The Tees Valley Collaborative

Expression of Interest for Health & Social Care Integration 'Pioneers'

The organisations in the Tees Valley Collaborative submitting this EIO are:-

- **Darlington Borough Council**
- **Darlington CCG**
- **Middlesbrough Borough Council**
- **Redcar & Cleveland Borough Council**
- **South Tees CCG (this CCG covers both Middlesbrough and Redcar & Cleveland)**

The collaborative has been established to enable us to achieve our goals of delivering integrated health and social care at a faster pace and greater scale than would otherwise be the case if we progressed our agendas individually (that is, just as local authorities or just within a single place).

Contents

The Problem

The health status of the people in the Tees Valley area, some of whom live in the most deprived local authority wards in the country, provides significant evidence of the high demands placed on local health care. There is a need to further shift the focus of our health and social care provision to improving health outcomes and reducing inequalities, in order to improve the overall health of the local population within the available resources. Historically, the area has been highly dependent on heavy industry for employment and this has left a legacy of industrial illness and long term conditions. This, coupled with a more recent history of high unemployment, as the traditional industries have retracted, has led to significant levels of health deprivation and inequalities that rank amongst the highest in the country. The area faces ongoing challenges around the major causes of death and the gap in life expectancy with statistics worse than England average around obesity, smoking and binge drinking.

Using PANSI and POPPI projections, there will be an increase in the number of people with early onset dementia, dementia and with a limiting long term illness and the predicted increase in the number of retired people living in the area will have a major impact on primary care services, requiring a wide range of health care services to be readily available in convenient, accessible and user friendly settings, with an increased emphasis on treating people with long-term conditions.

The numbers of people who are living in deprived wards is disproportionately high in all Tees areas compared with the rest of England. We need to improve the health of the population in the area and tackle the legacy of ill health, whilst meeting the increasing demands of an ageing population within decreasing public sector resources. To achieve this ambition, the shape, type and form of health care provision for patients, needs to be different from that available today.

Figure 1Population estimates for 2012 and projection for 2021 with number and percentage aged 65 and over and aged 85 and over

Authority	Mid-2012 population estimate			2021 population projection		
	Number	Number (%) aged 65 and over	Number (%) aged 85 and over	Number	% aged 65 and over	% aged 85 and over
Darlington	105,248	19,223 (18.26%)	2,661 (2.53%)	110,771	22,695 (20.49%)	3,539 (3.20%)
Middlesbrough	138,744	21,293 (15.35%)	2,591 (1.87%)	144,275	24,997 (17.33%)	3,911 (2.71%)
Redcar & Cleveland	134,998	27,396 (20.29%)	3,259 (2.41%)	135,466	31,782 (23.46%)	4,540 (3.35%)
Total	**378,990**	**67,912 (17.92%)**	**8,511 (2.25%)**	**390,512**	**79,474 (20.35%)**	**11,990 (3.07%)**

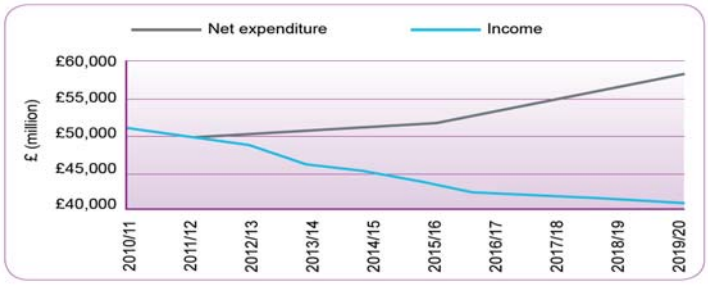
Source: ONS mid-2012 population estimates and interim mid-2011 based population projections

- In Redcar 16% of older people receive help from Adult Social Care and of these 71% are aged 65 years or older.
- In Middlesbrough 32% of older people receive help from Adult Social Care and of these 55.64% are aged 65 years or older.
- In Darlington 17% of older people receive help from Adult Social Care and of these 67% are aged 65 years or older.

If we do nothing…

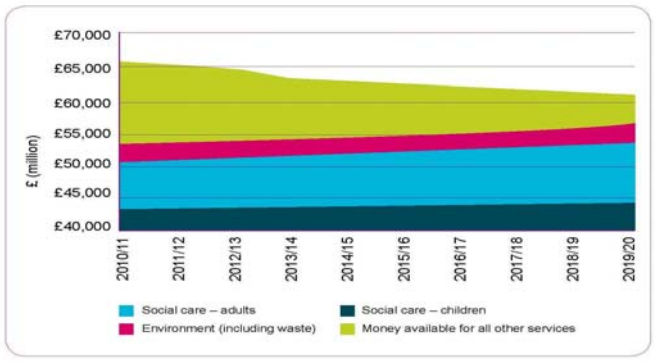
Leaving things as they are presents a problem both for those individuals who need and deserve better, but also for organisations who see the demand for their services, costs and expectations rising, at a time when the funding for providing such care is either standing still or decreasing. This is illustrated in Figure 2 in relation to local authority spend on Social Care.

Figure 2



To continue to try to meet service demand in the current way may ultimately result in Council's becoming bankrupt. Not only will we not be able to meet the needs of our patients, but there will be no funding available for more universal services. The impact will be felt across the whole of the population as demonstrated in Figure 3.

Figure 3



Our vision

Our overarching vision is that within 5 years "All care is planned care and all care is sustainable care".

From a resident/patient perspective, this means that they will be able to say *"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."*

From a service perspective this means whole system integration, including joint health & social care teams operating collaboratively with a common goal of delivering right outcomes for the residents/patients they serve.

In order to achieve this, and having learnt the lessons from previous collaboration programmes, we have agreed a governance and delivery framework which will deliver change on a scale and with a pace that we have never done before. Our basic premise is that if it works and if it is the most cost effective, then it will be implemented. There is an agreement that all agencies should use the limited resources in the most cost effective way and that local variation should be radically reduced. In practice, this will mean that work trialled in one area and proven to be the most cost effective will then be adopted and implemented in the other areas through the commissioning strategies of each agency. This is not about one size fits all; this is about everyone should have access to the best possible arrangements within the available resources.

System change to deliver the vision

The current system is no longer fit for purpose. We need to deliver the right care, in the right place and the right time, where all patients with a complex or long term condition will be managed within a system which identifies and responds to their individual needs, supported by a framework of integrated maintenance and interventional services, to keep them safely independent or in appropriate low cost provision whenever possible.
Specifically we aim to:

- build **community capacity and resilience** alongside the voluntary sector and through increased use of expert patient skills
- offer targeted and proactive **individualised case management** in a community setting (as part of a "Virtual Ward") with a range of additional support services for patients aimed at maintaining and improving their current health;
- **improve routine care for all patients with long term conditions** to prevent deterioration in their overall condition;
- **reduce avoidable unplanned hospital admissions** and readmissions for all patients following an exacerbation of their long term condition or deterioration of general health;
- **identify the need for and improve access to a range of integrated support services** for this cohort of patients on a 24/7 basis to allow them to better manage their own condition and remain as independent as possible, and thus avoid unnecessary A&E attendances;
- **meet national performance targets and outcome measures** around management of elderly and frail patients and those with long term conditions;
- To facilitate better management of this cohort of patients by health and social care professionals through **early identification and risk assessment of their condition**, thus supporting better health outcomes;
- **rationalise delivery of care and support for this cohort of patients** ensuring increased productivity and use of resource

How will we do it?

The Tees Valley Collaborative (TVC) is a new configuration comprising of Darlington Borough Council, Middlesbrough Council and Redcar & Cleveland Borough Council, Darlington NHS CCG and South Tees CCG. It has emerged from the recognition, implicit within Tees Valley Strategic Health Network ([1]all 5 councils, all 4 Foundation Trusts and all 3 CCGs) that there are challenges and solutions in common that can be addressed by working together. The collaborative has been established to enable us to achieve our goals of delivering integrated health and social care at a faster pace and greater scale than would otherwise be the case if we progressed our agendas individually (that is, just as local authorities or just within a single place).

Taking advantage of the new opportunities provided through recent health and social care reforms, the collaborative will build a new model of integration which will change culture and practice and encourage stronger co-production of new systems with the public in the context of the new arrangements. In doing this, it will build on the strong leadership and commitment to collaborative working that exists already in the Tees Valley and North East region.

The five organisations have the full support and co-operation of partner organisations including the NHS Local Area Team ([2]covering all of the 6 local authorities, 5 CCGs and 4 Foundation Trusts submitting o[3]r supporting the Pioneer expressions of interest), Tees, Esk & Wear Valleys NHS Foundation Trust, South Tees Hospitals NHS Foundation Trust, County Durham and Darlington NHS Foundation Trust, Durham Police, Cleveland Police, Cleveland Fire & Rescue Services, the Probation Service and the voluntary and third sector as well as registered social landlords.

Hartlepool Borough Council and Stockton-on-Tees Borough Councils are not submitting a separate bid but have stated their full support and their desire to be included in the scaling up of the products from the collaborative.
The Tees Valley Collaborative is led by senior politicians and chief officers of each of the participating organisations. They have given a commitment that evidence based practice will be implemented in each area.

[1] The Tees Valley Strategic Health Network consists of the organisations in the TVC plus Hartlepool & Stockton councils, North Tees CCG and North & South Tees Foundation Trusts.
[2] When reference is made to the 6 local authorities, this expands on the Strategic Health Network to include Durham County Council.

Within the collaborative, partners are already committed to two programmes of work which will deliver benefits on a locality basis (these are existing schemes which were intended to benefit a specified population):

- IMPROVE – Integrated Management and Proactive Care for the Vulnerable and Elderly – across South Tees CCG area (two local authorities)
- Darlington Long Term Conditions Collaborative (one local authority)

Our proposal is that we build on this through a collaboration framework at three levels:

- *Place-based collaboration* – between the Council and CCGs and others in the localities - delivering the IMPROVE and Long Term Conditions programmes (the existing work programme).
- *Sector-based collaboration* – amongst Councils across the Tees Valley, and amongst CCGs in the Tees Valley & Durham – achieved through transferring the learning from each of the locality based programmes and rolling out the approach on a wider geographical scale (the added value of the Pioneer programme and a route into the Challenge Fund).
- *Wider partnerships* – bringing together both of the above, along with other provider and voluntary sector partners to shape the whole health and social care economy (using the Challenge Fund to extend the scale of efficiencies).

The concepts of collaboration and integration can no longer be seen as innovative; what is innovative about the approach proposed here is the methodology used and the rolling out of programmes with fidelity from one area to another without delay. This implementation of proven best practice and maximum efficiency in areas where the work was not trialled will deliver a model of scalability that can be replicated elsewhere and will deliver change at a pace considerably faster than that normally associated with large scale change,

Building on the success of the Darlington Dementia Collaborative, once the initial scoping has been complete and a programme of work fully agreed, the improvements occur rapidly across all organisations involved in the patient pathway. This is achieved with the use of concentrated cross organisational improvement events, whether this be 3P, Kaizan or RPIW's. These events adopt LEAN methodology and ensure that the customer is fully involved by attending the events, telling their story and helping to develop the changes to the process. The aim of the events is to improve the pathway for the customer by fully involving both them and the operational staff. Whilst this methodology is frequently used in individual organisation it is rare for it to have political and organisational buy in to empower the staff to deliver cross organisational change in a short space of time (usually a week or less once an area has been defined for improvement).

Using the LEAN approach stimulates innovative service delivery practice and develop innovative operating models by allowing staff the time away from their 'day job' to consider the options and really study the issues. The resulting effects are quick implementation with appropriate testing and review built in, utilising the motivation of the team. The innovative changes also lead to improving quality and the patient experience while reducing staff effort and cost. Each of these events closely measures the impact on quality, staff effort, lead times and cycle times.

The expectation is for each organisation to adopt the common methodology for improvement and use it across its 'place' partners then to go a step further and adopt the improvements developed by another group of stakeholders in their 'place' will bring about the sector collaboration.

CASE STUDY FOR CURRENT AND FUTURE OPTIONS

What happens now?

Tom was admitted by ambulance to James Cook Hospital after suffering a stroke. After a period of medical treatment and assessment, Tom was left with some weakness down his left side and some speech difficulties. It was decided that he would need some Occupational therapy, physiotherapy and speech therapy to support his recovery.

After waiting for a bed to be free, Tom was then transferred to one of the Community Hospitals. The community hospital therapists worked with Tom a few days a week over a number of weeks until he was seen to be coping and then he was allowed home. His stay in hospital was over 8 weeks.

What will happen in the future?
Tom was admitted by ambulance to James Cook Hospital after suffering a stroke. After a period of medical treatment and assessment, Tom was left with some weakness down his left side and some speech difficulties. It was decided that he would need some therapy from the multidisciplinary team which included the Occupational therapist, Physiotherapist and Speech and Language therapists to support his recovery. The team assessed his home environment and decided that with support Tom would actually benefit from having his therapy delivered by the stroke specialist therapy rehabilitation team at home.
Tom left the hospital after five days. The specialist stroke team visited his home regularly over a six week period, delivering any necessary nursing and therapy care; this ensured Tom was able to carry out his routine daily living tasks in an environment that was meaning full to him and also enabled him to work with the therapists to access his local community. Tom was able to re- use public transport, regained the confidence to go shopping and use the public library. The Speech and Language therapists supported Tom with communication tools to enable him to be independent. Tom's confidence grew with each day; he felt happier about meeting people in public and was less reliant on his wife and family for support.
Tom's wife said how much easier it was for her to support Tom when the team were not present as she was taught how to assist him, what to watch for and how to encourage him, she said how much more confident she felt and this enabled her to return to her part time job. Being able to return to work was a positive outcome for both Tom and his wife.

Firming up the benefits

This Collaborative has clear benefits for the organisations involved, including:

- Opportunity to build on tried and tested innovative models
- More innovation and integration operating models available
- More satisfied service users
- More and improved self-management of conditions
- Greater resilience for each individual organisation
- Greater opportunity to work collaboratively to reduce demand
- Opportunity to address whole-system issues in a more structured and sustained manner
- Fewer people requiring emergency health and social care
- Opportunity to avoid future costs
- Opportunity to make existing services more efficient by reducing duplication and waste.

There is considerable potential for achieving efficiency savings through this route, and options for making use of QIPP will be actively pursued. Health and Well Being Boards in each of the localities have an agreed strategy for commissioning designed to increase resilience and reduce demand for high cost and high demand services over the longer term, by channelling investment in early intervention and prevention activity, as well as a continued focus on the most vulnerable.

This expression of interest is produced in conjunction with a bid to the DCLG Challenge Fund for collaborative working and for delivering efficiencies. The EOI is built upon current work streams, established before the opportunity to submit the EOI was made available. Both of the current work streams have planned efficiencies expected of them; it is difficult to quantify the savings that will be generated in the other authorities/CCGs through the replication of the work. This work will be completed in time for the submission for the Challenge Fund. To provide a context, however, Darlington Borough Council has identified a £1.5 million efficiency target in adult social care spend already and expects to deliver a further £3 million through the innovative practices identified here. The South Tees CCG has identified in its Clear and Credible Plan it need to make £24.1m of efficiencies over the next 5 years. Delivering savings of this magnitude is a challenge and requires a collaborative and integrated approach to redesigning patient pathways to offer high quality, safe, effective and efficient services to people. All partners in the collaborative intend that further efficiency savings will follow by greater integration over time. This is likely to include joint management and delivery arrangements that will arise from putting the patient at the heart of care and support. The Collaborative will be making efficiencies both through the immediate or short term priorities of increased prevention of diseases, and self-management and prevention of deterioration of existing condition, but also through working together to reduce demand for high cost services across the health and social care economy.

How we will measure success in the short term:- reduction in hospital length of stay; reduction in emergency hospital admissions; reduction in A&E attendances; reduction in delayed discharges or transfers of care; reduction in admission to residential and nursing care; increase in patient satisfaction scores; increase in reablement outcomes

In the medium term:- More people with Long Term Conditions are supported to manage their condition whilst living at home; reduction in the predicted Adult Social Care demands and reduction in costs

In the long term:- improvement in public health metric associated with preventative care: no longer be an outlier in terms of performance, improving at a faster rate than others to close the gap between ourselves and the national average

Governance and capacity to meet the vision

Strong project and programme management governance arrangements are already adopted in all three authorities to manage the improvement activity within 'place' and significant savings have already been achieved through these. This will be further strengthened by strong political involvement through joint Health and Well Being Board working (through a shared sub-committee) and a Steering Team that includes the 5 Chief Executives from Darlington, Redcar, Middlesbrough Councils and Darlington and South Tees CCG, as well as the NHS Local Area Team, and Social Care Directors.

The Tees Valley H&WBB Sub Committee will provide overall direction and assurance that emerging best practice is integrated within the locality commissioning strategies and efficiency programmes.
The Officer steering group will ensure that there is robust programme management, and crucially, that barriers to success are identified. It is likely that the programme will identify barriers relating to information sharing, to determining baseline data, and in enabling resources to be re-allocated across the system in response to emerging optimum service models. It is the expectation of partners that by working together and by working with the Department of Health through the Pioneer programme, that we will find innovative and practical ways through these structural impediments.

By adopting a more balanced approach to improvement, i.e. each authority delivering a strand which will then be adopted, this will create capacity and pace. In the past we have tried to develop models that will work across each organisation but with significant local variation, which have been limited by prolonged negotiation and discussion. The commitment to adopt a workable solution that will then be adopted across each authority should reduce timescales by approximately 6 months for each strand for two authorities implemented (this is a conservative estimation based on the usually project timescale to develop an options appraisal)

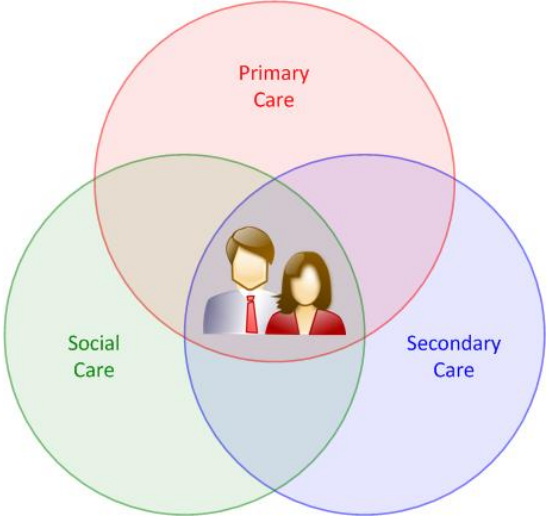
Capacity to deliver more change will be available within each authority as this 6 months timesaving would be across a project team (which typically can be 5-10 staff).

Operational risk analysis will be undertaken as a part of the project and governance planning and all organisations are familiar with a range of risk management models.

Our plan for whole system integration

Our challenge in the Tees Valley is how to create real person-centred and integrated care. For the individuals who receive a service, this means that:

- They are not faced with contacting many different organisations and are not confused about where to direct questions and concerns, potentially ending up in the wrong care setting.
- They do not have to tell their story many times to different people.
- They do not have to make too many unnecessary trips to hospital accident and emergency departments when they might have been able to manage at home.
- When they are in hospital, they do not stay longer than they need to if they have support at home.
- Their care is centred on their needs.
- Their carers can get the support they need at the right time
- Their expectations for their care meet what is provided to them.



Managing demand and rising expectations is a challenge for most health and social care organisations in the UK at the moment. Trying to tackle this on an individual basis is difficult as it limits:

- Resources available for innovation and transformation
- The ability to achieve economies of scale
- The scope for efficiency savings as 'easy' reductions have already been made.

Strategically, therefore, we will support the delivery of change on a larger footprint and will include in this work how we will reduce demand and how we will integrate public services with the unpaid contributions of family members and their wider communities.

Our current programmes

Within CCG localities, we are taking steps to delivery more integrated, patient centred services.

IMPROVE – Integrated Management and Proactive Care for the Vulnerable and Elderly

This programme is being led by the South Tees CCG in partnership with Redcar & Cleveland Borough Council, Middlesbrough Borough Council, South Tees NHS Foundation Trust and other key stakeholders.

An independent survey of bed use undertaken in 2011 for South Tees Hospitals NHS Foundation Trust indicated that approximately 49% of patients were medically fit and did not need to be in a hospital setting. Many were in hospital who could be at home if partners improve home based health and social care support. It is clinically recognised that delays in discharging patients from hospital are detrimental to the long term wellbeing of elderly people. A more integrated approach to the delivery of health and social care services will allow more patients to return home earlier and could reduce the need for the number of hospital beds across South Tees.

The work to establish integrated and pro-active care management across South Tees has begun, under the **IMPROVE** programme. Realising this vision will involve building a truly integrated model of support which spans health and social care. Partners will consider co-locating services, developing new and innovative provision, making best use of existing estate, as well as prevention and healthy living aspects. This includes considering:

- Putting GPs at the heart of an integrated service, undertaking more proactive management of patients to identify those at most risk and coordinating support across health and social care.
- Making better use of a "step up" (GP led direct admissions) model of care which would reduce the number of patients admitted to acute hospital beds.
- Delivering some out-patient clinics closer to home, where appropriate and reviewing the use of community hospitals to provide better access for patients.
- Better information sharing across health and social care teams.
- Providing healthy living advice and encouraging self management and self care to prevent escalation of health conditions.
- Increased involvement of the voluntary and third sector in providing community-based services.

The IMPROVE programme will deliver the following benefits:

- Improvements in quality of care offered to our patients and service users;
- Improved clinical outcomes to patients and service users;
- Improved access to services both in terms of times available and location;
- Better use of our workforce through better joined up provision of care across the whole system – i.e. across health and social care;
- Improved communication across the health and social care system which will support the integrated care model;

- Resultant better management of those patients who are more poorly in a hospital setting, by more appropriately managing demand of other less ill patients into a wider range of services;

Darlington Long Term Conditions – Improvement Collaborative

This programme is a continuation of the success of the Darlington Dementia Collaborative (main partners were Darlington Borough Council, Tees Esk and Wear Valley NHS Trust, County Durham & Darlington Foundation Trust and County Durham & Darlington Primary Care Trust (now Darlington CCG).

Individuals with long term conditions are the most frequent users of health and social care services, with 71% of the total health spend is on people with LTC's and numbers are expected to rise in line with the population profile depicted earlier. Many people with long term conditions also have mental health problems and all of this influences the level of social care needs of the individual. By 2030 the number of people (65+) in Darlington predicted to have a limiting long term Illness is expected to rise from 8,750 to 13,490.

Phase 1 of the Darlington's Long Term Conditions Collaboration has been to undertake research and analysis from patients, professionals, data and finance to understand the whole system working for patients with a LTC. A cohort of patients and service users has been drawn together already, identifying those people whose long term conditions have necessitated potentially unnecessary admissions to hospital. Members of this cohort are highly likely to have multiple long term conditions, and therefore there are likely to be wider efficiency savings than just those identified initially in relation to admission avoidance. As the cohort of service users is larger than that for the dementia collaborative, these benefits will be felt by a larger number of hospital wards, service users, community based health staff and social care professionals.

All public sector partners in Darlington have agreed to fund a voluntary sector organisation to implement a Good Friends scheme, recruiting sufficient volunteers to ensure that 1,000 additional people are supported to remain safe in their own homes and defer their entry to the health and social care system.

Commitment and Capability to deliver

The approach outlined above fits well with existing priorities. Cabinets at all three Councils have already approved papers that outline greater collaboration across adult and children's social care. The Health and Well Being Boards in each of three localities have identified a commitment to delivering more sustainable, integrated services:

Darlington
1. To focus resources in areas of highest need
2. To create a sustainable health and social care economy
3. To improve the management of long term conditions

Middlesbrough
1. Tackle the social causes of poor health
2. Ensure children and young people have the best health and wellbeing
3. Reducing preventable illness and early deaths
4. Ensure high quality, sustainable and joined up health, social care and wellbeing services

Redcar and Cleveland
1. Children and young people have the best start in life
2. People in Redcar and Cleveland live healthier and longer lives
3. More people lead safe, independent lives

Given the high level of priority for integration and collaboration within existing plans, and with additional support from the Department of Health Pioneers programme, we are confident that we can work together collaboratively to move further and faster to deliver whole system transformation.

Each of the Councils has a strong track record in managing service transformation within their own organisation and all have devoted resources specifically for transformation. They have all made changes to services following significant reductions to their budgets and have strong consultation and change management processes in place. All areas have strong relationships with their local Healthwatch.

There exists already within the Tees Valley a history of sharing services and collaboration. Arrangements currently in place range from economic development to the children's emergency duty team and back office functions. There are a range of other opportunities being explored and it is anticipated that this collaborative will further build cohesion. The Clinical Commissioning Groups already have a shared history through the former PCTs and have built on this to agree lead CCG arrangements for a number of legacy projects.

There is a strong commitment to locality integration already, with partners already involved in delivering the following:

- Darlington Council and CCG
    - A joint integration and management post in Darlington
    - Agreement for further future integration, confirmed in Darlington CCG's Clear and Credible Plan
    - Commitment to integration of services through the Health and Well Being Board
    - Integrated operational teams in Children's preventative activity
    - Many joint strategies and commissioning plans
- South Tees CCG and Middlesbrough and Redcar & Cleveland Councils
    - Commitment to integration of services through the Health and Well Being Boards
    - Redcar & Cleveland Council's Joint Strategic Commissioning Group with identified priorities for joint commissioning work
    - Redcar and Cleveland Ageing Better Strategy
    - Redcar and Cleveland Community Capacity Building Strategy

Not only is there a strong track record in relation to partnership activity, but there is also a strong track record in making use of evidence-based approaches to integration in the Tees Valley. The priorities of all of the Health and Well Being Boards are based on evidence from Joint Strategic Needs Assessments, Health Profiles and the Directors of Public Health Annual Reports. These have all been reported to the respective Boards and the proposals outlined in this paper are derived specifically from the evidence base demonstrated at those Board meetings. Specifically in the Long Term Conditions Collaborative, partners are working with clinicians and NICE to undertake a deep dive into what works for such conditions, as well as value stream mapping with staff involved in front-line delivery, to ensure that any proposals are rooted in the real experience and best practice that is available.

Notable examples of joint working include:

Darlington Dementia Collaborative – this was led from the top by the Chief Executives of Darlington Borough Council, Darlington CCG (formerly the Primary Care Trust), Tees, Esk and Wear Valley Foundation Trust and the County Durham and Darlington NHS Foundation Trust working together to achieve real results for patients and service users. It delivered success in:

- reducing length of stay in hospital for the cohort by four days
- reducing attendances at Accident & Emergency (A & E) at Darlington Memorial Hospital from the four care homes included in the study by 24%
- reducing admissions to Darlington Memorial Hospital from the four care homes involved in the study by 17%
- achieving a 47% reduction in lead time for people triaged in the non-urgent pathway when attending A & E
- reviewing paperwork to the Medical Assessment Unit resulting in 77 hours of doctors' and 27 hours of nurses time saved per week
- increasing in direct patient contact time with Liaison Psychiatry by 27 – 39%.

The Collaborative was also shortlisted for a Local Government Chronicle award for innovation in 2012. Two other areas in the Tees Valley have already begun their own Dementia Collaborative, building on the Darlington model.

Tees Public Health Shared Service is jointly commissioned by Redcar & Cleveland, Middlesbrough, Darlington, Stockton and Hartlepool, hosted by Redcar and Cleveland, providing specialist support for

public health professionals. Promoting healthy lifestyles is crucial in developing a culture of greater self management of conditions and reduces demand for more acute care.

Health & Wellbeing Services, School Nursing Services, child measurement programmes are all **jointly commissioned on a South Tees basis**. Sexual Health Services are jointly commissioned across the North East, as are Fresh (smoking cessation) and Balance (alcohol reduction).

Both South Tees CCG and Darlington CCG work closely with the North of England Commissioning Support Unit which promotes the sharing of learning and best practice across a wider scale. The willingness of all partners to develop, share and learn innovative practice is demonstrated through an example of a recent piece of work undertaken by NHS Hartlepool and Stockton-on-Tees CCG in conjunction with the Commissioning Support Unit on reducing GP variation to improve quality across the Tees health economy is now being rolled out across County Durham. This work was shortlisted for an award Sustained Improvement Award within the Lean Health Care Academy Awards 2012.

Commitment to sharing learning

Learning from one another and sharing the lessons of the work being tested are built into this proposal. Other organisations in the Tees Valley will be regularly involved through the existing mechanisms, and will be welcome to join in a future phase of the Collaborative making the model very scaleable. However we want to go further than simply sharing learning across the Tees Valley.

The model will be shared across the North East through the existing Directors of Children's Services, Directors of Adult Social Services and Directors of Public Health networks.

We will actively engage with national partners through the Integrated Care and Support Exchange. We will explore the potential for an 'Innovation Lab' which would test the economic and outcome impact of integration delivery proposals within a framework across the Councils and CCG, develop new ideas, provide challenge and support and share good practice. As an extension of this, we will also look to develop an 'Integration Academy' which will provide a platform for sharing the learning aspects of our proposal through learning materials such as papers, workshops and conferences as well as through more interactive methods such as seminars with outside speakers that are open to all, and made more widely available through a dedicated website containing all learning material, webcasts, webinars, videos, coaching, mentoring and buddying opportunities.

We don't underestimate the challenge presented through the need to change organisational cultures and working practices, and will work with Sector Skills Academy, Sills for Care and other health workforce bodies such as the RCNM, BMA to develop our approach to workforce development. Similarly, we will be keen to make use of the Sector Compact for the Social Care workforce that is being developed by the Department of Health.

Anticipated support required

The Tees Valley Collaborative feel that the Pioneer programme can offer a range of support for our ambitious programme including but not limited to:-

- Analytical support and Financial Modelling to build and evidence the value case.
- Data and service audits to ensure that both programmes use consistent financial models and analysis of data for accurate comparison.
- Helping to clarify the costs savings including evidence and mechanism to remove the cross organisational savings from budgets and to develop the mechanisms to work through the complexity of moving money between agencies where necessary
- Workshop development assistance, including champion support and development and implementation of action learning sets.