North Tees & Hartlepool NHS Foundation Trust

Board of Directors

Deputy Chief Executive / Director of Strategic Development

Momentum: Pathways to Healthcare Programme Update – May 2011

Strategic Aim: ***Momentum: Pathways to Healthcare: To develop and implement a new healthcare system for the people of: Easington, Hartlepool, Sedgefield and Stockton.***

Executive Summary

1. The following report provides the latest available updates from the three elements that make up the Momentum: Pathways to Healthcare Programme: Service Transformation, Primary and Community Care Capital Planning Project and the Hospital Capital Planning Project.

2. A review of bed usage alongside the physical bed stock demonstrates that progress has been made, particularly in reducing lengths of stay, but the harsh winter resulted in an increased demand for admissions. Work continues to identify and address areas for further improvement.

3. Areas of service transformation to highlight include initiatives to increase self care for patients, increased integration of service provision across acute and community services, improved access to therapies and extended use of available technologies.

4. The independent review of Accident and Emergency / Minor Injuries Unit service provision in Hartlepool, undertaken by the North East Strategic Health Authority (NESHA) and Hartlepool Health Scrutiny Forum (HHSF), has made their recommendations and these are being taken forward by a Steering Group led by NHS Tees and Hartlepool Health Scrutiny Forum.

5. It has been agreed to formally recognise the alignment of the Momentum and QIPP (Quality Innovation, Productivity and Prevention) agendas. Engagement with the emerging leaders of the General Practitioner Commissioning Consortia has been considered and representatives invited onto the Momentum and QIPP Programme Board.

6. Plans to develop primary care estate and facilities continue with schemes in Hartlepool (One Life Centre), Stockton, Billingham and Yarm.

7. The news from the Department of Health in April 2011 that the area had been unsuccessful in a bid for Social Care Credits to support the Integrated Health facility and Extra Care Scheme in Billingham has meant that revised arrangements will need to be agreed and an alternative scheme is being developed for the area.

8. The development of a scheme to replace Yarm Medical Centre has been approved by the Board of NHS Tees and is now being taken forward.

9. The revised Outline Business Case (OBC) for the new Hospital (Version 3.0 - previously presented to this Board) has now been presented and endorsed at the Boards of partner Primary Care Trusts and Strategic Health Authority (NESHA).

10. A Gateway Review (Level 2) has been undertaken by a team from the Office of Government and Commerce (OGC) and received an overall positive review with a rating of 'Amber'. A review of the scheme undertaken by Monitor was also rated overall as good with some areas of clarification being requested and provided by the Trust.

11. The 'Deed of Safeguard' as discussed with the Department of Health remains an area for future clarification. The Trust is working with the Department of Health to undertake a further review of the OBC prior going to the market and this will commence on the 25th May 2011. Work continues to develop timescales for procurement but it is likely that this will be delayed by three months.

12. In summary, the Momentum: Pathways to Healthcare and QIPP Programme Board will continue to lead to the transformation of services across the whole healthcare system, alongside the development of community facilities and the building of new single site hospital.

Carole Langrick
Deputy Chief Executive /
Director of Strategic Development
11 May 2011

North Tees & Hartlepool NHS Foundation Trust

Board of Directors

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Strategic Aim: ***Momentum: Pathways to Healthcare: To develop and implement a new healthcare system for the people of: Easington, Hartlepool, Sedgefield and Stockton.***

1. Purpose of Report

The purpose of this report is to provide members of the Board of Directors with an update on the progress of the Momentum: Pathways to Healthcare programme focussing in particular on the Service Transformation element of the programme set in the context of the two capital projects developing community facilities and the new hospital respectively.

2. Background

The Momentum: Pathways to Healthcare Programme will lead to the transformation of the local healthcare system, including the redesign of healthcare across primary, community and secondary care; the development of new community facilities and the building of a new hospital.

The programme is a partnership of local stakeholders, specifically North Tees and Hartlepool NHS Foundation Trust, Stockton Teaching Primary Care Trust and Hartlepool Primary Care Trust; closely aligned with County Durham Primary Care Trust and the North East Strategic Health Authority.

The programme is made up of three projects:

- Service Transformation
- Primary and Community Care Capital Planning Project
- Hospital Capital Planning Project

The Momentum: Pathways to Healthcare Programme orchestrates the interdependencies between the three projects and ensures alignment of the emerging service models and development of facilities.

3. Progress Report

The following outlines progress to date for the three projects that make up the Momentum: Pathways to Healthcare Programme.

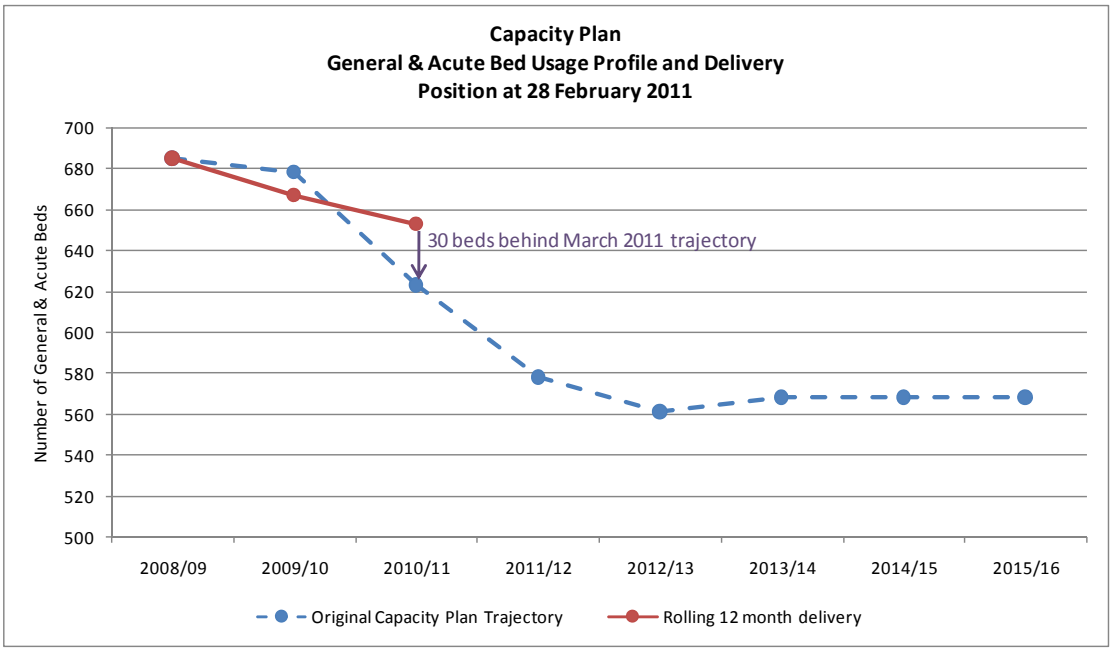
3.1 Service Transformation (Project Director: Carole Langrick)

The purpose of Service Transformation is to deliver the bed reductions required in the capacity plan, provide care closer to home and increase quality, accessibility, integration, responsiveness and value for money across the patient pathway.

Business Service Change Projects (BSCP) are being undertaken to achieve this and have been mapped to determine their contribution to delivering the bed usage reductions required for the new hospital as well as their impact on care closer to home.

The capacity plan is based upon an average bed usage over a 12 month period, not the physical number of beds available across the Trust at a point in time, however the physical bed count is considered below for completeness.

A review of progress of bed usage against the required trajectory for the delivery of a reduced number of General and Acute beds by 2014 (see graph below), shows that at 28 February 2011 (the latest available validated data used to track the 12 month rolling position) the rolling 12 month position is behind trajectory, with 30 beds from a total of 55 for 2010/11 still to be delivered. The twelve month rolling position is a reflection of bed usage over the whole year and therefore contains a period of activity over winter. The snapshot position in March 2011 is a reflection of the bed stock once the winter flex beds were closed.



The above trajectory predicted demand for General & Acute bed usage at the end of March 31 2010 to be 678 and this has been reduced across the year to date by 25 to 653 beds. In comparison, the actual Trust bed stock in March 2011 was 629. This is compared to a capacity plan trajectory for bed usage of 623.

The bed usage reduction achieved to date has been through a combination of Momentum work streams, operational efficiencies achieved via Cost Improvement Programmes and other Business Planning initiatives. The emergency bed usage reductions achieved have predominantly been in the stroke, cardiology and respiratory areas of medicine through significant reductions in lengths of stay. Overall, progress is being made in reducing emergency length of stay (down by over 5%), however emergency admissions continue to rise (by almost 3%). The rise in admissions during the particularly cold winter has contributed to this position.

The BSCP delivering reductions in bed usage have been provided with an updated 12 month rolling profile of their progress at HRG level regarding areas of improvement and potential risk. This review of progress by pathway at a detailed Healthcare Resource Group level has informed further work and this is being taken forward by the groups.

Whilst we have seen significant reductions in bed usage, a total of 32 out of the necessary 124 across the next five years, progress is expected to continue to be made across the whole health and social care system.

In addition to the bed usage reductions highlighted above to date, the following progress has been made to support these reductions since the last report to the Trust Board.

- Patients with newly diagnosed Type 1 diabetes can now access an enhanced education programme. The Professional Education Programme in Primary Care commenced in January 2011.

- A respiratory implementation group has been established between community and acute care staff to develop the integrated community respiratory service.

- A new cardiologist has been appointed and within the same discipline, staff meet regularly to develop integrated services across primary and secondary care.

- A weekend inpatient therapy service has been piloted for stroke patients to ensure continuity of care on a Saturday and Sunday, with work ongoing to secure 7 days per week access to carotid artery Doppler screening. Hyper acute stroke services have also been centralised.

- The relocation of Paediatric clinics from Caroline Street to the University Hospital of Hartlepool and the realignment of Community Paediatric Services and these moves were facilitated in early May 2011.

- The Acute Oncology Team continues to be developed and a Specialist Nurse has recently been appointed.

- “Toughbooks” for community service staff have been provided to improve access to up-to-date patient information and to update this information at the point of care. There has been further roll-out of access to pathology results in the community and Primary Care via ICE.

- A dedicated workforce team has been established to support the transition for staff and the development of a workforce planning tool initiated, linked to activity and national / local benchmarks.

- The relocation of the of wheelchair services from Caroline Street to the University Hospital of Hartlepool has also been facilitated and is expected to be operational in May 2011.

- An audit of intermediate care has been completed across the four localities of Stockton, Hartlepool, Easington and Sedgefield.

- Vascular clinics that could potentially be delivered in a community location have been identified. Also within vascular care, there is an agreement to implement a multi-disciplinary complex wound clinic.

- Patients with Parkinson’s Disease now have improved access to mental health services.

During the first quarter of 2011/12 we expect to see a number of other specific service changes, subject to staff and patient consultation, this includes the following:

- A diabetes clinic will be established in Peterlee with the shared care protocols extended to Easington at the request of local GPs.

- Further recruitment of cardiologists and other staff to provide a more complete, local cardiology service.

- The pilot weekend therapy service for stroke patients will be evaluated and single rehabilitation team for stroke patients will be initiated.

- Further additions to the acute oncology team are expected.

- The use of “Tough Books” and the availability of pathology results via ICE will be extended.

- Non face-to-face follow-up outpatient appointments for patients with myeloproliferative disorders will commence.

- Self-injection of methotrexate for patients in Stockton will be rolled out following successful implementation in Hartlepool.

- Non face-to-face review of pain management patients in receipt of TENS therapy to be implemented.

- Increased access / referral to Health Trainers and smoking cessation service to be progressed for vascular patients.

- Recommendations following the independent review of A&E / MIU services in Hartlepool by the North East Strategic Health Authority and Hartlepool Health Scrutiny Forum will be taken forward and a joint Steering Group has been established to lead this work.

- The relocation of some outpatient clinics and services planned for One Life Hartlepool may now be taken forward, taking due cognisance of the outcome of the SHA/Health Scrutiny Committee review.

Following discussion at the Momentum: Pathways to Healthcare Programme Board in November 2010, the Business Service Change projects that have been completed to date have been revisited to identify: those parts of the pathway that can be implemented with immediate effect; those parts of the pathway that require investment to allow them to be implemented; those parts of the pathway that may need to stand in abeyance pending other service changes or even the full implementation of the Momentum programme on completion of the new hospital.

This has resulted in the development of a number of service transformation implementation plan summaries (waterfalls) for the BSCP and these were presented to the Programme Board in March 2011. The implementation plan summaries will:

- Support the phasing of service developments
- Highlight service reconfiguration options and evidence of engagement
- Minimise double running
- Highlight future investment opportunities
- Enable the demonstration of incremental changes over time
- Clarify the impact of interdependencies across the whole system
- Improve the communication of service transformation to patients and other stakeholders, including the emerging GP Commissioning Consortia

Please see Appendix I for the list of Service Transformation BSCP and a summary of the actions underway to deliver the capacity plan.

In addition to recognising the progress highlighted above, the Programme Board also agreed that:

- The Programme Board was to be renamed as the Momentum: Pathways to Healthcare and QIPP Programme Board in recognition that the objectives of both were aligned
- GP Commissioning Consortia Chairs to be invited to become members of the Programme Board (Dr John O'Donoghue – Stockton and Dr Boleslaw Posmyk – Hartlepool)

In conclusion, service changes continue to be planned and implemented and progress continues to be made towards the strategic delivery of a healthcare system which is community based with a new hospital for those people and services that cannot be cared for or provided closer to home. Ongoing engagement with patients and key stakeholders remains a constant feature of the Momentum programme.

3.2 Primary and Community Care Capital Planning Project (Project Director: Alison Wilson, NHS Tees)

The design and build of community facilities in Stockton, Hartlepool, Yarm and Billingham continues to progress.

The impact of 'Equity and Excellence: Liberating the NHS – managing the transition' (Department of Health - February 2011) and the future of retained estate once Primary Care Trusts are abolished in 2013 is still unknown, although further guidance is anticipated. A joint team has been established to help manage the use of current estate in the community as well as at the current hospital sites and to coordinate the transition.

In Stockton, a 'space utilisation' review of all community estate to inform requirements of a new facility has been completed and will inform the final 'Schedule of Accommodation' for the Stockton scheme. NHS Tees are working with LIFTCo and Assura, who own two GP properties, to ascertain whether an integrated solution can be found that would also accommodate the GP practices.

In Billingham, the proposed scheme is a joint venture between NHS Tees and Stockton Borough Council (SBC). DH has informed NHS Tees and SBC that they will not receive social care credits to assist the financing of the Integrated Health Facility and Extra Care Scheme in Billingham. However, both partners remain committed to the ongoing development of Billingham Town Centre and the plans they are progressing with developers Stockland.

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Image: Hartlepool Integrated Care Centre

In Hartlepool, the Minor Injuries facility at the One Life centre became available for use in November 2010, and future service delivery is subject to the outcome of the deliberations of the A&E Steering Group. Northern Doctors are now providing out of hours service from One Life and it is anticipated that the 'General Practitioner led 'Walk in Services' will move into the building in early June 2011.

Community services previously provided from Caroline Street Hartlepool have now been relocated following consultation by the PCT with the Health Scrutiny Forum and staff groups. Wheelchair services are being relocated within The Hart Building and Paediatric services are also moving to the University Hospital of Hartlepool site. Other services, for example retinal screening and the continence clinic, have been re-provided at either One Life Hartlepool or at other sites within the town.

In Yarm, the business case for re-developing the Yarm Medical Centre has been approved by the Board of NHS Tees and developments should commence shortly.

3.3 Hospital Capital Planning Project (Project Director: Kevin Oxley)

The revised Outline Business Case (OBC), as presented to the Trust Board and approved on the 27th January 2011, has been formally presented to the Boards of the local Primary Care Trusts (PCTs) and Strategic Health Authority (SHA).

Image: Proposed single site Hospital at Wynyard Park

NHS Tees has agreed the content of the OBC in principle subject to certain caveats i.e. non existence of the PCT when the scheme is completed. A formal letter of support has been provided by NHS Tees and includes joint support from Stockton and Hartlepool GP Consortium. NHS County Durham has also provided confirmation of approval.

The SHA Board formally considered the OBC on the 14 April 2011 and also confirmed approval.

A review of the OBC has been undertaken by Monitor and the overall evaluation was good. A response has been provided to Monitor following their feedback.

A Health Gateway Review 2 of the Hospital Capital Planning Project has been undertaken by the Office of Government and Commerce (OGC) between 5 April and 8 April 2011. The overall assessment from the review team has been positive and the project rated 'Amber'.

As yet the Department of Health (DH) has not provided any further clarification regarding the provision of a 'Deed of Safeguard'. However, following a meeting with DH on 4th May there was an indication that progress had been made with the Treasury on the issue and a position would be communicated within a few weeks. DH had asked for the meeting with the Trust to build awareness in relation to the revised OBC, the areas of change and the progress in relation to moving towards procurement and the approval process at DH. They indicated that they would be undertaking a full review of the OBC (version 3.0) despite previous approvals including a recommendation to Ministers and an evaluation by Treasury. This process is likely to take approximately 3 months to complete. DH considered it would be premature to go to market without DH approval of the OBC. Susan Peak who is leading the team conducting the review will be visiting the Trust on Wednesday 25th May as part of a familiarisation process and to discuss aspects of the OBC with Trust staff.

Technical advisors have now been appointed as follows:-

- Tribal Healthcare Planners have been re-appointed
- P&HS Architects have been re-appointed
- Mott MacDonald Civil and Structural Engineers

The first draft of the design brief has been completed but there are a number of issues outstanding around clinical and technical processes: meetings are arranged with the technical advisors to resolve any outstanding issues. Clinical output specifications continue to be developed.

The New Hospital Capital Project Board will review the programme at its June meeting and decide how the timescales imposed by DH in relation to OBC approval and procurement documentation review will impact on the project timetable, it is likely however to delay procurement by approximately 3 months.

4. Conclusion and Next Steps

Momentum: Pathways to Healthcare and QIPP Programme Board will continue. The major next steps for the programme are:

- Continue to progress the Service Transformation; Hospital Capital Planning and Primary and Community Capital Planning Projects.
- Maintain alignment and integration across the three major projects that make up the programme.
- Manage risks and issues as they are identified.
- Continue engagement and communication with all stakeholders.
- Identify and realise new healthcare pathway efficiencies as soon as they become possible.
- Assess and manage the implications of service changes for the workforce and current staff.

5. Recommendations

The Board of Directors is asked to receive this report and note the progress in respect of the overall Momentum: Pathways to Healthcare and QIPP Programme in general and the Service Transformation Project in particular.

Carole Langrick
Deputy Chief Executive /
Director of Strategic Development
11 May 2011

The Momentum Service Transformation Projects (BSCP)

Each of the Projects have or will develop an implementation plan (waterfall) to manage the transition:

- The projects with draft 'implementation plans' are highlighted.
- The projects that are developing their 'implementation plans' are highlighted.
- The projects that are yet to start developing their 'implementation plans' are highlighted.

Beds

Diabetes

Respiratory

Cardio

Stroke

Paediatrics

Oncology

Orthopaedics (2)

Digestive System (2)

Other General Medicine (3)

Other General Surgery (4)

Urology

Enablers

Informatics

Workforce (2)

AHP and Therapies

Prescribing

Intermediate Care/ Community Services

A&E/MIU

Diagnostics

Outpatient Provision

Elderly Care

Telehealth

Estates

Capacity Plan & Benefits (2)

Communications and PPI

Care Closer to home

Haematology (Blood disorders)

Haematology (anti Coagulation)

Rheumatology

Gynaecology

Parkinson's Disease

Pain management

Breast Care (2)

Vascular

Maternity and Newborn

(no) incorporates BSCP objectives which have been merged from the group of 46 projects

momentum pathways to healthcare

Progress made so far by each of the pathways, and what we are doing this quarter and next quarter

Beds	Historic	This Quarter (Jan – Mar)	Next Quarter (Apr – Jun)
Diabetes	The DESMOND education Programme has been established for patients with Type 2 diabetes. This provides patients with the knowledge and skills they need to manage their own diabetes care.	Patients with newly diagnosed Type 1 Diabetes can now also access an enhanced education programme The Professional Education Programme in Primary Care commenced in January 2011	Asked by Easington GPs to extend our shared care protocols and guidelines to their patients. A clinic will be established in Peterlee Self care training and support will continue
Respiratory	Telehealth pilot has been undertaken and evaluated. Single Community Respiratory Service established building on the CRAMS service in Hartlepool and Lung Health Service in Stockton Self care education training provided to patients and primary care professionals undertaken	Telehealth service proposals are being developed. Respiratory implementation group established by community and acute care staff to develop the integrated community respiratory service.	Develop Telehealth pilot that my benefit respiratory and cardiology conditions Potential to relocate Outpatient Clinics to OLH (subject to the review)
Cardiology	CHD patients needing 'Pacing' are being repatriated thus providing care closer to home For those patients requiring Pacing, this service is now available at the University Hospital of North Tees	A new cardiologist has been appointed Staff are meeting on a regular basis to promote integration across primary and secondary care.	Additional cardiologists and other staff to be recruited to provide more cardiology services closer to home and specifically to increase the capacity for pacing to ensure all of the local demand can be met
Stroke Care	Implementation of the National Stroke Strategy Access to 24/7 Thrombolysis Access to specialist stroke physician within 24 hours of admission Access to CT scans 24/7 Full engagement of all community and therapy teams across the patch secured.	Patients who have had a Stroke and are still in hospital are now provided with a weekend inpatient therapy service (pilot) Work ongoing to secure 7/7 access to carotid artery Doppler scanning Centralisation of hyper acute stroke services	The pilot weekend inpatient therapy service for Stroke patients will be evaluated. The implementation of a single rehabilitation team for Stroke patients will be initiated
Paediatrics	Introduction of the new role of Paediatric Nurse Practitioner	Planning for Paediatric Clinics relocation from Caroline Street Hartlepool to UHH. Realignment of community Paediatric medical services 4 paediatric Patient pathways identified to develop tees wide	Relocation of Paediatric Community Clinics (subject to review) Development of Tees Wide paediatric patient pathways
Oncology	Additional consultant PA	Appointment of Oncology Specialist Nurse Development of Acute Oncology Team	The Acute Oncology team will be further developed to ensure cancer patients receive a timely specialist review
Orthopaedics	Planning for the provision of an integrated MSK and Orthopaedics service alongside the pain management service, increased self care and Osteoporosis nurse	To finalise Implementation Plan by May 2011	Presented to the Programme Board in June 2011
Digestive System	Review of planned and unplanned across the pathway	To finalise Implementation Plan by July 2011	Presented to the Programme Board in September 2011.

Enabling	Historic	This Quarter (Jan – Mar)	Next Quarter (Apr – Jun)
Informatics	Informatics Checklist produced to support each of the projects COIN fully deployed across both hospital sites and 'live' at 84/110 community service locations. 'Roll out of 'Tough Books' initiated.	'Tough Books' used by community service staff to increase access to the most up-to-date patient information and update this at the point of care Community services and some GPs are able to access results electronically (ICE).	The use of 'Tough Books' will be further extended in community services Extend the use of ICE for pathology results.
Workforce	HR Checklist produced to support each of the projects Extended working analysis begun Workforce section for OBC for new hospital developed and approved.	A dedicated workforce team has been established to support the transition for staff. Development of workforce planning tool linked to activity and national/local benchmarks. Training provided in workforce planning inclusive of train a trainer programme.	Implement Business Plan and workforce plans for each pathway. Organise the delivery of workforce planning training via those who underwent the train the trainer programme. Communicate/ disseminate utilising existing communication forums.
AHP and Therapies	Model developed and agreed. Capacity and utilisation reviewed via a RPIW. Implementation plan includes identification of future locations (therapies & wheelchair) and plan for single point of access (Central Booking).	Arrangements finalised for the relocation of wheelchair services from Caroline Street Hartlepool to the University Hospital of Hartlepool	Wheelchair Services moved into UHH.
Prescribing	Options for Community prescribing reviewed and associated costs identified.	One Life Hartlepool registered with Office of National Statistics as a prescribing site	Prescription pads introduced to enable community based prescribing
A&E/MIU	Revised model of care developed. (A&E /MIU proposals currently subject to review).	Contributing to the Independent Review undertaken by the North East Strategic Health Authority and Hartlepool Health Scrutiny Forum	Development and agreement of an Implementation Plan in response to the Independent Review
Diagnostics	Advised on technical specifications of the equipment and screens and produced implementation plan to facilitate diagnostics from OLH.	Finalise arrangements for provision of diagnostic services in OLH following Independent Review	Development of an Implementation Plan in response to the Independent Review
Outpatient provision	Informatics, HR and staffing, Storage (logistics, medical records, transport) support services and diagnostics, pharmacy OP Checklist produced and implemented Range of potential OP to relocate identified and costed.	To finalise Implementation Plan for relocation of a limited range of Outpatient appointments in OLH following outcome of the Independent Review.	Development of an Implementation Plan in response to the Independent Review
Elderly Care	Project group established. Integrated working (Health and Social care) and intermediate care agreed as key.	Audit of Intermediated care completed across Hartlepool, Stockton, Easington and Sedgefield.	Future demand and capacity requirements for community services forecast & identified.
Intermediate Care/ Community Services	Design of 60 Bed Sub Acute facility Element of TCS - Virtual Ward (Utilisation of DN and Community Matrons, Single Point of Access, and provision of 'Intermediate care services).	To agree terms and timetable for production of implementation, with links to Elderly Care project, Development of Telehealth and Re-ablement proposals.	Initiate the project.
Telehealth	Telehealth pilot for respiratory care has been undertaken and economically evaluated.	To agree terms of reference and timetable for production of implementation plan.	Initiate the project.
Estates	Community Estates group established to co-ordinate moves and ensure relocation of services.	Relocation of community services from Caroline Street into UHH. Agree implementation plan for work.	Relocation of Wheelchair services and non patient facing services into UHH. Relocation of some OP into OLH (subject to review).
Capacity Plan & Benefits (2)	Strategy and Implementation Plan in place.	The scale and scope of the new hospital build and supporting community capacity reviewed	Progress assessed against key capacity plan deliverables (Quarter 1 Review).
Communications /PPI	Strategy and Implementation Plan in place.	See Schedule. Including: Easington Labour group, Multi Link, Stockton OSC.	See Schedule

Care Closer to Home	Historic	This Quarter (Jan – Mar)	Next Quarter (Apr – Jun)
Haematology (Blood disorders)	Work has been undertaken to establish the patient pathway to support the management of patients with Myloproliferative disorders and ensure capacity is available to meet increasing demand.	An audit of patients with a particular type of blood disorder will be completed to inform the future level of non-face to face follow up outpatient appointments prior to implementation	Patients with Myloproliferative disorders will be followed up via a non face to face contact (telephone)
Haematology (anti-Coagulation)	All stable patients receiving anti coagulation therapy are now being monitored in Primary care, using shared care protocols, in Hartlepool. The use of near patient testing kit ensures patients are given an instant result from their blood test.	Patients on anti-coagulation therapy can now have their blood tests done in the community rather than having to go to the hospital	Service will be reviewed and dependent upon outcome continue to be delivered.
Rheumatology	Shared care guidelines approved between primary and secondary care across Stockton and Hartlepool	Hartlepool patients with rheumatoid arthritis can now self inject Methotrexate at home, supported by the rheumatology team from the Trust and their own GP	GPs in Stockton will sign up to shared care protocol Self injection of methotrexate will be rolled out to patients in Stockton.
Gynaecology	Evidence based referral guidelines based on map of medicine/best practice agreed between primary and secondary care. Partial booking established. No automatic follow up for day case procedures implemented.	Clinical staff revising the priority of review appointments where appropriate and reducing the new to review ratio.	Identification of inpatients that do not require automatic non face to face follow up.
Parkinson's Disease	Specialist Nurse appointed to lead the pathway. This has facilitated increased collaboration with Tees Neurosciences, established a dedicated helpline and introduced Choose and Book.	Improved access to mental health clinic implemented in Hartlepool	Implement improved access to mental health clinic in Stockton Improved access to Speech and Language Service and roll out of Lee Silverman training
Pain management	Revised pathway agreed in principle incorporating pain management, musculoskeletal and orthopaedics	-	Anticipate a move to non-face to face review of patients in receipt of TENS therapy, mainly for lower back pain
Vascular Care	Evidence based referral guidelines based on map of medicine/best practice agreed between primary and secondary care.	Identification of potential vascular clinics that may be undertaken in a community setting (subject to review) Agreement to implement a multi disciplinary complex wound clinic.	Increased access/ referral to Health Trainers and smoking cessation services to be taken forward by PCT
Breast Care	Implementation of expansion of Breast Screening Services (extension to age range from 50-70 to 47- 73 and digitalisation of equipment. Implementation plan agreed		