AGENDA ITEM

REPORT TO HEALTH AND WELLBEING BOARD

28 APRIL 2014

CHIEF OFFICER NHS HARTLEPOOL AND STOCKTON ON TEES CLINICAL COMMISSIONING GROUP

Everyone Counts Planning for Patients 2014/15-18/19 – Operational and Strategic Plans

SUMMARY

Following presentation of the NHS planning requirements as set out in the Everyone Counts Planning for Patients 2014/15-18/19 to the Health & Wellbeing Board on the 23rd January, this report is to update the Health and Wellbeing Board members of progress to date and the current position of the CCGs 2 year plan and DRAFT 5 year strategic plan both of which were required to be submitted to NHS England.

The final 2 year plans including the Better Care Fund (BCF) plans have now been submitted to NHS England Area Team (NHS England AT) for review and will subsequently receive ministerial review in relation to the BCF plans.

The submission dates for both the strategic and operational plans were set in accordance with a nationally mandated timetable and we expect to receive further feedback from NHS England following their and ministerial review of the plans following final submission of the 5 year strategic plan on the 20th June and will update Health and Wellbeing members accordingly.

BACKGROUND

As set out in 'Everyone Counts: Planning for Patients 2014/15 to 2018/19', the CCG is required to submit a 5 year Strategic Plan and a 2 year Operational plan, supported by detailed documentation showing the expected impact on finance, activity and outcome ambitions.

The 5 year strategic plan differs from an operational plan; it is meant to be short, focussed and describe the direction of the organisation(s) that have signed up to it. It describes to those outside the system what the system plans to achieve in a way that informs and engages. It provides the basis for further detailed planning and should stimulate change in a system. That said, the strategic plan must also be realistic and attainable, to allow those within the system to understand and align with the strategic vision whilst working at all operational levels. It is essential for these plans to be at the forefront of the planning process; they set the vision, ambitions and framework against which the two year detailed operational plans will be set. We are already some way in relation to developing the 5 year strategy as we have taken the approach to build upon and refresh our Clear and Credible Plan 2012-2017(CCP). The objectives set out in the CCP were agreed with our member practices and developed with partners therefore remain extant.

The 2 year operational plan (Appendix 1) is required to describe how the CCG will deliver the priorities set out in the refreshed NHS Mandate 2013 to 2015 and in Everyone Counts Planning for Patients 2015/19, to address the challenges and build a high quality, sustainable health and social care system for the future. This also details the ambition set in relation to the outcome measures and supports delivery of the ambitions set on a local basis as described in the BCF plans (Appendix 4 &5).

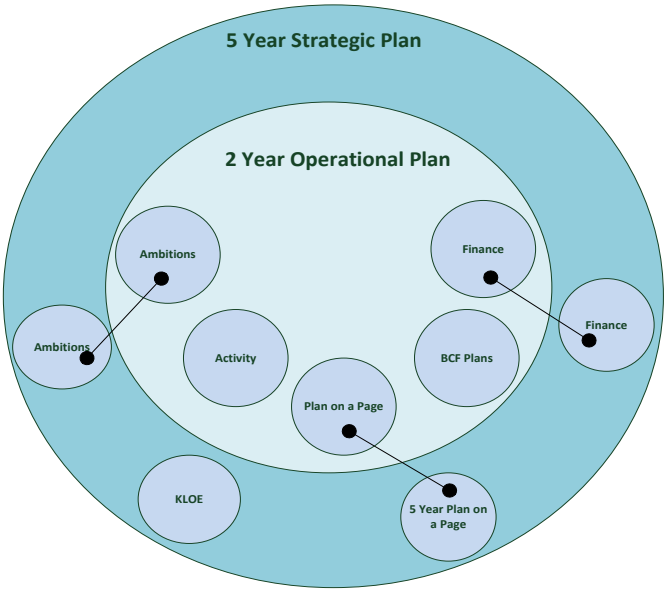
The 2 year operational plan also incorporates the Better Care Fund Plans which have been developed with our partners within Stockton local authority. The 2 year plans and 5 year strategy have been informed and developed on the basis of the shared vision agreed with partners and as described in Appendix 4. In developing our 2 year operational plans and the 5 year strategic plan we have used the BCF plans as a platform to develop the 5 year vision and strategy.

All partners have recognised as financial and service pressures facing the NHS and local government intensify, the need for integrated care to improve people's experience of health and care, the outcomes achieved and the efficient use of resources has never been greater.

The aim of the BCF is to act as a catalyst for the integration of health and social care, providing an opportunity to transform care so that people receive better integrated care and support. It is also acknowledged as a way of helping to deal with demographic changes in adult social care and the policy and legislative changes associated with the introduction of the Care and Support Bill.

The CCG is committed to build upon the partnership working undertaken in the development of the BCF and have outlined this in our 5 year strategic vision (Appendix 9). This is a shared vision agreed with partners that will ensure we all meet the challenges presented in future years to enable the delivery of quality integrated services, whilst delivering activity and financial balance across the health and social care system. The support of Health and Wellbeing partners in driving forward these plans will be critical to ensure delivery and to promote further partnership working as we move forward. The diagram below attempts to describe the interdependencies across the separate plans:

Planning 14/15 – 18/19



The Vision delivered

Our vision is over the coming years to improve outcomes for service users and carers through clearer and simpler care pathways and; proactive management of people with long term conditions. We will do this through co-designing models of care that will meet individual need. These pathways will be simple to understand, simple to follow and will be available for all staff, service users and carers to see and manage. Each person will have a package of care that improves their physical, social and emotional wellbeing, acknowledging that all three elements are necessary to enjoy good health. This will be achieved through delivering an integrated care package across health and social care making every contact adds value.

We will support personalisation and choice by developing a range of coordinated alternatives to hospital and residential care, by undertaking joint assessments and providing patients / service users with a holistic assessment of need aimed at keeping people safe and independent in their own homes for as long as possible This will be delivered through investment in personalised health and care budgets ensuring individuals are able to make informed decisions and by shifting care closer to home from acute to community settings whilst ensuring services are responsive and are able to recognise the need of individuals.

We will ensure we sustain quality care and services across health and social care. The work to deliver Momentum; Pathways to Healthcare and Secure Quality in Health Services (SeQIHS) will continue to drive this in relation to acute hospital services, informed by clinical and public engagement. It is clear from SeQIHS and national work (i.e. Sir Bruce Keogh's plan to drive seven day services across the NHS) that this will require commissioners to commission care and services differently and for providers to develop new ways of working that will inevitably lead to a realignment of services. Commissioners (health and social care) and providers will clearly need to work together closely to take this work forward in a coherent way. The NHS England paper NHS Services: Seven Days a Week highlights the fact that meeting the seven day clinical standards (which align closely with the SeQIHS standards for acute medicine and acute surgery) will be challenging for some health economies and "this points to the need for providers and commissioners to explore new ways of working, in networks, collaborative or federations, and to consider the distribution of different services between trusts."

We expect to improve access to community health and social care services seven days a week to improve user experience and provide responsive services in and out of hours. This should reduce delayed discharges and improve support to empower people to live independently whilst reducing the number of avoidable admissions and pressures of demand on our urgent care services. This will be further enhanced through the development of integrated community health and social care service with a specific focus on better management of long term conditions, targeted support to frail elderly (including end of life) and dementia sufferers delivering an integrated model of care which will build on existing care planning, care co-ordination, risk stratification and multi-disciplinary working. This will ensure individuals will be involved in decisions and planning their own care and support. Our aim is to streamline care and reduce activities that are carried out by multiple organisations ensuring the right services are available in the right place, at the right time through an integrated community approach. We envisage this will involve greater use of third sector and voluntary organisations as well as better use of digital technology.

We have developed a 5 year urgent care strategy and a detailed 2 year urgent care plan. The objective is to provide a 24/7 seamless urgent care pathway that will meet

the needs of the local population and will deliver the quality and financial requirements of QIPP. It will focus on revised pathways of care and will navigate patients and the public to the most appropriate service. Our commissioning plans will provide the infrastructure to progress the overall strategy with a strong emphasis on communication and education.

We will address health inequalities through actively seeking out unmet need as well as responding to expressed need by identifying the 'missing thousands' of people who have undiagnosed and unmanaged long term conditions such as cardiovascular disease (including atrial fibrillation and hypertension), diabetes, COPD, liver disease dementia and early cancer, maximising the independence and quality of life and help people to stay healthy and well. We will ensure by working closely with Public Health colleagues that the population has access to a wide range of primary prevention interventions including but not limited to smoking cessation services, exercise, weight management, as well as early intervention to prevent the deterioration of patients health where this can be avoided in relation to IAPT, problem drinking support, cancer screening programs, immunisation, social prescribing, carer's support and good nutrition. This will be supported through promotion of self-care by involving patients and carers in decision making and raising awareness.

In response to feedback from the public we will improve people's experience of services through the introduction of a single point of access across health and social care, whilst utilising the NHS number to enabling the sharing of information, we will work to improve the systems and connectivity 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.

We understand to deliver our vision we need to ensure that we make best use of digital technology and this is utilised innovatively to deliver the greatest possible benefit to people using services and carers across health and social care services and we will work with partners, patients, carers and providers to determine the best approach to undertake this.

Submission and Next steps

The structure of the submission had three core categories. These categories are operational plan requirements, strategic plan requirements and a planning checklist. Operational planning requirements are set out in Appendix 1-7, strategic plan requirements in Appendix 7-9 and a planning checklist is set out in Appendix 10.

The 2 year operational plans (including BCF) need to be consistent with the strategic direction and financial plans, triangulation across these various elements will be part of the assurance process undertaken by NHS England. The submission includes self-certification that the CCG will deliver the NHS constitution requirements i.e. 18 weeks referral to treatment (RTT), diagnostic test waiting times, cancer waits etc., quality requirements i.e. HCAI/MRSA and ambition for improving outcomes i.e. improving potential years of life lost, improving health related quality of life for people with long term conditions and reducing emergency admissions etc. The requirements also set out the CCG has to outline within a plan on a page our strategic objectives and commissioning intentions in place to deliver the objectives and outcome ambitions over the next 2 years. The BCF plans although separate documents are intrinsic to delivering our ambitions and our vision over the coming years and cannot be seen in isolation of the 2 year operational plans.

The narrative in the 5 year strategy KLOE document (Appendix 8) relate to, and underpin, the five year plans we have to submit within the finance templates, this also includes the activity and outcomes trajectories for the next 5 years that are incorporated in the 2 year plans.

The narrative set out in the planning checklist (Appendix 10) is intended to be used as a reference document to ensure the CCG is delivering or has in place plans to deliver the requirements set out in the Everyone Counts guidance. This narrative should offer assurance to the Governing Body that the CCG is sighted on all requirements and has included these within operational and strategic plans.

The plans set out the aggregated impact we estimate our programmes of work will have on activity, finance and outcomes. There is a requirement to submit a FINAL 5 year plan to NHS England on 20h June 2014. Key documents have been produced alongside relevant partners and shared with the North of Tees Partnership Board (our Unit of Planning) in advance of submission to NHS England; this approach will be undertaken before submission of the final 5 year plan.

Background/Supporting Papers

Supporting documents are set out in the Appendices as listed on the covering page

FINANCIAL IMPLICATIONS

Financial planning is required as part of the annual planning process and financial plans have been agreed with the CCG Governing Body. The plans provide an overview of expected work to be undertaken in order to make best use of resource and to create a sustainable health economy in Hartlepool and Stockton-on-Tees.

LEGAL IMPLICATIONS

All statutory responsibilities will be delivered. The plan attached is a statutory duty set that is required to be delivered by CCGs

RISK ASSESSMENT

Key risks are identified within the BCF plans and added to the risk register

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Appendices

Activity & Ambitions	Appendix 1	CCG_Com_Planning_ Template_(Functional
Ambition trajectories & (supporting narrative)	Appendix 2	1403 HAST trajectory narrative f
2 year plan on a page	Appendix 3	HAST - 2 Yr Plan on a Page.pptx
Better Care Fund plans Part 1 Stockton	Appendix 4	FINAL Stockton BCF Part1 250314.doc
Better Care Fund plans Part 2 Stockton	Appendix 5	FINAL Stockton BCF Part 2.xlsx
Better Care Fund plans Part 1 Hartlepool	Appendix 6	FINAL Hartlepool BCF Part 1.doc
Better Care Fund plans Part 2 Hartlepool	Appendix 7	FINAL Hartlepool BCF Part 2.xlsx
5 year Strategic Plan DRAFT Key lines of Enquiry (KLOE)	Appendix 8	HAST - KLOE DRAFT - Version 7 14.3.14.d
DRAFT 5 year plan on a page	Appendix 9	HAST - 5 Yr Plan on a Page.pptx
Planning Checklist	Appendix 10	Apx 10 - HaST Planning Checklist.xls