CCG are working as a collaborative across the North of England and have a representative who is the member of the scheme.)

The CCG will detail how to promote the benefits of technology to improve outcomes *(the emphasis here should be on the more rapid take up of telehealth and telecare in line with patient need)* aligned to Innovation, health and wealth: Accelerating adoption and diffusion in the NHS.

Self-certification (Yes – The CCG in accordance with requirements to access CQUIN for 13/14 have carried out a baseline assessment of Providers to ensure that they are rolling out telehealth and telecare as set out in the document Accelerating adoption and diffusion in the NHS. The CCG are supporting a more rapid take up of this by incentivising Providers through new CQUIN schemes 13/14 to enable Providers to drive adoption more rapidly. The CCG is also working collaboratively with Health and Social Care in relation to wider adoption of these technologies recognising that successful delivery of reablement schemes will be recognised by wider adoption, innovation and collaborative working.

Section 5 – Transforming health and social care at CCG level

The CCG will work with local stakeholders to transform their local health and social care system and then work collaboratively at a sub-regional or regional level to transform the way that health and social care is delivered for the local population and population of Hartlepool and Stockton-On-Tees.

5.1 Joined up Local Planning

The CCG has worked together with the local health economy to identify the parents of children with special educational needs or disabilities who could benefit from a personal budget based on a single assessment across health, social care and education. The following section outlines plans to deliver this.

The CCG is a key stakeholder in the SEND pathfinder with Darlington and Hartlepool Borough Council in response to the Government's plan to overhaul the special educational needs as detailed in the Queens Speech. A single, simpler assessment process will be introduced for children with SEND or who are disabled, backed up by the new Education, health and Social Care Plans. The bill is expected to be introduced in 2013 and be implemented during 2014.

The objectives/challenges of the pathfinder are:

- *Disaggregation of Education and Health budgets*
- *Streamlining assessment, approvals and review processes*
- *Delivering in a period of economic uncertainty and Council wide restructuring and efficiency reviews.*
- *Engaging a good cross section of families.*

This means for families there will be:

- *More choice and control*
- *Opportunities for integrated working*
- *Opportunities for a stronger local voice*
- *Focus on improved outcome*

The pathfinder has developed a single education, health and social care plan focusing on whether outcomes for disabled children and their families have been improved. The pathfinder intends to offer personal budgets (including elements of health and education) and the right to ask for a direct payment for the delivery of the package, NHS Tees has the power to offer direct payments as part of a Personal Health Budget in line with agreed health and well-being objectives outlined within the single plan.

There are currently three work streams operating within the health element of the pathfinder:

- Work is on-going within Tees to assess and report the financial impact and cost effectiveness and what the effects these changes may have on traditional NHS services. Including using the single plan to map current services for example CAMHS, LDCAMHS and SALT for the children selected as part of the pathfinder. To identify what services can reasonably and practically offered through a Personal Health Budget.

- Engagement with families and carers to identify what parents and young people want to change and why. Helping families navigate the system providing clearer information for families, feeding back information to influence future commissioning.

- Market place development, both developing 'traditional services' with the views and influences of young people and parents. Investigating the market which exists outside of commissioned services to be able to offer choice and control.

Workforce Development, Education and Training

The CCG recognises the importance of ensuring that the providers of NHS services commissioned by them have a workforce that is of sufficient size with the appropriate skills and competencies. It understands that the CCG role is not to performance manage the detailed workforce planning of provider organisations but to promote understanding of key workforce capacity risks and opportunities, and set an environment for potential joint action that reflects a healthy balance between contestability and collaboration in workforce issues across the local health economy. Further the CCG accepts the duty to promote education and training.

The NHS provider led Local Education and Training Governing Body for the North East and North Cumbria[1] has been operating as a sub-committee of the SHA for a year. It comprises a governing body made up of members from large providers of NHS services, the SHA and two primary care provider representatives; a number of special interest sub-groups and a partnership council.

The CCG discharges the statutory duties with respect to workforce planning, education and training by:-

- Ensuring that that all providers of NHS services commissioned by the CCG are members of the LETB through the contract compliance/performance management process.

- Setting up a process in partnership with all of the CCGs in the north east and north Cumbria area to ensure that there is a system wide approach to ensure the alignment of CCGs commissioning intentions and integrated strategies from Health and Wellbeing Boards, with long term workforce strategies and the plans for the commissioning and quality assurance of education and training

- Working though the North East Commissioning Support Service to consult with the LETB as commissioning plans are developed to ensure workforce development can rapidly respond to innovation and changes in the way services are delivered.

5.2 QIPP 2013/14

QIPP 13/14

Our Clear and Credible Plan outlines four key QIPP programmes and our commissioning initiatives for 2013/14 have been developed to support these programmes and priorities
The four QIPP programmes are:

- ***In hospital care*** – including re-design of elective pathways and demand management to contribute to savings and cost avoidance for elective and planned care.
- ***Out of hospital care*** –reform of the urgent care system and improved joint working with social care to contribute to savings and cost avoidance for non-elective and un-planned care.
- ***Mental Health & Learning Disabilities*** – supporting patients to better manage their conditions and provision of more services in primary care and community rather than acute settings.
- ***Medicines Optimisation*** - Medicines management seeks to release efficiencies through improvements and standardisation in prescribing practice and formularies working closely with Area and Local Prescribing Groups.

Learning from 2012/13

Hartlepool and Stockton-On-Tees CCG has gained significantly learning from the work undertaken in 12/13 to deliver the QIPP challenge. Through the workstreams outlined above the CCG will continue to progress those schemes initiated during 12/13 that present additional opportunities in relation to QIPP savings. Schemes to deliver and take forward in year to meet the QIPP challenge are;

- The CCG will continue to require implementation and adherence to the Consultant to Consultant protocol during 2013/14. This will be monitored on a monthly basis validating referrals against the protocol and ensuring that only urgent referrals or those within the agreed protocols are managed as a consultant to consultant referral. We will collaborate with South Tees, DDES and Darlington CCGs to ensure a standardised approach

- The CCG will continue to implement a programme of specialty based reviews, expanding on work undertaken throughout 2011/12 and 2012/13 to encompass both Elective and Non Elective Care, mental health and community services identifying and delivering key QIPP initiatives that mutually benefit both the provider and commissioner. We will collaborate with South Tees, DDES and Darlington CCGs to ensure a standardised approach

- The CCG will continue to build upon the work undertaken during 12/13 which was a key deliverable to meet the QIPP challenge in reducing GP variation in spend through the visits and commissioning support provided to practices to review processes and pathways. This approach will ensure member practices will remain engaged. The CCG will further develop this approach to reducing variation through the use of the RAIDR tool. The Trust will continue to use the predictive risk tool (LACE) built into RAIDR building on its use in 2013/14 with an aim to reduce non-elective admissions due to the exacerbation of a patient's condition.

- The CCG will continue the work carried out in relation to medicines optimisations, continuing to review variation in spend across the two localities to gain a better understanding and determine if this is appropriate variation according to clinical need and not variation due to clinical practice. This approach successfully delivered the QIPP challenge in this workstream during 12/13.

- The CCG will use the key findings from the Acute Quality Legacy work to inform the focus of future RPIWS to ensure we are commissioning more effective pathways of care with contracted providers; this will support work to reduce the numbers of emergency admissions, readmissions and associated system wide non-elective related pressures this is a joint initiative with our partners.

Further QIPP schemes will be identified and developed within the workstreams in support of delivering our QIPP challenge, workstreams and priorities are set out in our Plan on a Page Appendix 2.

Sustainable Commissioning

The CCG, working with commissioned providers, is seeking to ensure that funding streams continue to follow the patient and that this in turn supports the key principles that patients can (and will) access the right services at the right time, and that where appropriate patients should be able to access treatment within the their own home or within a suitable community based setting.

In progressing the commissioning plans for moving services to a community setting (Momentum Pathways to Healthcare), Community Renaissance and Urgent Care, the CCG is seeking to ensure that resource is appropriately targeted at those services which best meet patient's needs in order to deliver best practice pathways of care, while recognising the need to support provider organisations through a period of significant transition i.e. while these pathways are implemented and services are being moved into community settings in order for the single site hospital to be developed.

Triangulation and CIP

The CCG is cognisant of our responsibility to ensure that services commissioned deliver high quality standards. The CCG will continue the approach of the Clinical Quality Review Group (CQRG) assessing, identifying any causal links in variation, either planned or unplanned, and providing assurance to the Quality Performance and Finance Committee (QPF) that any cost improvement initiatives do not affect the quality or safety of care.

The CCG will review the Provider's CIPs and carry out a clinical quality impact assessment in accordance with the processes outlined in section 2 of this document.

Activity Plans

Activity plans have been developed using previous years activity levels and seasonal trends, combined with any known developments (Commissioner or Provider led) or workforce changes (i.e. extended planned leave or retirement etc.) along with the impact the increase in working days in 2013/14 over and above 2012/13 and any known or anticipated demographic changes including increased prevalence.

It is anticipated that as a result of demographic shifts there will be moderate growth in Elective Activity, with a shift from Elective to Day case in line with historic trends. Outpatients will see minimal growth in Consultant led 1st attendances with an increase in nurse-led and non-face to face consultations, with a reduction in follow-up attendances based on the work

being undertaken within the specialty based review programme and consultant to consultant reviews. As a result of the work undertaken in Primary Care to manage conditions that do not require a surgical intervention within alternative setting those patients who are referred are more likely to result in an elective intervention in comparison to previous years.

In terms of Non Elective Activity it is anticipated that there will be a marginal reduction in the growth in the number of Non Elective FFCEs in 13/14, it is anticipated this reduction will accelerate as workstream projects take effect.

Local Metrics

In developing the plan the CCG, has engaged with a wide range of partners including the Health and Well Being Boards, Public Health, Provider Organisations and Patient groups (via local groups) in order to identify the needs of the local health community. These needs have been considered and the Plan on a Page (see appendix 2) is the CCGs response as to how it is intended to meet these needs.

Key tools such as the Joint Strategic Needs Assessment, Health and Wellbeing Strategy and Safety Thermometer have been utilised to further enhance all partners understanding of the needs of the local health community.

The NHS better care, better value indicators, NHS comparators, Programme budgeting and the CCG/LA outcome benchmarking support packs will be utilised in year to identify potential areas for improvement in relation to meeting our QIPP gap, and in order to develop services to improve the patient experience and maximise efficiency that can be used to fund new initiatives and areas of increasing demand.

Section 6 – NHS 111 and Emergency Preparedness Resilience and Response

6.1 NHS 111

The CCG will continue to work with the local health economy to ensure full implementation of NHS 111, how it continues to be embedded within the local health economy through a Clinical engagement and the process for assessing and evaluating the impact of NHS 111.

A significant amount of work has been done to prepare for the introduction of 111 on the 2nd April 2013. Engagement with all service providers has allowed the project team to compile a robust Directory of Services (DOS) which will ensure local people enter the right urgent care services first time.

In addition to the above, 'The 5 stages of the patient pathway' has been completed with each individual provider to ensure each pathway was seamless and offered the patient an optimal service. These pathways have been ratified by each provider to ensure ownership and accuracy of services reflected within the DOS.

Scenario testing has been instrumental in demonstrating any omissions or gaps within services profiled within the DOS and this has been clinically led by Dr Alex Barlow (Stockton GP). It has also allowed any themes or issues to be highlighted to both providers and commissioners and ensured mitigation or remedial action can be undertaken prior to 'Go Live'.

Across Tees a robust engagement plan has been adopted to facilitate this element of the project which encompassed key stakeholders from both health and social care, in conjunction with service providers. In addition, local medical councils, dental, pharmacy and optometry councils were also included.

The project implementation team on Tees prioritised a good relation with the LMC as a conduit to ensuring local GP support. This was performed two fold - firstly by meeting with LMC officers and secondly communicating in writing to the committee for consideration.

There has been great emphasis placed on ensuring clinical engagement is apparent throughout the NHS 111 implementation planning phase. Empowering clinical staff within service providers cannot be underestimated; allowing them to engage and make informed decisions ensures change can be implemented non problematically.

A transformational approach to engagement has been adopted to ensure maximum collaboration and partnership working with service providers.

Throughout both the Directory of Service Workshops and 5 stages of the patient pathway, clinicians and managers from both commissioning and service providers engaged continuously until all involved were reassured that demographics and patient pathways were robust and reflective of their services.

Clinical engagement has been invaluable in respect of obtaining a wealth of expertise and knowledge from those services that recognise their own specific issues currently and pre-empt those potential issues which need to be considered. The knowledge obtained has allowed the project implementation team the liberty of reflecting upon both short term and future developments which will enhance the urgent care services within Tees.

The “Clinical Engagement” events held in Tees allowed local health care professionals the opportunity to test NHS Pathways which will be the triage tool used by the 111 service.

CCG Clinical leads have been identified and the current project clinical lead will assist in the transition of transferring NHS 111 to them. Regular contact and teaching throughout the transition has commenced and will continue until the team and the leads are confident.

As part of the mobilisation of the NHS 111 service a Clinical Governance Forum has been established to review the quality of the service in place on an on-going basis, charged with looking at patient safety, clinical effectiveness and patient experience. In order to achieve this, processes are in place to undertake end-to-end reviews of recorded calls to the service as well as reviewing the feedback from healthcare professionals via incident reports, letters, complaints etc.

We have already stated in our clinical governance submission to the Department of Health that the effectiveness of the NHS 111 service is a key plank to delivering the challenging QIPP requirements going forward so there will necessarily be close integration with the wider Urgent Care/In-Hospital workstream.

6.2 Emergency Preparedness Resilience and Response

The CCG can provide assurance that:

Providers of NHS funded care have business continuity plans in place	Self-certification (Yes) This is a requirement of the NHS standard contract
CCGs have a schedule to review commissioned providers' business continuity plans	Self-certification (Yes)
CCGs have a process/rota in place to enable their commissioned providers to escalate issues to them 24/7	Self-certification (Yes) A proposal has been put forward from the Northern CCG Commissioning Forum to establish a North East wide CCG on call rota, to address the capacity of individual CCG organisations, it is suggested this would be piloted for a period of six months.

Appendices

Workstream	Appendix
Appendix 1 – Workstream Summary	1302 Workstreams summary (HAST).doc
Appendix 2 –Plan on a Page	1301 Hartlepool and Stockton plan on a pa
Appendix 3 - Outcome map	Plan on Page - Outcome Map V2.xlsx
Appendix 4 – Risks	Risks.docx
Appendix 5 –Rationale for Local Indicator Selection and local working documents	CCG indicators.ppt; Tees CCGs Local Priorities Working Doc
Appendix 6 – Trajectories To include update activity plans	HP&ST 00K - Planning Round 2013; CCG CDiff Trajectory 220213.xlsx; Everyone Counts - Trajectory Setting ov