System Vision

'To develop outstanding, innovative and equitable health and social care services, ensuring excellence and value in delivery of person centred care working across both Health and Social Care'

We will do this by;

- Ensuring commissioning for quality outcomes and services deliver the required standards
- Putting patients at the heart of what we do and creating a system that is flexible and responsive enough to recognise the different needs of individuals
- Actively seeking out unmet need as well as responding to expressed need
- Establishing systems and processes that are sustainable and affordable to deliver continuity of care ensuring patients are involved in treatment decisions and planning their own care, including referrals, and being helped to navigate services and systems outside the GP practice
- Striving to improve on what we do through change and innovation
- Learning from successes and setbacks
- Remembering to always be caring and compassionate

Residents of Hartlepool and Stockton-on-Tees deserve the best possible, "joined up" health and social care. This is why NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG), alongside all our partners in the public, independent and voluntary sector are working to improve our local Health and Social Care system. We believe everyone should get the right care, in the right place, at the right time, which will help them have longer, healthier lives ensuring ***"I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me."*** *(Integrated Care and Support: Our Shared Commitment; pg7)* is how our communities.

Different organisations have responsibilities for different parts of commissioning services and changes are needed to ensure we work jointly to improve experience and outcomes for our communities.

The CCG Strategic Commissioning Plan sets out a description of our vision in relation to what healthcare services will be commissioned over the next five years. These plans will ensure local residents have access to the best possible health and health care services that deliver the best outcomes.

The plan describes the CCG's undertaking to ensure continual improvement in the quality of health services, reduce health inequalities, prevent illness and promote health, driving greater efficiency and productivity in services and to look for

innovative solutions to ensure the very best healthcare is available to patients through an integrated and evidence based approach.

Our Vision and Plans are being developed through working closely with all our stakeholders and partners in the NHS, Local Authority and voluntary and community sector (VCS), as well as through active consultation with our patients and the public. This partnership working is crucial to achieving our ambitions and to meeting the challenges of the years ahead. We need to ensure we are able to sustain services whilst we work within the financial and resource constraints across our organisations, ensuring we are able to deliver effective patient centred services and simpler care pathways that reduce duplication and inappropriate use of resources through integration in the next five years.

NHS England's Call to Action forecasts a financial gap of £30 billion by 2020/21 and the affordability challenges in 2014/15 and 2015/16 are real and urgent. The prospect of resources being outstripped by demand, driven largely by an ageing population and an increasing prevalence of chronic diseases presents a significant challenge to the way we currently commission care from providers. We cannot meet future challenges alone and we recognise the importance of prevention and co-ordinated pathways of care and it is clear that by working with stakeholders and partners to deliver effective change, whilst ensuring we continuously seek patient's views and opinions.

There is already a strong focus on Partnership working within Hartlepool and Stockton-on-Tees, Momentum: Pathways to Healthcare has been the blueprint for the last 5 years. Working in close partnership with our Providers this has helped us to achieve many changes in clinical services which improved quality, safety and patient experience in the services we commission. We now need to ensure that we continue this and ensure a joined up approach with our social care partners, the Better Care Fund is therefore seen as a significant step forwards in developing integrated health and social care services. Ensuring we work together to provide better support at home and earlier treatment in the community, through this joint planning we will be able to reduce the pressures on urgent care and prevent people needing emergency care in hospital or care homes.

Given the constructive partnership that has developed through the establishment of the Health and Wellbeing Boards within Hartlepool and Stockton, there is a strong desire and commitment to further develop the partnership working that has been achieved to date and to build on this utilising some of the additional opportunities that the changes in national policy bring.

Our vision of service delivery as we move forward is to have a sustained focus on integration, meaning **organisations working together to create services that maximise health and wellbeing and address individual needs, improving outcomes and experiences for individuals and communities.** (*Integrated Care and Support: Our Shared Commitment*; *pg13*).

This is seen as particularly important in our local economy given the financial constraints that individual organisations are already experiencing. This, coupled with a continuing increase in the needs of our aging population and increased prevalence of long term conditions and a recognition that we have patterns of care and services that will be unsustainable in their current form, means we will need to work differently if we are to achieve the transformation of care required and deliver more with less. The development of a sustainable care system in Hartlepool and Stockton will only be possible through an integrated approach and stronger alignment of priorities, resources, and incentives and rewards.

Partners consensus is that 'going it alone' is not an option and we will not be able to achieve the objectives of individual organisations or the shared priorities of the Health and Wellbeing Strategy unless we focus on shared priorities, coordinate our efforts and align our resources across the economy and all organisations.

Our vision is that by 2018/19 everyone is able to live at home longer, be healthier and get the right support services where required, whether this be provided by health and or a social care. We will have a healthcare system where we have integrated health and social care, a focus on primary prevention, early diagnosis and intervention, and supported self-management. Where a person requires hospital treatment if this cannot be provided in a community setting, we expect this will be carried out as a day case treatment or in an outpatient setting.

Care will be provided to the highest standards of quality and safety, with the person remaining at the centre of all decisions. Our focus will be to ensure that people can remain in their own homes or when this is not possible and they have to be treated in hospital we will ensure that their discharge is appropriately planned to ensure that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

Each individual's care will need co-ordination, decision-making and leadership. Those with the greatest need will have a named professional health and social care coordinator who will have responsibility for leading their care and taking a proactive approach to meeting the individual's health and social care needs.

Our five year plan builds upon the excellent progress made during 2014/15 in partnership with member practices, stakeholders and the public. It reflects the CCG's current direction of travel and local priorities as set out in our Clear and Credible Plan 2012/17 (CCP) as these objectives remain extant and the CCG is committed to deliver our obligations as well as those that are set out in the NHS Constitution.

What does this mean for the people we serve?

We want the people of Hartlepool and Stockton-on-Tees to live as healthily as possible at home, supported by high quality primary care, community health and social care services, supported by new advances in technology.

We want

- To ensure that the population of Hartlepool and Stockton-on-Tees have access to a wide range of primary prevention interventions including but not limited to smoking cessation services, exercise, weight management, IAPT, problem drinking support, cancer screening programs, immunisation, social prescribing, carer's support and good nutrition.

- To identify the 'missing thousands' of people who have undiagnosed and unmanaged long term conditions such as cardiovascular disease (including atrial fibrillation and hypertension), diabetes, COPD, dementia and early cancer.

- To maximise independence and quality of life and helping people to stay healthy and well through the development of integrated community health and social care services with a focus on long term conditions, frail elderly (including end of life) and dementia. This will be delivered through the roll out of an integrated care model building on existing care planning, care co-ordination, risk stratification and multi-disciplinary teams in place

- To streamline care and reduce activities that are carried out by multiple organisations ensuring the right services are available at the right place, right time through an integrated community team providing rapid response to support individuals in order to remain at home and avoid admission

- To improve people's experience of services through the introduction of a single point of access across health and social care, utilising the NHS number. We want to work towards a digital information system across the whole health and social care system that will share people's information to enhance the quality of care and ensuring continuity of delivery.

- To improving outcomes for service users and carers through clearer and simpler care pathways; proactive management of people with long term conditions. We will do this through co-designing models of care that will meet need. These pathways will be simple to understand, simple to follow and will be available for all staff, patients and carers to see.

- To have a skilled workforce that understands both the health and social care system and works across organisational boundaries, making every contact count.

- For each person to have a package of care that improves their physical, social and emotional wellbeing, acknowledging that all three elements are necessary to enjoy good health.

- To support personalisation and choice by being able to develop a range of coordinated alternatives to hospital and residential care, this will be delivered through investment in personalised health and care budgets ensuring individuals are able to make informed decisions

- To ensure the innovative use of digital technology are utilised to deliver the greatest possible benefit to patients and carers across health and social care services

- To improve access to community health and social care services 7 days a week to improve patient experience and provide responsive services in and out of hours, reduce delayed discharges and improve support to empower people to live independently

Our vision for integration is ambitious, it is about establishing a landscape in which different public bodies are able to work together, and with their partners in the third and independent sectors, removing unhelpful boundaries and using their combined resources, to achieve maximum benefit for patients, service users, carers and families.

It is acknowledged that this means new ways of working and a change across the current landscape. Acute, Primary, community care services (including Mental Health services) and the independent and voluntary sector play a central role in helping people live healthy, independent lives with dignity and respect. It is these services that will ensure delivery of quality and improvement in patient experience and deliver support and education packages to patients and their carers to enable them to manage conditions to the best of their ability. This will change how health and care services are delivered so we can deliver care in a personal setting that ensures hospital admission is avoided where appropriate resulting in a consolidation of acute care to optimise efficiency and deliver the highest quality and safety standards required nationally.

Our vision is of primary and community care services working ever more closely together, along with voluntary organisations and other independent sector organisations agreeing common goals for improving the health and well-being of local people and communities. We will engage with partners and the community and work with service users to develop innovative approaches. Community engagement and community development will become increasingly important in our joined up approach to health and well-being.

Our Provider organisations are of critical importance in delivering our vision for the future of primary and community care requiring a commitment to drive service transformation, build on existing care planning care co-ordination and risk stratification across multi-disciplinary teams to ensure an integrated approach.

GPs are central to organising and coordinating patient care. Clinical leadership brings real added value to the commissioning of local services. As professionals working on the frontline with patients every day, Hartlepool and Stockton clinicians understand the local health economy and are well placed to work with colleagues across health and social care to improve the local quality of care and outcomes for our patients. CCG members and clinical leaders are also attuned to their patients' views and the choices they make in practice consultations. The CCG is structured to reflect these consultation room choices in its future commissioning plans within the existing workstreams haven already been configured. We will therefore ensure investment in the enhancement to the provisions in relation to extending GP services to 7 days per week and a focus on better supporting people with complex health needs and those with long term conditions and those most at risk of admission to hospital or those most in need of social and emotional support.

The CCG will operate with the strong clinical leadership of local practices to commission and improve local services. Just as our clinical experience gives us a deep insight into local health and care services, we recognise that as users of these services, patients and the public play an equally important role in establishing the priorities we set and the decisions we take and should be central to developments so services are developed around the patient and not that patients are defined around the structures in place.

Better planned, person centered services are expected to deliver a more responsive service across health and social care with a continued focus on those with greater need such as those such as those at the end of their lives or those with complex medical problems.

We will work with our partners to improve the way we commission services as we have a joint Health & Wellbeing Strategy which clearly sets out our shared health and wellbeing goals and we will determine which services could be jointly commissioned where appropriate.