Better Health Programme Joint Health Scrutiny Committee

Meeting on Thursday 13 October 2016 at 1.00 pm in The Jim Cook Conference Suite - Municipal Buildings, Church Road, Stockton

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Agenda

1. **Apologies for Absence**
2. **Substitute Members**
3. **To receive any Declarations of Interest by Members**
4. **Minutes (Pages 1 - 8)**

   To receive and approve the minutes of the Better Health Programme Joint Health Scrutiny Committee held on 8 September 2016.

5. **Accident and Emergency Services - Performance against waiting times**

   At the Joint Committee's meeting held on 8 September 2016, members received a presentation setting out performance within those Acute Hospitals within the Better Health Programme Footprint. During consideration of this information, members requested further information regarding the current national clinical standards which applied to A&E services in respect of waiting times and how these are applied within Acute Hospitals' A&E services.

   Representatives of the Better Health Programme Board will be in attendance to give the Joint Committee a presentation on this issue.

6. **Sustainability and Transformation Plans - Update (Pages 9 - 22)**

   To consider the attached cover report of the Principal Overview and Scrutiny Officer, Durham County Council and an associated presentation by Alan Foster, Chief Executive of North Tees and Hartlepool NHS Foundation Trust and STP lead for Durham, Darlington and Tees ;Hambleton, Richmondshire and Whitby STP.

7. **Better Health Programme - Phase 4 Engagement Plan**

   Presentation – Representatives of the Better Health Programme will give a presentation to the Joint Committee updating members in respect of the Phase 4 Engagement process including further information regarding the revised long list scenarios/options and evaluation criteria to be used during options appraisal.

8. Better Health Programme - Not in Hospital Services (Pages 23 - 26)

Presentation – Dr Neil O'Brien, Better Health Programme lead for the "Not in Hospital" workstream will update members of the Joint Committee on the development of a Not in Hospital strategy, its key elements and the links to and input of Local Authority Adult and Children's Social Care services within the Not in Hospital workstream.

A copy of the Not in Hospital strategy is attached for members' information.

9. Chairman's urgent items

10. Any other business

11. Date and time of next meeting

- **Thursday 1 December 2016 at 1.30 p.m. – Council Chamber, Hambleton District Council, Northallerton**

Published:

5 October 2016

Contact Officer: Stephen Gwillym, Principal Overview and Scrutiny Officer, Durham County Council **Tel:** 03000 268 140

Membership:

DARLINGTON BOROUGH COUNCIL
Councillor Wendy Newall
Councillor Jan Taylor
Councillor Heather Scott

DURHAM COUNTY COUNCIL
Councillor John Robinson
Councillor Jan Blakey
Councillor Watts Stelling

HARTLEPOOL BOROUGH COUNCIL
Councillor Ray Martin-Wells
Councillor Stephen Akers-Belcher
Councillor Rob Cook

MIDDLESBROUGH COUNCIL
Councillor Eddie Dryden
Councillor Bob Brady
Councillor Jeanette Walker

NORTH YORKSHIRE COUNTY COUNCIL
Councillor John Blackie
Councillor Jim Clark
Councillor Caroline Dickinson

REDCAR AND CLEVELAND BOROUGH COUNCIL
Councillor Ray Goddard
Councillor Mary Ovens
Councillor Norah Cooney

STOCKTON-ON-TEES BOROUGH COUNCIL
Councillor Sonia Bailey
Councillor Allan Mitchell
Councillor Lynn Hall

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Better Health Programme Joint Health Scrutiny Committee

At a meeting of **Better Health Programme Joint Health Scrutiny Committee** held in the Mandela Room, Town Hall, Middlesbrough on **Thursday 8 September 2016 at 2.00pm.**

Present:

Cllr J Robinson (Durham County Council) in the Chair

Councillors –

Councillors W Newall, J Taylor and L Tostevin (Darlington Borough Council)
Councillor J Blakey (Durham County Council)
Councillors R Cook and R Martin-Wells (Hartlepool Borough Council)
Councillor B Brady, E Dryden and J Walker (Middlesbrough Council)
Councillors J Clark and C Dickinson (North Yorkshire County Council)
Councillors N Cooney, R Goddard and M Ovens (Redcar and Cleveland Borough Council)
Councillors D Brown, L Hall and A Mitchell (Stockton BC)

Officers –

Stephen Gwillym (Durham County Council), Joan Stevens (Hartlepool Borough Council), Daniel Harry (North Yorkshire County Council), Alison Pearson (Redcar and Cleveland Borough Council) Elise Pout (Middlesbrough Council) and Peter Mennear (Stockton-On-Tees Borough Council)

Better Health Programme –

Ali Wilson
Julie Gillon
Dr Nick Roper
Caroline Thurlbeck
Edmund Lovell
Dr Boleslaw Posmyk
Douglas McDougall

Also in attendance – Representatives from North East Empowerment and Diversity

1. Apologies for Absence

Apologies for absence were received from :-

Councillors H Scott (Darlington BC), W Stelling (Durham County Council), S Akers-Belcher (Hartlepool BC), J Blackie (North Yorkshire County Council) and S Bailey (Stockton BC).

2. Substitute Members

D Brown for S Bailey, Stockton BC and L Tostevin for H Scott, Darlington BC

3. To receive any Declarations of Interest by Members

There were no declarations of interest declared.

4. Minutes

The minutes of the meeting on 21 July were confirmed by the Committee as a correct record and signed by the Chairman.

5. Better Health Programme – Phase 3 Engagement

Ali Wilson, HAST CCG on behalf of the Better Health Programme Executive delivered a presentation which included a summary of the information the Committee had received so far including the details of the NHS England's Five Year Forward View.

The presentation went on to inform Members about the Sustainability and Transformation Plans (STPs) which were being developed to deliver the NHS England Five Year Forward View. Local NHS organisations and local authorities were developing their plans for health and care in their area by 2020/21. There are 44 geographic areas – known as 'footprints'. There are no statutory bodies, the STPs were collaborations of organisations working together to ensure there was a shared strategy. Work was currently on-going in local communities between the local authorities and the CCGs etc.

Working in a larger geographical footprint ensured benefits from economies of scale but the plans would ensure that local information was not lost.

The STPs acted as an 'umbrella' plan and included plans for certain challenges, for example: improving cancer diagnosis; mental health care; transforming urgent and emergency care services; and providing more care outside hospital.

Footprint areas should build on existing engagement through health and wellbeing boards and other local arrangements. Each area was responsible for engaging local people and stakeholders on their draft proposals.

It was acknowledged that the introduction of STPs and the Better Health Programme, along with other local engagement could cause confusion for the public, when they are being asked to comment and get involved with the wide range of consultation on different issues.

The draft STPs were submitted in June for review by NHS England and NHS Improvement. The Better Health Programme (BHP) was included as a key element for the Durham, Darlington and Tees footprint. The link between the STP and the BHP was based on how people currently used the services and how the services could work together. Discussions had taken place on whether or not health officials had got the footprint right and work was ongoing in that respect.

Work that had taken place with regard to the BHP meant that the Durham, Darlington and Tees Valley area was well ahead of many other areas in developing plans. BHP representatives explained that in considering patient flows across both the North East STP (covering Northumberland Tyne and Wear) and Southern STP, suggested changes to the 'footprint' of the southern STP had been put forward during August to remove North Durham CCG from the Southern STP and BHP footprint and add it to the North East STP Area. This had been put forward to take into account patient flows from North Durham into Tyne and Wear and meant local commissioners could influence the pattern of services to the North. These recent developments across the 2 Regional STPs would have an impact on the original timescales envisaged for the BHP and formal consultation and the original timescale of November 2016 appeared unlikely.

Councillor Martin-Wells expressed his concerns that the STP was just another name, people have little faith and that the lack of scrutiny of the STP concerned him. In response Ms Wilson outlined that the STP was not an entity or organisation that makes decisions.

Councillor Cook agreed that the STP needs scrutiny to ensure some form of checks and balances were applied.

Mr Gwillym confirmed that the statutory and legal responsibility for the establishment of this committee was to examine any substantial developments or variations in services the proposals might create along with associated proposals for consultation and engagement.

Councillor Clark outlined his concerns that the STP was part of the NHS family and a partnership of NHS, local authorities and the voluntary sector. He asked if additional funding would be available through STPs and areas would be asked to bid for funds. Ms Wilson outlined that there was a funding formula, and therefore a variation in who gets what when they bid for monies. She outlined that unfortunately the NHS can't give everybody everything they want and that tough decisions have to be made.

In terms of the BHP progress, the committee was informed that a process of scenario development had been undertaken. The modelling process had created a long list of 13 scenarios, which required refinement and evaluation.

The long list was defined by what the area was required to have nationally and that couldn't be changed. The major trauma centre has to be at James Cook due to national and regional configuration of trauma units. Vascular services and Critical Care (levels 1-3) have to be present at the same site.

There are 9 scenarios for the key services – the Committee was provided with the details of each of the scenarios.

In terms of scenario development, reference was made to the discussion earlier around the potential changes to the BHP footprint and how that might invariably

lead to re-modelling of scenarios prior to formal consultation. The Committee was also advised that all STP submissions were required by NHS England in October, which would also include potential implications for the Better Health Programme. The Committee requested that details of the STP submissions be brought to a future meeting of the Joint Committee alongside details of the re-modelling work undertaken for scenario development together with details of the work undertaken to date in respect of Not In Hospital activity/services.

Councillor Dryden stated that it was hard to get a picture of how it would all look and lots more 'meat was needed on the bones'. He asked at what point in the modelling process does a service reach a critical mass and become overwhelmed. Ms Wilson explained that they were working with ambulance colleagues to look at the percentage shift in overall activity and when it might not be sustainable.

Cllr Dryden asked when the committee would receive that information and was told that it would be given in the phase 3-4 engagement.

Cllr Martin – Wells stressed the importance of having accurate scenarios developed alongside a deliverable implementation plan and associated consultation and engagement strategies.

Ali Wilson HAST CCG indicated that the move to 24/7 acute services across those disciplines covered by the BHP would lead to improved outcomes for patients. To reference this point, Mr Cruikshanks cited the development of Major Trauma Centres and that this had reduced Major Trauma mortality rates by around 30%.

The committee were presented with an update from John Pendleton regarding the phase 3 engagement that had been undertaken, which was an independent assessment of the consultation process that had been undertaken to date.

There were come general concerns amongst Members about the numbers involved but the Committee heard that it was on par with public engagement for this sort of event. Cllr Newall said that for the main part those who attended were health professionals or Councillors and that efforts should be made to make the sessions more accessible, perhaps removing the prior registration aspect. Edmund Lovell indicated that should any local authority wish to have a drop in session for BHP then steps would be taken to try and accommodate such requests.

6. Better Health Programme – Evidence requested by the Better Health Programme Joint Health OSC

The Committee received a presentation by Julie Gillon, Dr Nick Roper and Caroline Thurlbeck. The presentation outlined information requested by the Committee on performance and emergency care.

The introduction outlined the issues the North East is facing in terms of visits to pharmacies, GP consultations, calls to NHS urgent and emergency care

services, ambulance journeys, attendances at A&E and emergency admissions. Demand is growing, there are huge variations in mortality, the population is aging, deprived wards have higher mortality and improvements need to be made to improve clinical outcomes for patients.

The presentation outlined the patient flows for James Cook Hospital, The Friarage, North Tees Hospital, University Hospital North Durham and Darlington Memorial Hospital.

Local A&E performance statistics showed deterioration in the 95% standard for people being seen in A&E within 4 hours. Although this was nowhere near the deterioration that had been seen nationally.

Councillor Robinson asked that information be prepared for the next meeting which explained the 4 hour statistics including the mechanism for deciding the process for how people were seen.

The committee were taken through the statistics for cancelled operations and ambulance response times.

The national vision was outlined to Members and included key issues such as: faster and consistent same day; every day access to primary care and community services for people with urgent care needs; develop 999 ambulances so they become mobile urgent treatment services; not just urgent transport services; and support the co-location of community-based urgent care services in coordinated Urgent Care Centres.

The vision also suggested two levels of hospital based emergency centres to replace the inconsistent levels of service currently provided by A&E departments which included: Emergency Centres which will be capable of assessing and initiating treatment for all patients; Major Emergency Centres which are larger units capable of assessing and initiating treatment for all patients and providing a range of specialist services; and Major Trauma Centres located at 12 major emergency centres nationally.

7. Better Health Programme – Terms of Reference and Membership

The Committee requested the information which outlined the terms of reference for the programme board. The attached report provided details on the BHP governance arrangements, its responsibilities, consultation, decision-making and behaviours, accountability and authority, quorum, task and finish groups, membership and meetings.

The information was noted.

8. Transforming Urgent and Emergency Care in England – The Keogh Report

The Committee was provided with the Keogh review report into Urgent and Emergency Care and the establishment of Major Trauma Centres. Further information was given in the presentation at item 6.

9. Better Health Programme – Community representations from North East Empowerment and Diversity

Information was received by the Committee from the members of the North East Empowerment and Diversity Group (NEED) in Hartlepool (which incorporated Save Hartlepool Hospital). The Group outlined a number of concerns they had that they wished the Committee to receive. The information raised a number of questions which it was felt were addressed by the presentation at the meeting.

The representatives from NEED agreed to re-group to consider the information heard following the presentation at the meeting

Agreed – that there would be an opportunity to revisit any outstanding issues and that a special meeting should be arranged to open up discussions with similar groups who may wish to present evidence to the Committee.

10. Notice of Motion from Richmondshire District Council

Richmondshire District Council submitted a Notice of Motion relating to the Better Health review of Critical Care services at Darlington Memorial Hospital, considered that their Council meeting held on 19 July 2016.

Councillor Blackie had requested consideration of the following notice of motion:
'The Better Health review of Critical Care services, including Accident and Emergency and consultant-led maternity and paediatrics services at the Darlington Memorial Hospital is causing Richmondshire District Council great concern as any reduction or cut in these services would have a hugely detrimental impact on the health, well-being, and peace of mind of all those who live in the District. It strongly supports the initiative launched at the May meeting of North Yorkshire County Council which has led to a high level alliance between the Leaders of the political administrations at Darlington Borough Council and North Yorkshire County Council and the establishment of a joint Scrutiny of Health Committee between the two Councils.

It instructs officers at Richmondshire District Council: 1) to convey its deep concerns to the relevant NHS organisations, including the organisation conducting the Better Health review itself and the Hambleton, Richmondshire and Whitby Clinical Commissioning Group. 2) to inform Darlington Borough Council and their joint Scrutiny of Health Committee of its support, and to offer to join in these initiatives in any way it is considered appropriate.

Richmondshire District Council considers the maintenance at their current level, or preferably with an embedded programme committed to their continuous improvement, of the Critical Care Services at the Darlington Memorial Hospital

essential to guarantee their availability to deal with the immediate, urgent and unplanned healthcare needs of all residents in the District, and it resolves accordingly to adopt appropriate actions or measures to resist any attempt to downgrade them.'

Councillors from Darlington were grateful for the enthusiastic support and construction discussions.

The Committee received the Notice of Motion and noted its contents.

11. Chairman's urgent items

No urgent items were received.

12. Any other business

No other items of business were received.

13. Date and time of next meeting

Thursday 13 October 2016 at 1.00pm – The Jim Cook Conference Suite, Municipal Buildings, Church Road, Stockton

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Better Health Programme Joint Health Scrutiny Committee

Better Health Programme Joint Health Scrutiny Committee

13 October 2016

Sustainability and Transformation Plans

Report of Principal Overview and Scrutiny Officer, Durham County Council

Purpose of the Report

1 This report provides members with background information in respect of the development of health and care system Sustainability and Transformation Plans in advance of a presentation updating members on the progress made to date in respect of their development and submission to NHS England.

Background – Sustainability and Transformation Plans

2 In December 2015, the NHS shared planning guidance 2016/17 – 2020/21 outlined a new approach to help ensure that health and care services were built around the needs of local populations. To do this, every health and care system in England, involving local organisations such as NHS providers, commissioners, and local authorities, were asked to produce a multi-year Sustainability and Transformation Plan (STP), showing how local services would evolve and become sustainable over the next five years – ultimately delivering the NHS Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

3 To deliver plans that are based on the needs of local populations, local health and care systems joined together in January 2016 to form 44 STP "footprints" across England. The health and care organisations within these geographic footprints are working together to develop STPs which aim to drive genuine and sustainable transformation in patient experience and health outcomes of the longer-term.

4 The footprints were required to be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required, along with how they best fit with other footprints. A map showing the originally identified STPs is attached to this report. (Appendix 2).

5 STP leaders have been agreed for the most areas with the STP leaders for the North East Region being:-

- Durham, Darlington and Tees ;Hambleton, Richmondshire and Whitby
  Alan Foster – Chief Executive of North Tees and Hartlepool NHS Foundation Trust

- Northumberland, Tyne and Wear
  Mark Adams – Chief Officer, Newcastle and Gateshead CCG

6 These officers have agreed to convene the STP process and to oversee the development of local plans. They have been selected following local discussions about who is best placed to play this role, together with discussions with national bodies.

7 Over the last few months NHS system leaders have met to discuss how best to create these plans, reflecting on the work that has already been developed in a number of areas across the North East and Cumbria.

8 During such discussions professionals have considered carefully the geographical footprint which will best enable the NHS to plan services and, as a result, it was agreed that the North Durham area will move from the Durham, Darlington and Tees ;Hambleton, Richmondshire and Whitby STP into the Northumberland, Tyne and Wear STP for planning purposes.

9 This change in the way the STP boundaries have been planned will provide an opportunity to plan the best possible care for patients and partner organisations will work together on the next iteration of the STP draft document which will be submitted in October 2016.

10 STPs footprints are not statutory bodies, but rather collective discussion forums which aim to bring together health and care leaders to support the delivery of improved health and care based on the needs of local populations. They do not replace existing local bodies, or change local accountabilities.

Sustainability and Transformation Plans – Development and Submission Timelines progress

11 Representatives of the programme will give a presentation updating members on the progress made to date in respect of the development and submission to NHS England of the Durham, Darlington and Tees ;Hambleton, Richmondshire and Whitby STP.

Recommendations

12 The Better Health Programme Joint Health Scrutiny Committee is recommended to:-

(a) receive this report, and

(b) consider and comment upon the contents of the presentation in respect of the STP development process.

Background papers

- NHS England Guidance – Sustainability and Transformation Plans

Contact: Stephen Gwillym, Principal Overview and Scrutiny Officer, Durham County Council Tel: 03000 268140

Appendix 1: Implications

Finance - None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty - None

Accommodation - None

Crime and Disorder - None

Human Rights - None

Consultation – None

Procurement - None

Disability Issues - None

Legal Implications – None

March 2016

Sustainability and Transformation Plan footprints

1. Overview

The NHS Shared Planning Guidance asked every local health and care system in England to come together to create their own ambitious local plan for accelerating the implementation of the Five Year Forward View (5YFV).

These blueprints, called Sustainability and Transformation Plans (STPs), will be place-based, multi-year plans built around the needs of local populations. STPs will help drive a genuine and sustainable transformation in health and care outcomes between 2016 and 2021. They will also help build and strengthen local relationships, enabling a shared understanding of where we are now, our ambition for 2021 and the concrete steps needed to get us there.

To deliver these plans NHS providers, Clinical Commissioning Groups (CCGs), Local Authorities, and other health and care services have come together to form 44 STP 'footprints'. These are geographic areas in which people and organisations will work together to develop robust plans to transform the way that health and care is planned and delivered for their populations.

These footprints are of a scale which should enable transformative change and the implementation of the Five Year Forward View vision of better health and wellbeing, improved quality of care, and stronger NHS finance and efficiency.

This document provides information on the 44 STP footprints in England.

In forming their footprints, local areas will have taken the following factors into account:

- Geography (including patient flow, travels links and how people use services);
- Scale (the ability to generate solutions which will deliver sustainable, transformed health and care which is clinically and financially sound);
- Fit with footprints of existing change programmes and relationships;
- The financial sustainability of organisations in an area; and
- Leadership capacity and capability to support change.

The boundaries used for STPs will not cover all planning eventualities. As with the current arrangements for planning and delivery, there are layers of plans which sit above and below STPs, with shared links and dependencies. It is also important to note that these boundaries may change over time as STPs are implemented, based on local circumstances.

2. Summary of footprints – national

NHS region	Total number of STP footprints	Average number of CCGs per footprint [1]	Average footprint population[2] (million)
England	**44**	**4.8**	**1.2**
North	9	7.4	1.7
Midlands and East	17	3.6	1.0
London	5	6.4	1.7
South	13	3.8	1.1

[1] One CCG (Cumbria) is split across two footprints.
[2] ONS 2014 population estimates used.

2.1 England – footprint map (index on next page)

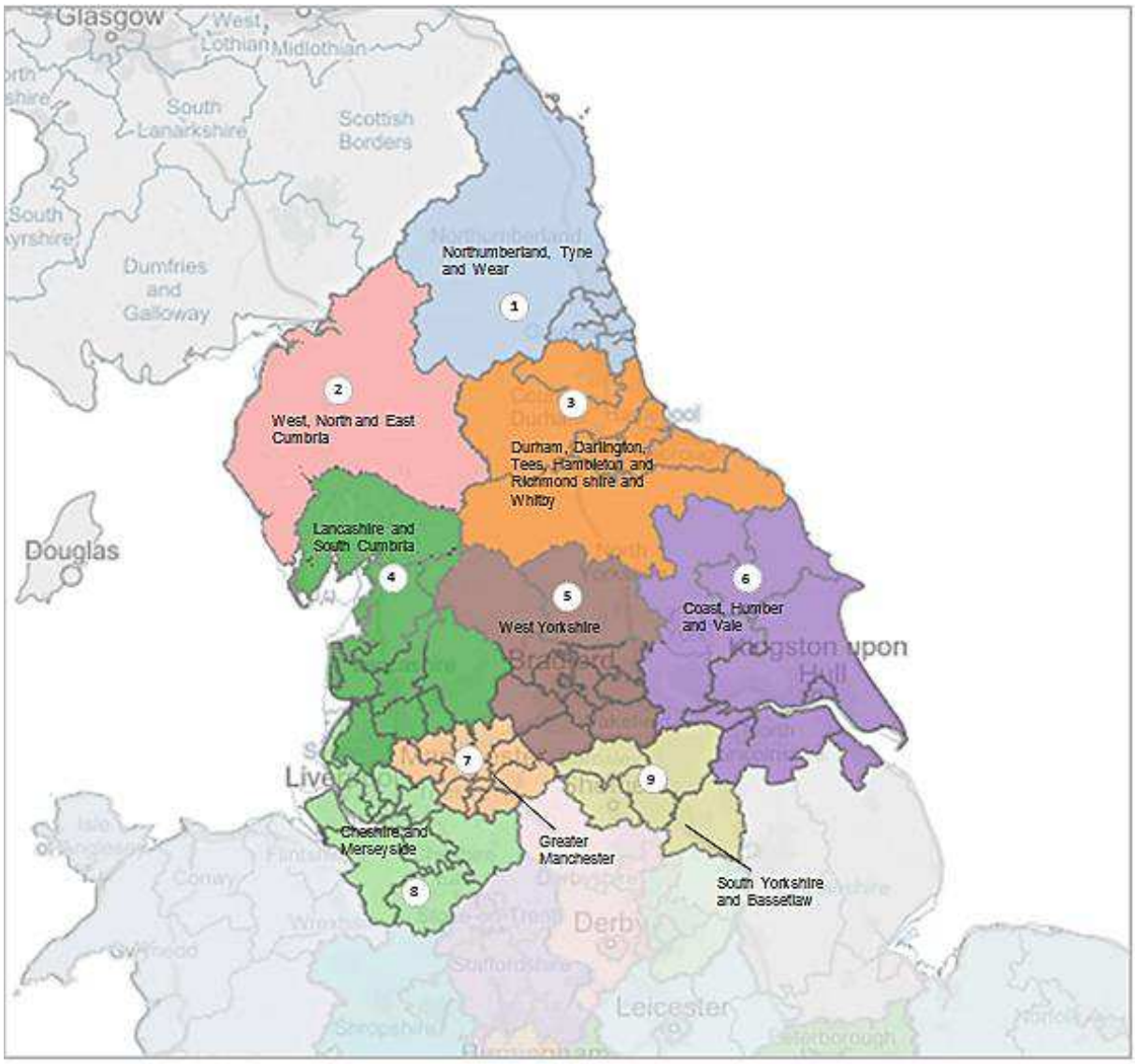
2.2 Index to national footprints map and key statistics

STP no	Footprint name	Footprint population (million)	Number of CCGs
1	Northumberland, Tyne and Wear	1.4	5
2	West, North and East Cumbria	0.3	1
3	Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby	1.3	6
4	Lancashire and South Cumbria	1.6	9
5	West Yorkshire	2.5	11
6	Coast, Humber and Vale	1.4	6
7	Greater Manchester	2.8	12
8	Cheshire and Merseyside	2.4	12
9	South Yorkshire and Bassetlaw	1.5	5
10	Staffordshire	1.1	6
11	Shropshire and Telford and Wrekin	0.5	2
12	Derbyshire	1.0	4
13	Lincolnshire	0.7	4
14	Nottinghamshire	1.0	6
15	Leicester, Leicestershire and Rutland	1.0	3
16	The Black Country	1.3	4
17	Birmingham and Solihull	1.1	3
18	Coventry and Warwickshire	0.9	3
19	Herefordshire and Worcestershire	0.8	4
20	Northamptonshire	0.7	2
21	Cambridgeshire and Peterborough	0.9	1
22	Norfolk and Waveney	1.0	5
23	Suffolk and North East Essex	0.9	3

24	Milton Keynes, Bedfordshire and Luton	0.9	3
25	Hertfordshire and West Essex	1.4	3
26	Mid and South Essex	1.2	5
27	North West London	2.0	8
28	North Central London	1.4	5
29	North East London	1.9	7
30	South East London	1.7	6
31	South West London	1.5	6
32	Kent and Medway	1.8	8
33	Sussex and East Surrey	1.8	8
34	Frimley Health	0.7	5
35	Surrey Heartlands	0.8	3
36	Cornwall and the Isles of Scilly	0.5	1
37	Devon	1.2	2
38	Somerset	0.5	1
39	Bristol, North Somerset and South Gloucestershire	0.9	3
40	Bath, Swindon and Wiltshire	0.9	3
41	Dorset	0.8	1
42	Hampshire and the Isle of Wight	1.8	7
43	Gloucestershire	0.6	1
44	Buckinghamshire, Oxfordshire and Berkshire West	1.7	7
	Total	**54.3**	**210***

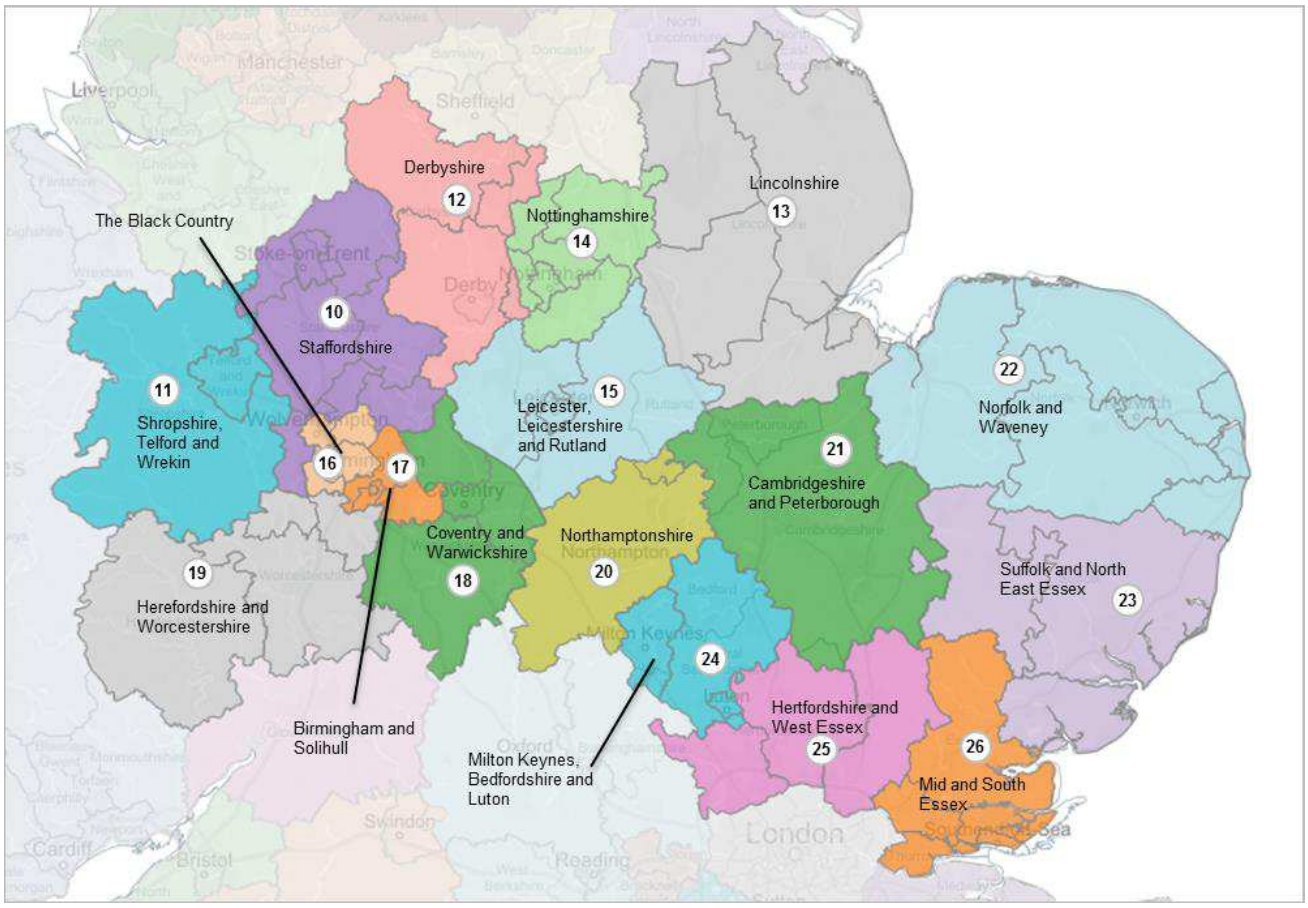
3. North region

Footprint map



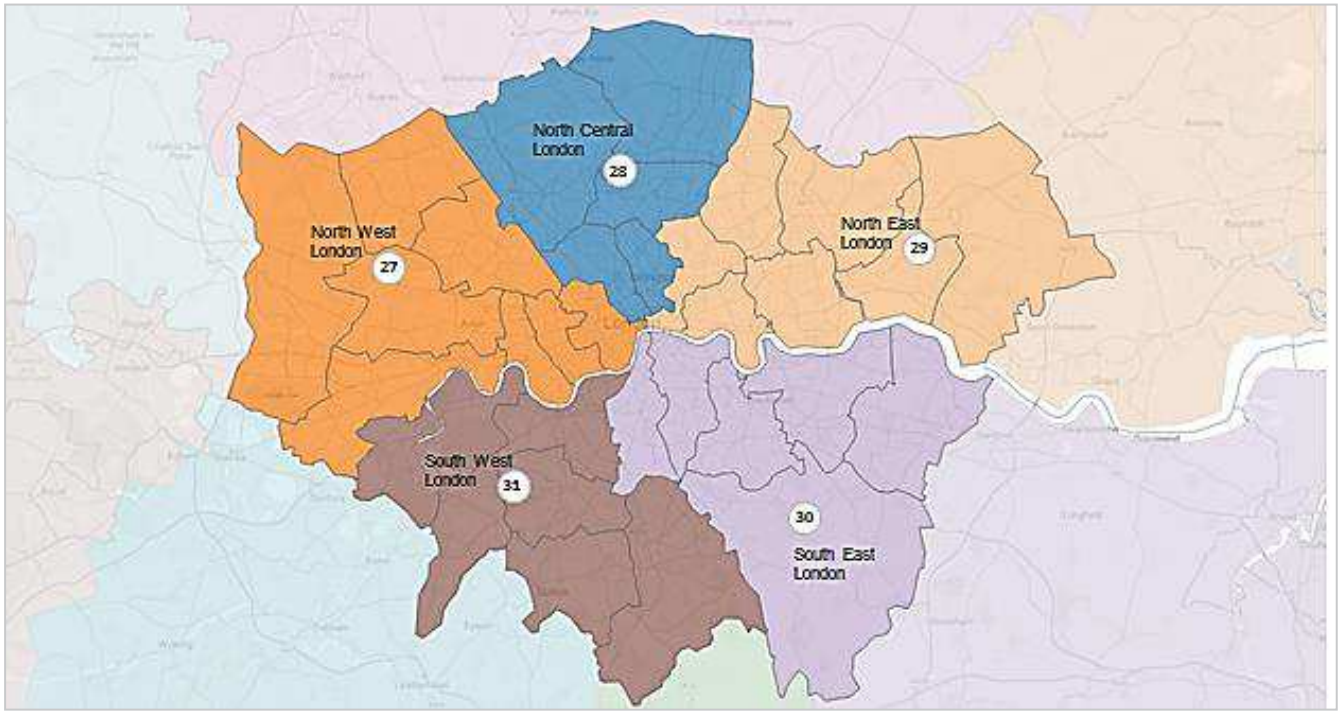
4. Midlands and East region

Footprint map



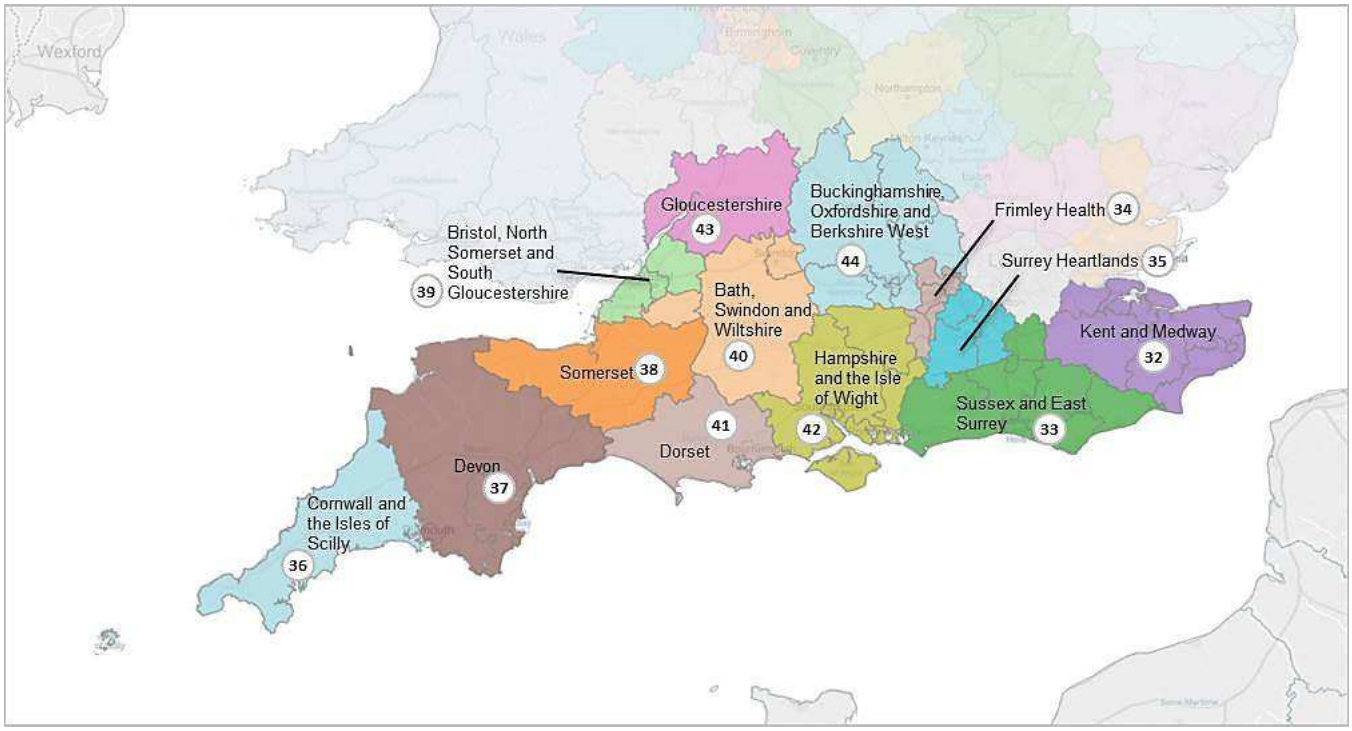
5. London region

Footprints map



6. South region

Footprint map



For more information please contact england.fiveyearview@nhs.net

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Not in Hospital Strategy

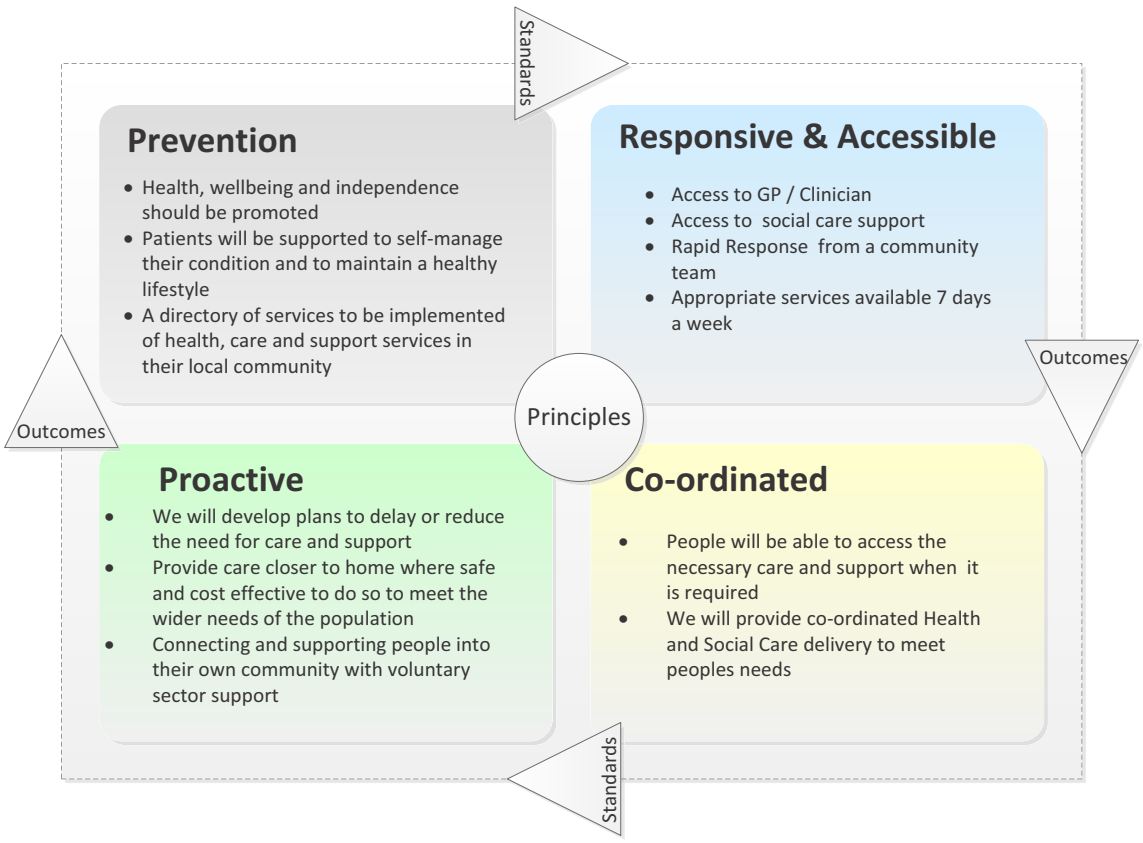
Joined up community health and care enabling people to live longer, healthier lives.

The Not in Hospital programme aims to develop and implement models of care which ensure the sustainability of primary and community care now and in the future. To deliver high quality care which is person centred, irrespective of organisational boundaries. People will receive continuity of care that is effectively co-ordinated and delivered where possible close to home.

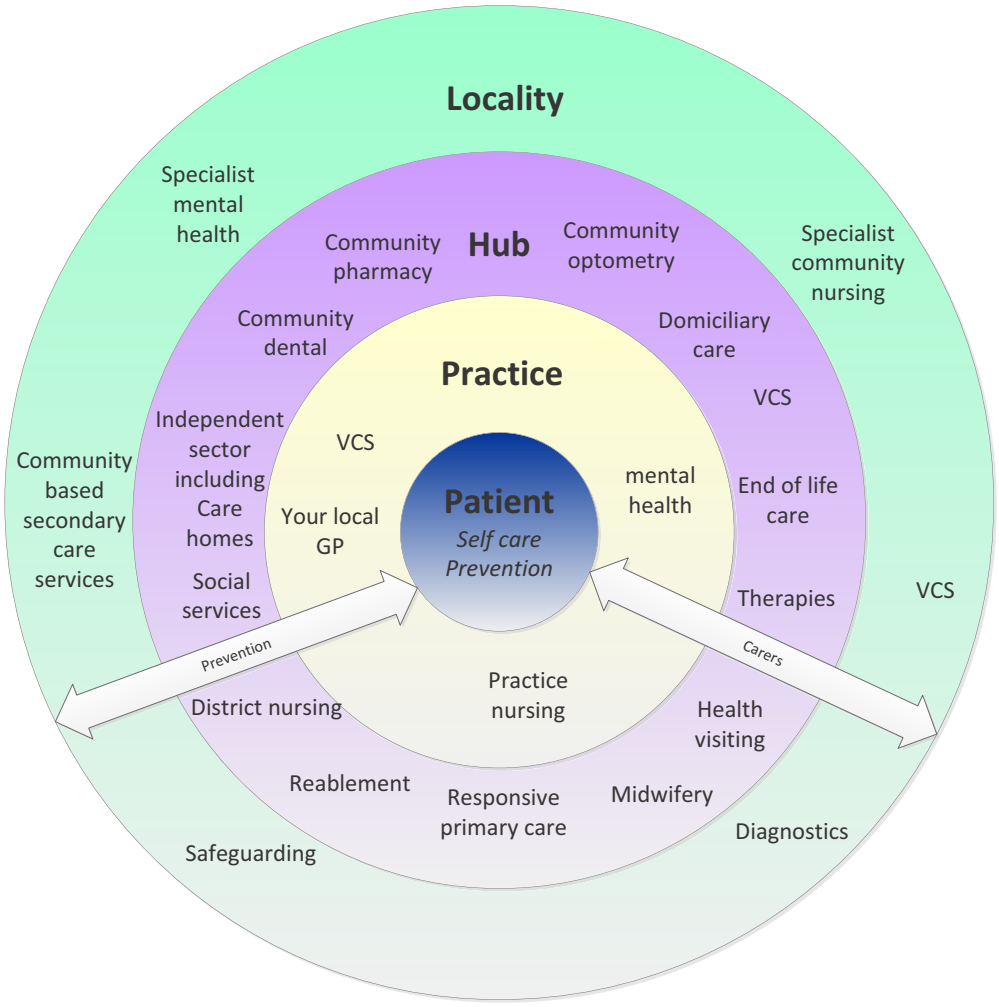
Stakeholders across the Better Health geography have developed a set of quality standards which set out the ambition of the Not in Hospital workstream to deliver person-centred outcomes based on four key principles;

- Prevention
- Proactive care
- Responsive and accessible care
- Co-ordinated approach

Not in Hospital Principles



Not in Hospital Model of Care



VCS – Voluntary Community Sector

Enablers

Integration will enable the delivery of the not in hospital model and will feature as an overarching principle of the work programme. The following are the key issues which need to be delivered in an integrated way;

Workforce

- To deliver the NiH model of care we need a workforce which has an enhanced set of skills, delivered in a different environment and that promotes a different philosophy and culture

Estates and Informatics

- Information sharing and access to support person centred care

- Make best use of shared estates to support the Not in Hospital model of care

Interface

- The Not in Hospital workstream needs to ensure alignment with the models of care within the 'in-hospital' programme and across the system

Outcomes

The Not in Hospital programme has developed a range of outcomes which can be categorised into two elements; person centred and system outcomes.

Person centred outcomes focus on:

- I will get quick access to my primary and community care team
- I will feel well informed about how to lead a healthy lifestyle and feel supported to manage my own condition
- I will have the information and support I need to be as independent as possible with someone available to navigate my care
- If I need to go to hospital I will be supported to be discharged as soon as possible and receive the appropriate support in the community
- I know that I will only need to tell my story once and people will have access to this information
- I will only be admitted into hospital or a care setting when it's absolutely necessary

System outcomes include:

- Improved range of Not in Hospital Services, that provide earlier intervention, better coordinated care, improved community services and hospital stays.
- Supporting patients at home to have improved patient outcomes, satisfaction and provide better value for the public pound.
- Reduced variation in access to care and the quality of care.
- Reduced bed usage across all acute hospital sites within Durham, Darlington and Tees Valley
- Appropriate length of stay in all care settings.
- Timely and well supported discharge across the system.
- Increased number of people supported to live at home longer.
- Resilient and sustainable health and care services.
- Improved support available to family and carers providing Care Closer to Home.

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