HARTLEPOOL BOROUGH COUNCIL

NHS
Hartlepool and Stockton-on-Tees Clinical Commissioning Group


# Hartlepool Matters!

## Shaping the Future of Health and Social Care in Hartlepool

Professor David Colin-Thomé (Independent Chair)

# Contents



Photo © careimages.com

## APPENDICES

# Foreward by Professor David Colin-Thomé (Independent Chair of the Local Health and Social Care Plan Working Group)

It has been a privilege to be nominated by the Northern England Clinical Senate to be the independent chair of the Hartlepool Local Health and Social Care Plan Working Group (the Working Group).

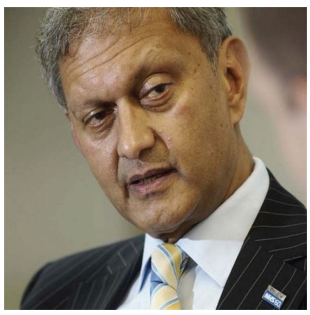
Hartlepool Borough Council on 12th March 2015 resolved that a Working Group be established with NHS Hartlepool and Stockton on Tees Clinical Commissioning Group to identify health and social care planning priorities to inform the development of a Plan for the delivery of integrated health and social care services across Hartlepool, including the University Hospital of Hartlepool site. The Borough Council recognised the importance of an Independent Chair for the Working Group and approached the Clinical Senate to identify a suitable individual. My appointment to the position was approved by the Borough Council on 6th August 2015.

I trained many years ago at Newcastle Medical School and in several North East hospitals, and now live in Northumberland. In the intervening years I worked for thirty six years as a GP in Runcorn, Cheshire and also for virtually ten years as the National Clinical Director for Primary Care at the Department of Health. The Clinical Director's job entailed me working beyond primary care with involvement in hospital, community and social services and the commissioning of NHS services.

As the chair of the Working Group, I have met members of the public, many as members of NHS interest groups, NHS clinical staff, chaired five public meetings and met the very impressive Hartlepool Youth Council who inspired us all. I have developed this report with senior staff of the Borough Council and the Clinical Commissioning Group.

So what have I learnt? The people of Hartlepool are proud of their town and its history but are very much aggrieved at what they see as the loss of many of their hospital services. An integrated plan must give prominence to community based services working closely with the University Hospital of Hartlepool. There is now a widespread feeling, and indeed cynicism, that the clinical safety reason given for removing some University Hospital of Hartlepool services is more to do with a managerial agenda than a clinical agenda.

The main body of this report provides in more detail the developed integrated plans, focusing mainly on the priorities identified by the Working Group (outlined in Section 3). Underpinning all of these plans is a policy to improve the general health of the population, a particular and urgent need for Hartlepool, which in turn will lead to services which can focus more on health than illness. At the same time, services must continue to demonstrate the provision of high quality illness services.



# Section 1 - Introduction

**Aims and Terms of Reference for the Working Group**

The Working Group was formally established by Full Council on 25th June 2015, to work in partnership with the Clinical Commissioning Group, to:

- Progress the identification of local strategic priorities for the provision of health and social care services in Hartlepool; and
- Inform the development of a Hartlepool Care Plan (the Plan) for the delivery of integrated health and social care services across Hartlepool, including the University of Hartlepool Hospital site.

**Chairmanship of the Working Group**

The Northern Clinical Senate was formally approached to nominate a representative to take up the position of Independent Chair. In response to concerns regarding a conflict of interest for Senate members in taking up the role as Chair, given the active involvement of some members in supporting the development of health services in Teesside and/or their substantive employment by local NHS provider organisations, Professor David Colin-Thomé (OBE) was appointed as the Independent Chair on 6th August 2015.

**Membership of the Working Group**

The membership of the Working Group reinforced the fundamental theme of partnership working and consisted of:

- All 33 Hartlepool Borough Councillors; and
- Co-opted representatives from the Clinical Commissioning Group.

In addition to this, the Working Group brought together a range individuals and experts from health and social care organisations responsible for the provision of services in Hartlepool and surrounding areas. These included:

- Representatives from the North Tees and Hartlepool Foundation Trust;
- Representatives from Tees, Esk and Wear Valleys NHS Foundation Trust;
- Representatives from the North Durham Clinical Commissioning Group;
- Representatives from the North East Ambulance Service; and
- Other individuals with suitable clinical / medical expertise.

Views were also obtained from 'other interested parties' to inform the identification of local strategic priorities for consideration in the development of the Plan. These included:

- Residents from Hartlepool, Stockton-on-Tees and East Durham;
- Hartlepool Healthwatch;
- Councillor / Officer representation from Durham County Council and Stockton Borough Council; and
- Members of Parliament for Hartlepool, Easington and Sedgefield.

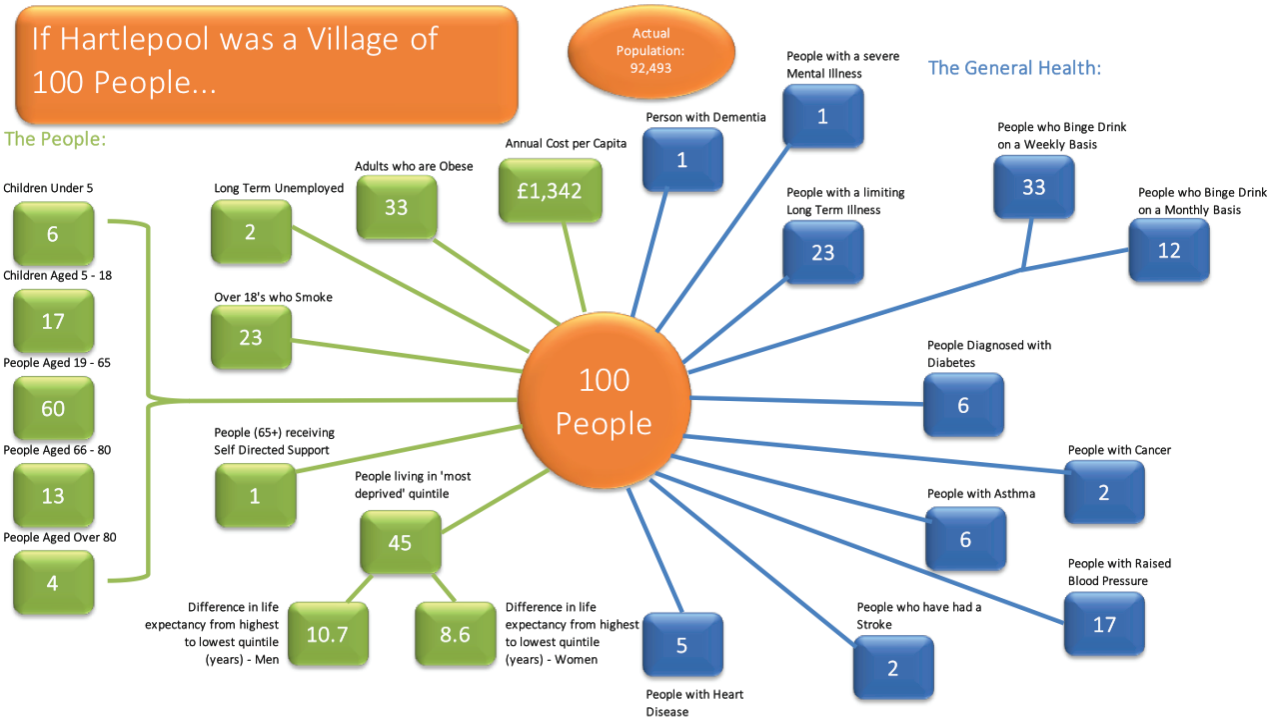
A full list of attendees can be found in **Appendix A**.

# Section 2 - Our context and our challenges

Hartlepool is one of the most deprived areas in Britain, ranked 24th most deprived out of 354 Local Authority areas and with 7 of the 17 wards in Hartlepool amongst the 10% most deprived in the country. It faces demographic challenges in terms of deprivation as well as in relation to an ageing population and an increasing number of people with disabilities.

To put this in context, if Hartlepool was a village of 100 people its challenges would look like this!

**Table 1 - If Hartlepool was a village of 100 people**




Indicators for Hartlepool highlight the breadth of the challenges being faced, as detailed in **Appendix B**.

Key challenges for health and social care services include[1]:

- Whilst about 8 out of 10 people across the town do not smoke, in some areas half of adults do still smoke. Smoking contributes to, and indeed in some cases causes, a large proportion of illness across the town, such as lung cancer, respiratory disease, chronic obstructive pulmonary disease and heart disease;

- Not everyone across the town can expect to live as long as each other. People who live in areas where there is high unemployment and poorer circumstances, have shorter lives on average. This is as stark: as people living in Rural West Ward can expect to live almost 11 years longer if you are a man and almost 7 years longer if you are a woman, than someone living in the town centre (Victoria Ward);

- Before a baby is born in Hartlepool, 1 in 5 of them has possibly experienced the effects of nicotine as their mother smokes;

1 Hartlepool Joint Strategic Needs Assessment (JSNA)

- When the baby is born, only 1 in 5 of them will be breastfed, yet this is the best food and nourishment a baby can have;

- Being overweight or obese can contribute to illnesses such as Type 2 diabetes. In Hartlepool almost 7 out of 10 people are overweight or obese;

- People in Hartlepool are more likely to attend hospital than people in other parts of the country due to excessive drinking of alcohol. The reasons for attending hospital where alcohol has played a part in needing to attend hospital, range from being injured to suffering from alcohol related diseases such as some liver cancers, cirrhosis and heart disease;

- Higher than the England average levels of unemployment;

- Higher than the England average rates of limiting long term illness and health problems;

- A high proportion of working age adults receiving benefits compared to the England average;

- A decreasing working age population and increasing population of over 65s and over 85s;

- Increasing numbers of people with learning disabilities and physical disabilities;

- People are living longer and, whilst the increase in life expectancy is welcomed, this presents challenges for health and social care services as people living longer often have complex health conditions and require significant levels of support to remain independent;

- Research shows that older age is associated with an increased incidence of multiple long term conditions and a growing number of functional and cognitive impairments. It is estimated that 58% of those aged 60 and over report having a Long Term Condition (LTC), with 25% of over 60's having two or more LTCs. For Hartlepool this would mean that by 2020 there will be approximately 4,700 over 65s with two or more LTCs;

- The number of older people who are living alone is increasing at the same time as informal support networks from families are declining. This significantly increases the risk of social isolation and loneliness. It is estimated that 2,340 older people in Hartlepool (14%) are currently living alone;

- The number of people living with dementia is also expected to increase significantly. Data indicated that in 2014 1,193 older people in Hartlepool were estimated to have dementia (6.9%). This is predicted to rise to 1,358 people by 2020 (7.2%) and 1,811 people by 2030 (7.8%);

- These trends have resulted in a growing demand for health services to treat multiple long term conditions as well as care services to help individuals cope with everyday activities such as dressing, bathing, shopping or preparing food;

- In Hartlepool, there were 4,526 emergency admissions to hospital for people aged over 65 in 2014/15. Given the ageing population and associated levels of need for health services, this is expected to increase significantly over the next 5-10 years if services continue to support people in the current way. The demand on social care services, and particularly long term care, is also predicted to increase significantly over this time period.

The challenges identified were instrumental in the selection of the themes identified by the Working Group as a focus for its work, including the health of Hartlepool's children. With a higher proportion of children in Hartlepool (30%) living in poverty compared to the England average (22%)[2], challenges facing the Council and its partners include not only health issues, but also the wider determinants that impact on overall health and wellbeing, as detailed in Appendix B.

It is anticipated that further integration of health and social care services will help to address these issues through:

- Ranking/grouping of risks and targeting of resources at those people who are most at risk of poor health outcomes and most likely to require intensive health and social care services in the future;

- Improved care planning, care co-ordination and care delivery;

- Better use of limited resources through multidisciplinary assessment and responses; and

- A shift from reactive services to a more planned approach focusing on early intervention and prevention. Although prevention does not offer an immediate return on investment. There are ways to model the health economies around health interventions.

However, it must be recognised that these challenges are also compounded by reducing resources across all public sector agencies. From a Local Authority perspective, continuing significant grant cuts mean that by 2019/20 the level of Government grant to Hartlepool Borough Council will be £44.2m less than it was in 2010/11. This represents a total grant cut of 57% and includes a further cut for the period 2017/18 to 2019/20 of £9.8m[3]. After reflecting continuing grant cuts, legislative changes and inflation, the Council has a projected deficit of £20.8m by 2019/20. This equates to a 25% reduction from the 2016/17 base budget.
In terms of the Clinical Commissioning Group, a new 5 year allocations framework is now in place to ensure that all Clinical Commissioning Groups are no more than 5% under target for Clinical Commissioning Group commissioned services. Whilst there are funding increases planned for national budgets (i.e. the National Primary Medical Care Budget with increases of 4% in 2016/17, 3.1% in 2017/18, 2.5% in 2018/19, and 3% in 2019/20), the Clinical Commissioning Group has a shortfall in its funding of £11.5m in 2016/7. This is projected to grow to £40.0m by 2020/21.

Both organisations are facing challenging financial times, and in addition to this face challenges in terms of the recruitment and retention of experienced and qualified staff. However, it is recognised that as the Marmot Review[4] makes clear, a person's health and wellbeing in later life is affected by a wide range of determinants such as poverty, housing, employment and education, as well as healthy lifestyles and health care. Hartlepool already recognises within its Local Plan the importance of these determinants and includes health and wellbeing as one of its 'ambition themes'. The Local Plan further includes a clear vision that by 2031 Hartlepool will be a more sustainable community, having raised the quality and standard of living, increased job opportunities (through developing a strong, diverse and thriving local economy which contributes positively to the sub-regional economy), maximised quality housing choices and health opportunities to meet, in full, the current and future needs of all residents.[5]

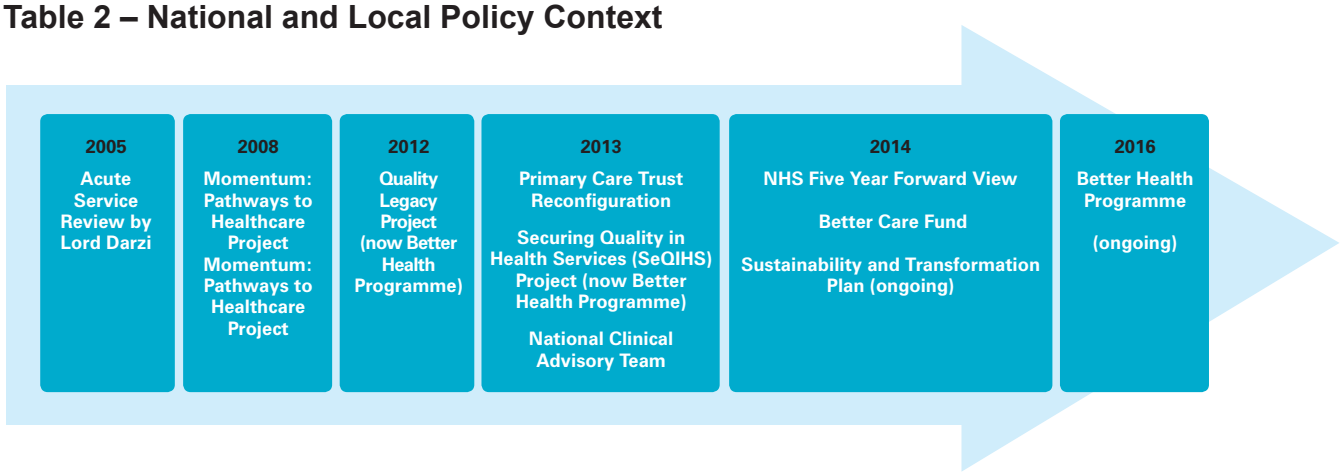
2 Hartlepool JSNA
3 Hartlepool Borough Council - Medium Term Financial Strategy
4 The Marmot Review 2010 - 'Fair Society, Healthy Lives',
5 Hartlepool Local Plan 2016

The Hartlepool Matters Plan also recognises these wider determinants of health and promotes earlier intervention through a more holistic approach to care planning, which incorporates:

- Early intervention and prevention;
- Primary, community and social care;
- Local Hospital; and
- Specialist.

Whilst there continue to be challenges in improving the health and wellbeing of people in Hartlepool, the journey to improve outcomes through the delivery of integrated and effective health and social care services has been ongoing for many years. Service changes, and in turn the development of an overarching Plan for the delivery of health services in Hartlepool, have been shaped over the last 10 years by a series of national, regional and local policies. This is illustrated in Table 2, from the Lord Darzi Acute Service Review in 2005 to ongoing work in relation to the Sustainability and Transformation Plan and Better Health Programme.

**Table 2 – National and Local Policy Context**




In terms of policy direction, Lord Darzi's Acute Service Review was a key point in the development of proposals for the provision of health services in Hartlepool. However, its recommendations were superseded by the findings of the Momentum: Pathways to Healthcare Project, including the national decision not to provide funding for the replacement of University Hospital of Hartlepool and the University Hospital of North Tees. The publication of the Five Year Forward View also identified a need to change how health services are commissioned and provided in the future in order to meet demand and improve standards. It highlighted that England has one of the more centralised hospital models amongst advanced health systems and whilst it is right that small hospitals should not be providing complex acute services (i.e. Accident and Emergency / trauma), help to sustain local hospital services where the best clinical solution is affordable was supported.

There is a mutual responsibility to meet the health and social care needs of all people across the town. This is particularly the case for those sections of the population who may require additional support at certain times in their lives. The development of the Hartlepool specific Integrated Health and Social Care Plan must pay due regard to this and the potential outcomes of the Better Health Programme and Sustainability and Transformation Plan in terms of the provision of services on a regional / national basis.

It was with this in mind, that I undertook a series of informal introductory meetings with Elected Members, and representatives from local action groups, to help me to gain an understanding of the key issues and priorities for the people of Hartlepool. These meetings led to the identification of five specific groupings of services, around which it was suggested each meeting of the Working Group could be most effectively themed (detailed in Section 3). These themes, and details of three fundamental questions to be asked at each meeting, were suggested to the Working Group at its first meeting and approved as the way forward.

The questions and themes agreed with the public were:-

**i) Key Themes**
- Frail and Elderly;
- Primary and Community Based Services;
- Urgent / Emergency Care;
- Maternity, Acute / Sick Children; and
- Mental Health.

**ii) Questions**
- What works well?
- How can they be improved?
- Three main priorities for the future?

# Section 3 - You Said

The Working Group met on five occasions, between October 2015 and March 2016, with each meeting exploring one of the agreed themes. Baseline information in relation to each of the themed areas was presented by experts in their respective fields. Workshops were utilised to facilitate the involvement of residents as a fundamentally important source of 'first hand' views in relation to the provision of existing services and the needs of the residents. In addition to this, as Independent Chair, I met with a number of individual residents, representatives from special interest groups and other groups, as detailed in **Appendix D**.

At each meeting of the Working Group, attendees were asked to identify priorities for the future delivery of health and social care services in Hartlepool. Details of the bespoke outputs from each of the five public meetings, and individual meetings with the Chair, are summarised in **Appendix E** of this report. A selection of the comments expressed include:

***'We just want the best care for our families and for it to be local. But, we wouldn't think twice about travelling to get the best specialist care'***

***'Travelling to appointments, and to visit relatives, is really hard for people on low income and without access to cars'***

***'Services need to fit <u>our</u> needs and not the other way round'***

***'We aren't sure what services are provided where and what is the difference between Urgent Care and A&E'***

Photo credit Hartlepool Mail

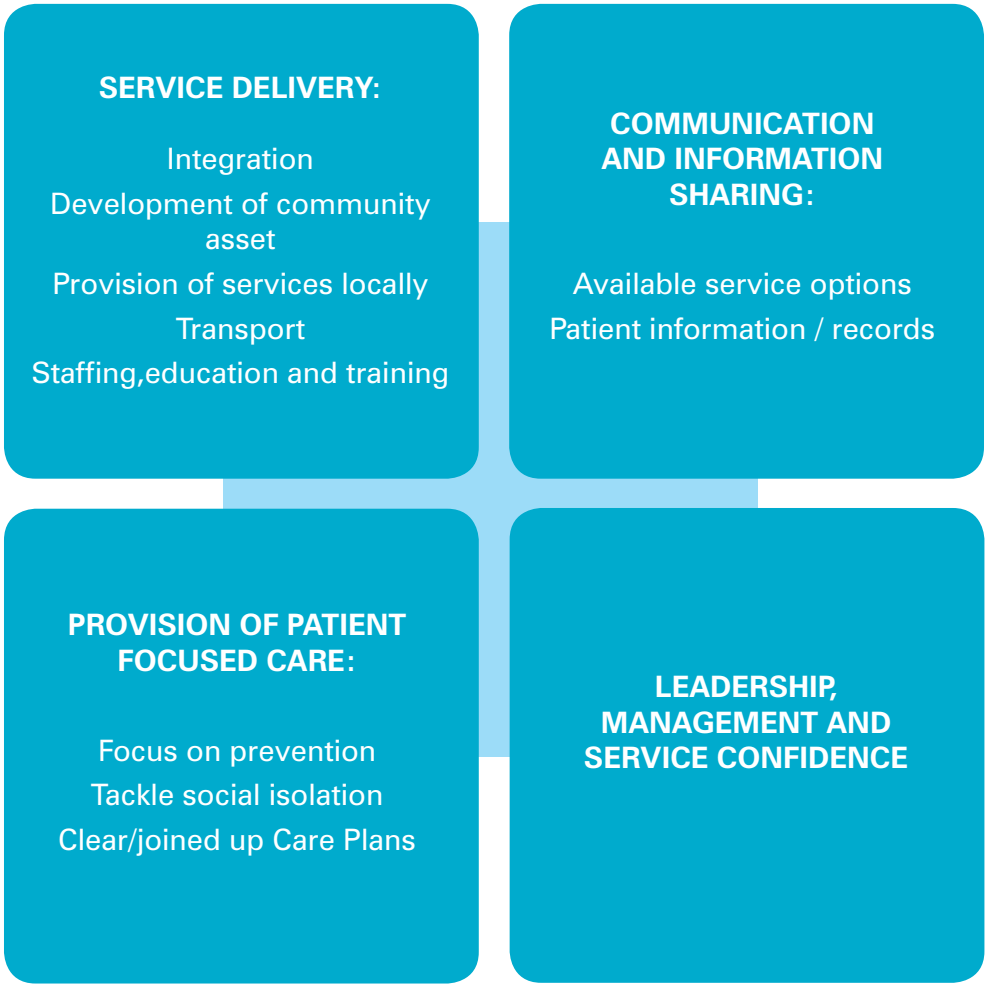
***'A&E needs to be in Hartlepool, at the Hospital'***

***'There aren't going to be any more Hartlepudlians if mothers are encouraged to (or are frightened into) going to North Tees to have their babies'***

***'We have problems getting appointments with our GPs'***

Information obtained at each of the meetings demonstrated that many of the issues and priorities identified are shared across the themed service areas. In addition to this, it was clear that the issues / priorities could be placed under four distinct headings. These are detailed in Table 3, which identifies the fundamental areas of concern for residents and where, from a strategic perspective, residents feel change is needed to address their health needs.

**Table 3** - Summary of Overlapping Priorities – Areas of Concern




The development of an integrated plan to address these priorities will require an urgent management response from key health care organisations and the local authority, with an expectation that each agency will work together to deliver a shared Plan for true service integration.

# Section 4 - Recommendations

The recommendations of this report do not come with a time frame as only local health and care organisations can identify resources and address current capacity and capability issues. But as soon as possible must be the time frame for the people of Hartlepool who should be an integral part of reviewing implementation of the recommendations of this report. Even in our socially-just NHS an inverse care still prevails – where there is most need there is often a lack of services. In Hartlepool there is a shortage of general practitioners and in the capacity to prevent emergency admissions, to hospital. Emergency admissions, which are mostly of elderly patients, are higher in areas of economic hardship. Many would be avoidable with good and integrated local services.

In responding to the identified priorities (as summarised in Table 3), the recommendations contained within the Local Health and Social Care Plan fit easily in to four distinct areas of service provision:-

1) Prevention;
2) Primary / Community and Social Care;
3) Local Hospital, Acute and Urgent Care; and
4) Specialist Care.

**1) Prevention Services**

Local Authorities are the local leaders in improving the public's health but the NHS also has a major part to play. Both are statutorily required to take steps to improve and protect the health of the population. The Clinical Commissioning Group also has a statutory duty to consider how health inequalities can be reduced through the services it commissions.

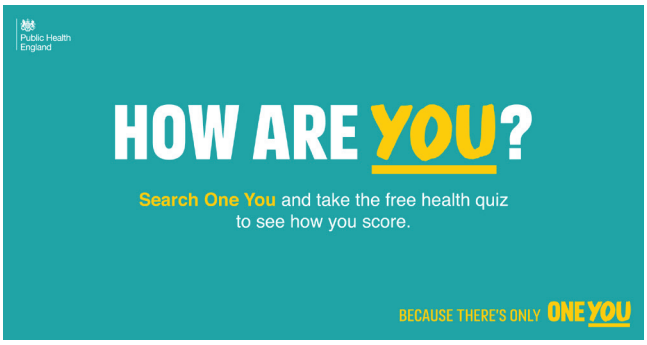



Photo © careimages.com

Prevention is a well used term, but what is actually meant by prevention is complex to define. The terms primary, secondary and tertiary prevention are also often used. Considering each term:-

Primary Prevention - aims to stop or prevent disease from occurring in the first place, for example following advice relating to taking exercise, not smoking following alcohol consumption guidelines and immunisation.

Secondary Prevention - focuses on reducing the impact of diseases already detected, including for example modifying lifestyles to prevent a condition from worsening, such as weight management to reduce the impact of Type 2 diabetes.

Tertiary Prevention - focuses on reducing the impact of an ongoing illness that will have lasting effects, including cardiac, stroke rehabilitation programmes or chronic disease management programmes.

There are many examples of preventative activities across the whole of the life course, from children to adulthood. So for example, breast feeding has major benefits to babies lasting into adulthood. Vaccination and immunisation is one of the most cost effective public health interventions and are almost entirely delivered by GPs. Specific national programmes designed to improve the health of children have, over the years, required local authorities and NHS to work together. The Healthy Child Programme and the more targetable Sure Start and Family Nurse Partnership have all contributed to improving health and well being of children and their families, and are examples of better working together to improve the lot of families.

For adult prevention, there is a range of public health activities designed to offer opportunities for primary, secondary and tertiary interventions. These include stop smoking services, the NHS Health Check Programme, Health Trainer service, sport and recreation services and get active on prescription to name but a few.

Diagnosing long term conditions early lessens medical problems later, and prevention is even healthier. Once diagnosed patients should expect a regular review of their condition(s) comprising:

- Disease management support for people able to manage their own conditions; disease management by primary care teams for people with conditions that could be controlled through regular contact with a family GP, nurse, or other team member; and

- Case management/care coordination for patients whose complex needs require them to have a more intensive support than that available through self-management and disease management.

A measure of success is not only life expectancy, but also the quality of life individuals experience; hence public health is focused on not only how long you live but the years spent free from illness.

**Recommendations:-**

**i) That arrangements / services in place as a resource to help people find out what's available in their local community be reviewed, including Hartlepool Now and the Family Services Directory;**

**ii) Better co-ordination of primary, community and social care services and initiatives that aim to tackle social isolation;**

**iii) Supported self-care i.e. provide people with the information and tools needed to make decisions for themselves to improve their health status; and**

**iv) Work with the Youth Council to spread their mental health work more widely.**

## 2) Primary / Community and Social Care Services

Photo © careimages.com

General Practice (GP) - General Medical Practice has always been central to NHS primary care but primary care, also includes community pharmacy, dentistry and optometry. Community services are predominantly nursing but also include therapy and mental health services. All of which today accounts for only a fifth of total health service expenditure even though 90% of all care take place in the community.

General Medical Practice is the service most under pressure in the NHS. GPs nationally now undertake an estimated 370 million consultations each year (80% of all NHS clinical consultations), 60 million more than five years ago, yet in nearly every year of the past 20 years the number of GPs as a proportion of NHS doctors has fallen, and in the past 10 years the number of hospital consultants has increased at twice the rate of GPs. In Hartlepool, there are even fewer GPs than the national average.

Recognising this crisis magnified by the monies for general practice actually having fallen as a percentage of NHS monies over the last 5 years (that of hospitals has correspondingly risen), the government has very recently announced a big financial rescue package for General Medical Practice. The Five Year Forward View also offers a central role for General Practice which the recently formed local GP Federation is to take advantage of. General Practice must remain a local service for their patients and at the same time work together to be large enough to support individual practices and provide care that no longer needs to be in hospital.

To provide a comprehensive local provision, NHS community and local authority services must work with General Practice. Community services have their problems and may need further investment as there was nationally a 38 per cent drop in the number of community nurses in the ten years 2001-2011[6]. The Five Year Forward View has incorporated the Primary Care Home[7] in the policy, an approach to care currently being delivered on and could be the optimum model for working closely with Hartlepool Hospital.

When discussing services for the frail and elderly, many of the public who are elderly (over 65 years old) feel well, are active and only require occasional contact with clinical professionals. Many of these patients live with long term conditions such as high blood pressure, arthritis and Type 2 diabetes (not requiring insulin) and yet do not feel ill. Of course many people with a long term condition(s) will be younger than 65 years. Long term conditions can deteriorate over time so need to be regularly checked, particulary if that individual has many conditions (known as multi-morbidity). The group offered the care coordination service, are those with multi-morbidity, high-risk patients including some of the very high risk. This is typically 5% of the total population or 100 patients per 2000 population. 30% of these high-risk patients will require full multi-disciplinary clinical team input, whilst the care coordinator with the primary care team can meet the needs of the others. This programme is intensive of NHS clinical resources; mainly community based staff, but has an international evidence base and if implemented fully in Hartlepool will lessen the need for emergency care. For example:

6 *The Future of Primary Care, Roland 2015*
7 Colin-Thomé, 2011

- Relatively low per patient cost; and
- Independent evaluations confirm significant reductions in unscheduled care costs.[8]

Photo © careimages.com

Elderly - Frailty is a distinctive state related to the ageing process as multiple body systems gradually lose their in-built reserves. This means the person is vulnerable to sudden changes in health triggered by seemingly small events such as a minor infection or a change in medication. There is strong evidence that medical assessment within two hours, followed by specific treatment, supportive care and rehabilitation, is associated with lower mortality, greater independence and reduced need for long-term care. Much of this response is provided in hospitals by Geriatric Medicine, now the largest medical speciality in England. More recent research has demonstrated better outcomes from acute older care assessment units ('Frailty Units') at the front end of the hospital. Even more exciting has been steadily-accumulating confidence that more people presenting with a frailty syndrome crisis can be safely assessed and managed at home. This requires dedicated, well-led, multi-disciplinary community teams. Their development, with the right skills, integrated into primary and secondary care, is becoming the norm.

Maternity - Healthy women are most likely to be healthy pregnant women, so ante natal care in reality begins before conception. Planning a pregnancy is an exemplar of that principle. For instance, women can start the necessary folic acid supplement prior to conception. Regular ante natal checks are important for the health of mum and baby. Members of the public felt strongly about the right to be born Hartlepudlians. There is a free-standing birthing unit at Hartlepool hospital but a strong feeling persists that maternity staff do not encourage Hartlepool-based births. Of course it is completely valid for maternity staff to offer guidance including about any possible risks to mum or baby, but access to independent advice is essential. Guidance[9], updated in December 2014, supports the right for women to be informed about their options and choose where to have their baby - be that in a midwifery unit, at home or on a hospital labour ward. The NICE guidance advises that planning to give birth at home or in a midwifery unit is particularly suitable for women with straightforward pregnancies who have already had a baby. For women with straightforward pregnancies who are expecting their first baby, it is advised that planning to give birth in a midwifery unit is particularly suitable, but that there is a small increase in risk for the baby if they plan birth at home.

Children's Services - Nearly three million children (equivalent to 28% of all children in England) attend Accident and Emergency departments in hospitals in England each year, accounting for more than 25% of patients seen in Accident and Emergency nationally. The number of children presenting to urgent care is increasing and there is significant variation, if admitted to hospital, in average length of stay between organisations, ranging from 1.06 to 5.08 days.

Unwarranted variation in healthcare is an international problem which is difficult to fix. The following national statistics demonstrate the UK issues:-

8 *Mathematica Policy Research., 2011/12*
9 National Institute for Health and Care Excellence (NICE)

i) Accident and Emergency: There is a 3.5-fold variation in Accident and Emergency attendance for children aged 0-4;
ii) Breastfeeding: There is a three-fold variation in breastfeeding rates for babies aged 6-8 weeks across the country;
iii) Asthma: Variation in the treatment of child asthma has got worse. In 2008/09, there was a four-fold variation in the rate of children admitted for emergency hospital treatment – now, that has risen to a five-fold variation;
iv) Epilepsy: There is a four-fold variation in the emergency admission rate for children with epilepsy; and
v) Diabetes: There is a 2.6-fold variation in the percentage of children with diabetes admitted to hospital for diabetic ketoacidosis – a serious emergency condition that can lead to coma or even death if Type 1 diabetes is not properly managed.

Photo © careimages.com

The NHS Institute (2010) suggests that children should be admitted only when absolutely necessary, and that we should keep children at home whenever it is safe to do so. Based on a review of paediatric ambulatory care practice across the UK, they suggest that delivery models based on this philosophy have resulted in decreasing number of admissions, and fewer unnecessary and often painful investigations; it was also highlighted that they can be delivered safely.

These diagnoses are indicative of common episodic illnesses and are all diagnoses that could be managed by Advanced Paediatric Nurse Practitioners (APNPs), based in the community.[10] In accordance with guidance from the NHS Institute (2010), management in the community could improve the children's experiences, avoid unnecessary and often painful investigations and save money all without compromising children's safety.

The 5 paediatric ambulatory-sensitive conditions (PASC) are:

- Asthma and wheezing without complications;
- Upper respiratory tract disorders without complications;
- Lower respiratory tract disorders without complications;
- Minor infections without complications; and
- Acute infectious and non-infectious gastroenteritis.

Based upon data supplied it was estimated that by 2009-10 the national cost of treatment for these five conditions in England would be £283 million pounds (major variation in the costs by locality).

The report, 'Doing Better for Children' published by the Organisation for Economic Co-operation and Development (OECD), focused across six dimensions: material well-being; housing and environment; education; health and safety; risk behaviours and quality of school life. If we are to make a difference in Hartlepool, improvements in those six dimensions over many years will make the biggest contributor to good health and well being.

10 Holbourn, 2007

Mental Health Services - Evidence shows that:

Photo credit TEWVFT

- People in England who have had mental health problems are five times as likely to be admitted to hospital as an emergency as those who have not.
- Both the Nuffield Trust and Health Foundation think tanks found most admissions were for physical ailments.
- Researchers said the findings suggested the NHS was too often treating mental health conditions in isolation.
- Overall, just 20% of admissions were explicitly linked to mental health.
- Instead, mental health patients were more likely to be admitted as an emergency for what are usually routine problems like hip replacements.
- Visits to Accident and Emergency units were also three times higher, with more than 1,300 attendances for every 1,000 patients with mental health; and
- These figures are even worse for black and minority ethnic members of the public and even worse are more likely to be referred to the criminal justice system or compulsory detained.

Surprising to many, mental health services as a related set of services are the highest funded in the NHS; but nationally, similarly to primary care services, insufficient monies go to community-based care. It was, however, encouraging to find that the Tees, Esk and Wear Valleys NHS Foundation Trust have shifted the balance and are now spending more on community services than bed-based provision.

Mental health conditions including dementia are long term conditions, and service users / patients should expect to receive a systematic long term conditions programme of care for their mental and physical conditions. Such a programme incorporates; Prevention, Early diagnosis, Self care, Regular review by a clinician in primary and where appropriate in secondary care, the concept of a meeting of two experts (patient and clinician) to jointly develop a care plan and review at least yearly. A criticism of these programmes is they do not necessarily focus sufficiently on, for instance, disability and limitation of normal activity hence the need for input of Social Care.

As described in the section for the elderly and frail, a programme must offer self-management support for people able to manage their own conditions; disease management by primary care teams for people with conditions that could be controlled through regular contact with a GP, nurse, or other team member; and case management/care coordination for patients whose complex needs require them to have a more intensive support.

The reference to the elderly and frail work stream reinforces how much overlap there is between needs and issues across the five care priorities identified by the Health and Social Care Plan Working Group. The overarching issue is prevention and an environment and services that make for healthy children is a necessary precursor to a healthy adult both mentality and physically.

Early diagnosis leads to early treatments which usually ensure a less serious condition. Half of lifetime mental illness (excluding dementia) starts by the age of 14 and 75% by mid 20s.[11] The involvement of the impressive local Youth Council in mental issues could encourage awareness and de-stigmatise mental illness that hopefully will lead to early diagnosis.

Issues identified by the Working Group:

- Education, training and raising awareness with professionals and public and ensuring easy access as early as possible to make certain that the first assessment counts with all options available being considered, including self help and IT solutions, not just prescribing medication.
- Better integration with health services and local authority services.
- Increase and improve navigation to services and ensure they were facilitated, raising awareness of services available including online and face to face.
- Better use of community and voluntary sector as they have a key role to play to support individuals in their home and to help patients to navigate services.
- Working together for change document to be considered in developing the Local Health and Social Care Plan.
- Accident and Emergency attendance features strongly of which the majority could be dealt with locally.

Treaments - Hartlepool is served by a very good mental health trust. It has, however, a large catchment area. There is a national intiative to offer talking therapies for those with anxiety and depression which as one outcome may lessen the need for medication. The local Clinical Commissionig Group has commissioned an impressive range of mental health services. The government's Five Year Forward View strongly advocated local solutions for services.

Dementia - People with dementia of all types, and their carers, should expect to be offered a long term conditions programme for their condition. Early diagnosis is often difficult and yet important to ensure that patients receive the support and the treatments that could initially improve symptoms. Currently there is no cure but much ground breaking research is happening. GPs need early access to experts in dementia investigation and diagnosis. Unlike other conditions, most people with the varying forms of dementia die in care homes. Of those who died with dementia as the leading cause of death, some 59% died in a nursing or residential home compared to 32% in hospital. This contrasts sharply with the figure for deaths overall: nationally 58% people die in hospital and only 16% in care homes. Hospital is rarely the best place to die as a result of a long term condition and yet there is a shortage of care home beds in Hartlepool. The hospital site offers big opportunities for varying types of community beds: essential facilities for a Hartlepool-based organisation.

11 *Kessler, et al, 2005, Kim-Cohen, 2003*

**Recommendations:-**

**i) That care records be integrated to enable key information to be shared between health and social care professionals, so that more joined up services can be delivered and duplication can be reduced;**

**ii) Further integration of health and social care services during and outside of normal working hours that focus on admission prevention and supporting independence;**

**iii) Improve the early diagnosis of long term conditions and review patient care regularly to ensure that emphasis is placed upon the importance of case management / care co-ordination by professionals and the self-management of conditions by patients;**

**iv) General practice by itself or supported by others can provide:-**
- **First point of contact care;**
- **Continuous person and family focused care;**
- **Care for all common health needs;**
- **Management of chronic disease;**
- **Referral and coordination of specialist care; and**
- **Care of the health of the population as well as the individual.**

**v) Make better use of assistive technology (i.e. using telehealth and telecare to remotely monitor vital health signs and/or support independent living).**

**vi) Implement the Better Childhood Programme which integrates social care and health services for children and explore how this model can be strengthened and further development to integrate with general medical practice and CAMHS**

**vii) Building on the excellent work of the mental health trust and commissioner, we need to develop and implement a Hartlepool-focused, Hartlepool-sited mental health service integrated with general practice(estimated 30% of GP consultations have a mental health component) and the range of local authority mental services. Local solutions for local people.**

**viii) That progress across six dimensions (material well-being; housing and environment; education; health and safety; risk behaviours and quality of school life) be reviewed annually by the Local Authority and the Clinical Commissioning Group through the Health and Wellbeing Board.**

It is clear that key to the provision of affordable, and effective, health and social care solutions in the future is 'integration'. The implementation locally of the Better Care Fund (BCF) has seen Hartlepool Borough Council work in partnership with the Clinical Commissioning Group to put in place a model for integrated health and social care early intervention services.

The aim of the Model is to provide a flexible, and responsive, service that recognises the different needs of individuals shifting from reactive (unplanned) care to prevention and proactive care. Its implementation has gone some way to achieving the desired integration of health and social care services in Hartlepool, and provides a foundation and experience that can be built upon, in partnership with the Clinical Commissioning Group, through the Hartlepool Care Plan. Integrated services already in place include:-

Hartlepool Now
Assistive Technology
Support for Carers
Information and Advice
Low Level Support
Luncheon Clubs (Plus)
Social Inclusion
Single Point of Access
Adult Services First Contact Team (co-located with NHS Single Point of Access (SPA))
A Clinical Triage Function - within the SPA
Weekend Working Pilot
Daily Discharge Planning Meetings
Enhanced pharmacy support (care homes / domiciliary care providers)
Dementia Services (Advisory Service, Dementia Friendly Hartlepool and The Bridge)
Children's Hub

The services listed above are outlined in more detail in **Appendix C.** They are to be built upon in 2016/17 by enhancing the Early Intervention Model (EIM), co-locating the Falls Prevention Team in the Single Point of Access, further developing the relationship with Cleveland Fire Brigade and establishing a Befriending Network.

It is recognised that there is still much to be done in the delivery of true health and social care integration in Hartlepool, and this Plan is a fundamental part of it.

**3) Local Hospital, Acute and Urgent Care**

Government policy fits in well with our ambition for urgent care in Hartlepool: 'For those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised services outside of hospital, and deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families.'[12]

Photo credit Hartlepool Mail

It is apparent that the difference between Urgent and Emergency Care understandably causes much confusion and that this creates problems in terms of patients turning up to the least useful location for their needs. In discussion about the issue of acute and urgent care, it was essential for the Working Group itself to be clear on the definitions of each. It was clarified that:-

12 Five Year Forward View

**Urgent Care –** Is non-life threatening but requires urgent care or advice i.e. sprains, strains, infections, minor head and eye injuries, some broken bones and a range of other symptoms.

**Emergency Care** – Is where life or long term health is at risk – medical emergency i.e. severe bleeding; severe chest pain, severe burns/scalds/allergic reactions and breathing difficulties which may require specialised services in a hospital.

It was shown that most patients who attend Accident and Emergency have urgent and not emergency problems. For instance, nationally around 13 per cent of people who attend Accident and Emergency are discharged without requiring treatment, and a further 35 per cent receive guidance or advice only[13]. More specifically, in Hartlepool during 2014/15, there were 12,538 Accident and Emergency attendances[14], of which:

- 3,837 (Major severity / admitted to hospital)
- 3,868 (Major severity / not admitted to hospital)
- 4,833 (Minor severity – with the opportunity for a proportion to be seen in a community setting)

It is important to be clear that urgent cases can be fully attended to in Hartlepool and only the rarer emergency problems need to travel further. Emergency care services must be provided from fully staffed and equipped Accident and Emergency centres, such as those that are currently provided at University Hospital of North Tees and for some conditions such as strokes, heart attacks and major trauma, specially staffed and equipped centres could be farther afield.

Strong international medical evidence tells us that centralising these very specialised services with paramedic led ambulance transport offer the safest and best care. The Better Health Programme is developing that multi-hospital approach, with only some centres having the specialised expertise required.

Accident and Emergency services are probably the most myth-laden of all NHS services. The King's Fund, an academic centre which specialises in health care, recently published an urgent and emergency care myth buster's document[15]. Being guided by them will enable the pressures in Accident and Emergency departments to be better managed, as shown in many departments around England, and will support an urgent care alternative. The message being that problems are surmountable:-

- Myth one: Accident and Emergency waiting times have risen dramatically;
- Myth two: The number of people going to Accident and Emergency is increasing;
- Myth three: Increases in Accident and Emergency attendances are mainly a result of reduced access to GPs;
- Myth four: Accident and Emergency pressures are due to an inadequate number/mix of staff; and
- Myth five: Delays discharging patients from hospital are increasing because of problems with social care.

If most, and possibly all, urgent care is to be delivered in Hartlepool, existing services need to be fully integrated. Many community pharmacies offer or can be encouraged to offer a minor ailments service, and if so need to be incorporated into a wider service plan. Several residents have said that they find the three separate urgent care services delivered from the One Life

13 HSCIC 2016
14 Presentation to the Local Health and Social Care Plan – 14 January 2016
15 An alternative guide to the urgent and emergency care system in England - Kings Fund (2015)

Centre at best confusing. Hartlepool and Stockton Clinical Commissioning Group commissioners have listened to this and are procuring an integrated service comprising minor injuries, minor ailments and GP Out of Hours.

In 2014/15, there were 54,346 patient contacts in community settings, as detailed below, with 81% of Hartlepool patients treated in a community setting appropriate to their condition.[16]

- 17,099 Minor Injuries attendances;
- 28,043 attendances Walk in centre Hartlepool; and
- 169 attendances Walk in centre Stockton.

The facilities at the One Life Centre do, however, seem very cramped for extended urgent care. If moved to Hartlepool hospital the facilities could extend the 24 hour service, working with the 111 phone service, day time general practice, community based and hospital staff. Working with the hospital based emergency admission prevention programme can incorporate the three care priorities of elderly and frail, primary and community, and urgent care. In this situation, specialist hospital / Accident and Emergency staff at North Tees University Hospital could offer real time support to Hartlepool based GPs, paramedics and community teams. A 24/7 clinical decision / support system of this kind would ensure that no decision is taken in isolation.

It must be said that if the expanded urgent care model was to be based in Hartlepool hospital, as many of the public and the author of this report recommend, the One Life centre will remain a very important facility. It will provide an opportunity for the transfer, and further integration, of services currently delivered elsewhere by the local authority and its health and other partners.

**Recommendations:-**

i) **Integrate the 111 phone service with the three urgent care services as national policy is for NHS 111 to become the single NHS number to dial for all your urgent health needs (for emergencies still phone 999);**

ii) **Integrate the existing Minor Injuries Unit, GP Out of Hours and Walk In Centre services to ensure a single pathway of care and expand the provision of urgent care, and related services, from the Hartlepool hospital site;**

iii) **Maintain a fully functional One Life Centre for scheduled care (non urgent and non emergency) and the existing general practices and consider options for further integration of health and social care services currently delivered by health and other partners from that site;**

iv) **Review existing arrangements to explore options to increase the levels of planned surgery undertaken from the Hartlepool hospital site;**

v) **Ensure there is ongoing mental health service support for urgent and emergency services;**

vi) **NICE guideline intrapartum care 2014 to be made publically available; and**

vii) **Regularly audit children's admissions to hospital with particular reference to length of stay, costs and the paediatric ambulatory-sensitive conditions identified by the NHS Institute.**

16 Presentation to the Local Health and Social Care Plan – 14 January 2016

# Section 5 – The Model For Hartlepool

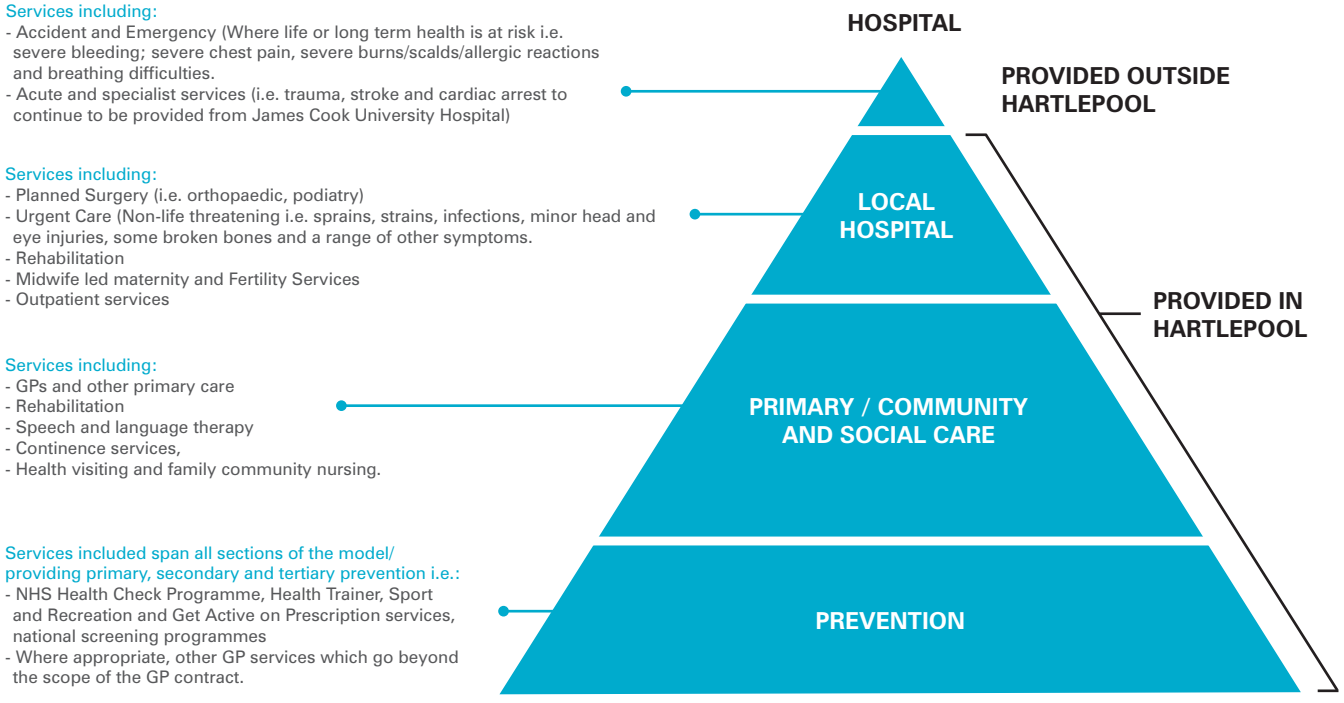
A new care Model for Hartlepool must span all four service areas outlined in Section 3 and, based on the priorities identified by the Local Health and Social Care Plan Working Group, focus on prevention. It has, at its core, the following overarching principles for a new way of working:

i) Move services out of hospital to be delivered in a community setting with the associated funding transfer;
ii) Provide capacity in the right part of the system, with a trained and competent workforce;
iii) Integrate community, local authority and hospital services with general practice;
iv) Commissioner and ambulance provider to ensure sufficient paramedic led ambulances when patients need safe transfer to specialised centres;
v) Ensure that:
- The right care is provided in the right place, at the right time;
- True integration of all parts of the local urgent care system;
- All Hartlepool health and care organisations work together to increase the effectiveness and coordination of support to those who need care and support; and
- Patients are part of the process to hold the whole system to account.

vi) Obtain public agreement for:
- The Hartlepool Care Plan and its delivery model; and
- Local outcome measures to complement those in place nationally.

In fulfilling these overarching principles, the operating model has to see most services provided in Hartlepool, with specialist acute services (i.e. trauma) provided centrally to ensure the best possible outcomes for patients. Support for this model (as represented in Table 4) is demonstrated through the findings of the Local Health and Social Care Plan Working Group.

**Table 4 - Operating Model**



The benefits of the new model are demonstrated by the following case study:

Existing Model – Sid's Story[17]

Sid is 87 and suffers from emphysema, Type 2 diabetes and arthritis. He was coping pretty well until his wife passed away, but is now lonely and increasingly depressed. He frequently visits his GP, but finds it difficult to discuss all his needs in a brief consultation. If he can't get hold of his GP in a crisis, he calls for an ambulance. Each time, Sid spends time in Accident and Emergency and is often transferred to a ward as well. He sees lots of different healthcare professionals and has to explain his conditions repeatedly...frustrating!

He often has to wait to be assessed by social services before he can go home. The result of this is unnecessary time in hospital. When he gets home, a lack of co-ordination between his GP and social care often means he doesn't get the support he needs.

Eventually, after several hospital visits in just six months, it is decided to admit him to a care home. But what if Sid's health and social care services were more joined-up? Let's imagine one of his carers is given overall responsibility for co-ordinating his care – for example Kathy, a District Nurse. Kathy meets with Sid, his GP and his social worker. Sid explains that he wants to manage his conditions at home and, together, they design a care plan, which they can all access online, any time.

New Hartlepool Model

Sid now gets more visits from Kathy at home, which helps him to manage his emphysema and diabetes. On the occasions when he does have a crisis, Sid calls Kathy rather than an ambulance, so he goes to hospital less frequently. Even when he is admitted, he is discharged after a quick review of his care plan, rather than having to be reassessed.

In this scenario, Sid's health and social care is funded from a joint budget, so the team can make smart decisions about how it's spent, and call on the help of other social services.

For example, as his condition deteriorates, the team decide to fit a seat in Sid's shower, provide him with an oxygen cylinder to ease his breathing, as well as a medication dispenser with a voice prompt to remind him to take his pills.

Kathy talks to Sid about his loneliness, and he agrees to weekly trips to the shops with a volunteer from a local befriending charity. So now, Sid doesn't have to be admitted to a care home, instead getting the help he needs in his home. He feels happier, is healthier, and better use has been made of resources within the system.

What transformed Sid's care is that local leaders in the NHS, social services and the voluntary sector created a shared vision of what good integrated care looked like, centred around the needs of people like Sid, and their carers. They pooled resources across health and social care, built multi-professional teams and created systems to allow Sid's information to be easily shared.

In taking forward the development and implementation of the Model, the recommendations contained within the Hartlepool Care Plan will be presented by me as the Independent Chair to a Joint Committee in Common (Hartlepool Borough Council and the CCG's Governing Body). Monitoring of the implementation of the Plan will occur through the Health and Wellbeing Board, and a specifically convened meeting of the Local Health and Social Care Plan Working Group within 12 months.

17 Adapted from Sam's Story

# Section 6 - Conclusion

There is a real future for expanding current services in Hartlepool and introducing new community based services that will lessen the need for patients to travel to the University Hospital of North Tees. It must be said however that given the workforce pressures in the NHS, it is very unlikely that acute emergency services will return to Hartlepool. The various medical Royal Colleges make recommendations about numbers of doctors needed for staffing and also decides if a department is good enough to train junior doctors without whom it is difficult to attract consultant doctors. The Royal College of Emergency Medicine for instance state that there are currently on average 4.39 emergency consultants per Accident and Emergency (they call them emergency departments) and the recommended minimum is ten for each Accident and Emergency department. There are simply not enough doctors in the NHS to keep all Accident and Emergency departments open and emergency in-patient care in every hospital. But to reiterate, many services can be developed in Hartlepool including urgent care if we can deliver on the model of care I describe in Section 5 of the report. It is important to note the vast majority of people who attend Accident and Emergency do so for urgent not emergency care.

It seems we need to 'draw a line' under what has gone before, and the associated anger and frustration, and begin anew. We need a Hartlepool-based policy and to develop a Hartlepool-based organisation – Hartlepool Care.

Of course the immediate focus of our work is developing the plans so that all healthcare and social care services are better integrated for the benefit of the people of Hartlepool and surrounding areas. Once plans are in place, we must ensure the public has a central role in ensuring the plans are implemented and maintained.

However, if the full plan is to work for the benefit of the public, as well as the sustainability of the wider local NHS and social care, I feel some general issues need to be addressed:

i) Integration has to demonstrate an improvement in the care of individual members of the public, who in turn must have the opportunity to hold the health and social care system to account for their delivered care.

ii) The Hospital Trust's most senior leaders must openly address the current widespread public mistrust of their plans and also be given the opportunity to explain their future vision for Hartlepool.

ii) All health and social providers of care need to work in close partnership together, committing to abide by some general principles to which they collectively hold each other to account, as good behaviours are paramount for successful partnerships. Some suggested principles are:

- The interests of patients and citizens trump those of institutions;
- No disputes but acceptable to have disagreements;
- Need to choose leaders for their behavioural attributes not only their knowledge and experience;
- A need to focus on relationships underpinned by a contract, not relationships defined by the contract;
- Design, develop, test and implement system-wide outcome measures for which all members are jointly held to account; and

- A key focus for commissioners is how to commission for individual patients /service users who have complex problems, as well commissioning for the whole population.

These principles can be upheld by agreement only. But as it will be a very different way of working in an environment mostly based on the needs of individual organisations often at the expense of the whole system, some formal process is usually required. Internationally, the most frequently used process is the Alliancing contract but there are other methodologies to utilise.

Will that be enough to match the aspirations of local people? In answer to my own question - I fear not. For the sustainability and transformation of services I feel we need a more specific Hartlepool approach. Both major NHS organisations – the North Tees and Hartlepool Foundation Trust and the Clinical Commissioning Group – do not only serve Hartlepool. The local Council of course does, but so do the local General Practitioners.

The current focus of NHS strategy and planning is for place-based care with an emphasis on primary and community services. We need to use the direction and thrust of national policy to come up with a Hartlepool transformation plan with the attendant promise of possible extra resources if successful - Secretary of State Jeremy Hunt, it seems, intimated as such in his meeting with councillors. How can we create a Hartlepool organisation, however tough the journey, encompassing council, local GP and community services, together with Hartlepool Hospital? One option is to utilise the hospital site very differently with an emphasis on increasing community beds and on facilities for all GP practices working together to expand their services and role. All working as one, with a future of being budgeted for its population. Such an approach certainly fits perfectly as a care model within the national policy of the Five Year Forward View. Very importantly it can be achieved without the distraction of having to restructure public sector organisations. It can be achieved by a commitment to collaboration, integration and working across traditional boundaries.

Instead of time consuming arguments about structural change, all can be achieved by a strong leadership commitment to a Hartlepool place-based option within present structures. Indeed, the North Tees and Hartlepool Foundation Trust and Clinical Commissioning Group very much support a Hartlepool-based approach.

For optimum care, some services need to be centralised at a large scale. For instance, the treatment of strokes, heart attacks, major trauma. But many services should be delivered more locally and owned locally (Section 5 of this report describes in summary a similar approach I have advocated for many years – The Primary Care Home – and now accepted as part of national policy). The leadership of the new GP Federation (HASH), even though it also covers Stockton, strongly supports a Hartlepool option and supports the development of General Practice.

General medical practitioners are the clinicians under most NHS pressure and need extra staffing in their practices to sustain their services. In the short term, there are opportunities for working closer with community pharmacists, many of whom offer a range of specific services beyond dispensing prescriptions and 'over the counter' advice and employing pharmacists within their practices. The latter is supported by the government as there is an oversupply of trained pharmacists. If care locally is to be transformed and expanded, GPs should have easy access to all other clinicians even if hospital employed. Working in this new way with Hartlepool hospital opens up that possibility and supplemented by associated easy access to hospital specialist opinion from other hospitals. The patient remains local (in Hartlepool) for all but the most specialised service; the specialist advice comes from further afield. For too long, general medical practice has been left isolated even though it is where the majority of care is delivered.

More support means more local services.

A challenge and test for all, if we are to meet Hartlepool's aspirations for 21st Century Health and Social Care services, will be true integration that avoids duplication and bureaucracy, using existing assets far more imaginatively and being accountable to both individual patients and the public. I believe that North Tees and Hartlepool Foundation Trust wish to be an important partner in this.

This can only be achieved with purposeful leadership, focusing on the common aim and not narrow self-interest. The international evidence demonstrates in particular for care of the frail elderly and for patients with complex problems, often lessening the need to be admitted to an emergency hospital or much shortening the length of stay.

A Hartlepool organisation for Hartlepool people! Hartlepool Care.....

# Appendix A

**LOCAL HEALTH AND SOCIAL CARE WORKING GROUP – ATTENDEES**

**Hartlepool Borough Council**

**Councillors:**
Jim Ainslie, Stephen Akers-Belcher, Allan Barclay, Paul Beck, Sandra Belcher, Alan Clark, Rob Cook, Kevin Cranney, Marjorie James, John Lauderdale, Jim Lindridge, Brenda Loynes, Ray Martin-Wells, Carl Richardson, David Riddle, Chris Simmons, Kaylee Sirs, Sylvia Tempest, Steve Thomas and Paul Thompson.

**Officers:** Gill Alexander, Chief Executive; Louise Wallace, Director of Public Health; Sally Robinson, Jill Harrison, Simon Howard, Jacqui Braithwaite, Neil Harrison, Joan Stevens, Amanda Whitaker, David Cosgrove, Denise Wimpenny and Angela Armstrong.

**Partner Organisations**

**Hartlepool and Stockton on Tees Clinical Commissioning Group:** Ali Wilson, Paula Swindale, Sue Greaves, Karen Hawkins, Paul Pagni, Nicola Jones, Boleslaw Posmyk, Evelyn Schock, Tracie Jacobs, Paul Pagni, Jo Heaney and Paul Hendrie

**North Tees and Hartlepool Foundation Trust:** Julie Gillon, Jean Macleod, Julie Parkes, Helen Skinner, Andrew Simpson, L Johnson, Nick Ropen, Sally Thompson, Lynn Kirby and Jane Barker

**Tees, Esk and Wear Valley NHS Foundation Trust:** Dominic Gardner and David Brown, David Brown, Lynne Brown (CAHMS), Ben Smith and Emma Thompson

**North East Ambulance Service:** Douglas McDougall and C Thurlbeck

North East Commissioning Service: Gill Carlton, Helen Metcalf, Ruth Kimmins and Rob White

**Hartlepool Youth Council Representatives:** Lauren Howells and Emma Jennen

**Durham County Council:** Melanie McDougall, Michael Duffy, Mark Smith and Jackie Candish

**Stockton Borough Council:** Peter Kelly

**Hartlepool Mail:** Mark Payne and Tom Banks

**Local Groups**

**Healthwatch:** Ruby Marshall, Margaret Wrenn, Evelyn Leck, Judy Gray, Stella Johnson, Gordon Johnson, Tony Leighton, Margaret Metcalf and Zoe Sherry

**Fighting For Hartlepool Hospital:** Angela Hughes, Gemma Rhead, Kath Mathieson, Nicola Kenny, Glenn Hughes, Joyce Iredale and Ron Leigers

**Town of Hartlepool Challenge:** Stella Leighton, Irene Gilhespy, Julie Clayton, Janice Lynne, Gill Crane, Doreen Short, M Smurthwaite, Ken Low, Pauline Hope, N Hope, J Doherty, A Atkinson, Gordon Goddard, Stan Cronin, Steve Cronin, Julie Clayton, Rebecca Goddard and Tony Kramer

**Save our Hospital:** Keith Fisher

**Hartlepool Carers:** Karen Gibson

**Public:** Veronica Duggan, Mary Green, Kenneth Thompson, C Thompson, S A Ralton, Charlene Twidale, Mrs S Picton, Joan Anderson, Jack Nicholson and Eric Plews

# Appendix B

## Summary of Indicators[18]

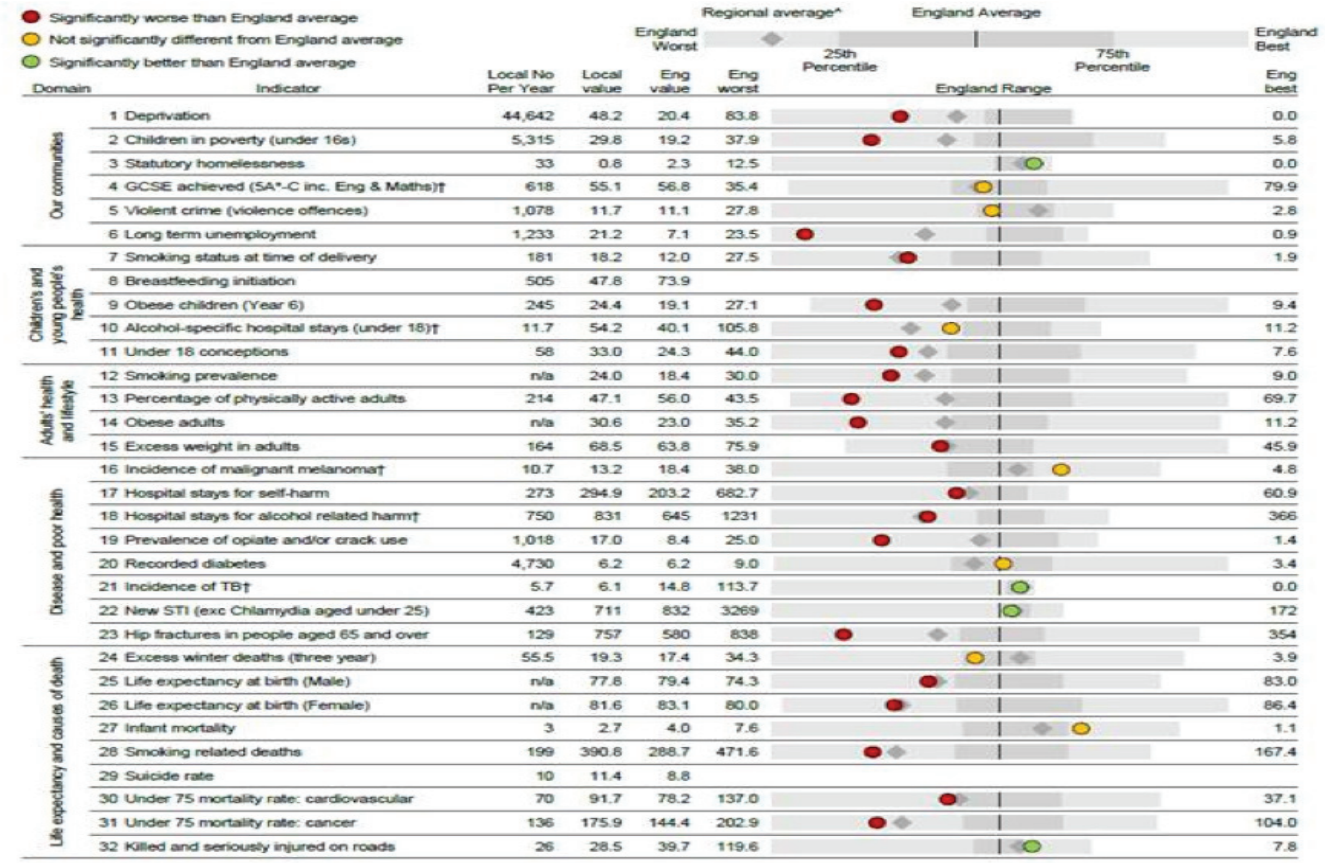
| Vulnerable Groups | | | | |
|---|---|---|---|---|
| **Topic** | **Indicator** | **Hpool %/rate** | **Hpool no.** | **England %/rate** |
| Learning disabilities | Proportion (%) of supported adults with a learning disability living in settled accommodation | 83.6% | 255 | 72.9% |
| | Proportion (%) of eligible adults with a learning disability having a GP health check | 43% | 221 | 44% |
| Autism | People with autism in receipt of support services | - | 140 | - |
| Physical disabilities | Those with severe physical disability (age 18-64) or with a limiting long-term illness (age 65+) receiving services | 41% | - | 29% |
| Sensory disabilities | People with a hearing loss referred by their GP for a hearing test | 55% | - | - |
| Sexual violence victims | Increase in sexual violence offences reported to the Police | 41% | - | - |
| Domestic abuse victims | Domestic abuse incidents reported to the Police in Hartlepool involving a repeat victim | 48.2% | - | - |
| Carers | Overall satisfaction of carers with social services | 56.4% | - | - |
| | Carers who report that they have been included or consulted in discussions about the person they care for | 84% | - | - |
| | Carers (and people who use services) who find it easy to find information about services | 80.1% | - | - |
| End of life care | Proportion of population on the palliative care register | 0.4% | - | 1% |
| Ex-forces personnel | Information as part of the Joint Strategic Needs Assessment is due to be updated. | - | - | - |
| Migrants | Families involved in Syrian resettlement programme | - | 10 | - |
| Travellers | Gypsy & Traveller children who obtain five GCSEs A*-C grades (including English & Maths) | 10% | - | - |
| Offenders | Reduction in the re-offending rate of the most prolific and priority offenders | 36.7% | - | - |
| | Offenders who re-offend within a 12 month period | 33.7% | - | - |
| Child sexual exploitation | Cases discussed by the Vulnerable Exploited Missing or Trafficked practitioners group | - | 50 | - |
| **Wider determinants** | | | | |
| Crime | Support for Victims of Crime and Anti-social Behaviour | - | 550 | - |
| | Crime rate per 1,000 population | 87.8 | - | 61.4 |
| Education | Children with free school meal status achieving a good level of development at the end of reception | 68.4% | - | 66.3% |
| | GCSE achieved 5A*-C including English & Maths | 53.1% | | 57.3% |
| Employment | Adults with learning disabilities in employment | 15.9% | 65 | 6.7% |
| | People in long-term unemployment (rate per 1,000 working-age population) | 12.8 | 1,137 | 4.6 |

18 The Director of Public Health Annual Report 2015/16

| Topic | Indicator | Hpool %/rate | Hpool no. | England %/rate |
|---|---|---|---|---|
| Environment | Complaints about noise (rate per 1,000 population) | 5.6 | 521 | 7.4 |
| Housing | Statutory homelessness | 1.3% | 74 | 2.4% |
| Poverty | Reduction of children in poverty (under 16s) since 2010 | 3.6% | - | - |
| | Children in poverty (under 16s) | 29.1% | - | 18.6% |
| Transport | Killed and seriously injured on roads (rate per 100,000 population) | 27.8 | 116 | 39.3 |
| | Children killed or seriously injured in road traffic accidents | 24.5 | 13 | 17.9 |
| **Behaviour and lifestyle** | | | | |
| Alcohol misuse | Under 18s admitted to hospital for alcohol specific conditions | 36.4 | 22 | 36.6 |
| | Alcohol-related mortality | 61.8 | 55 | 45.5 |
| Illicit drug use | Eligible new presentations (Non Opiate Users) accessing drug treatment that accept the offer of Hepatitis B treatment | 89% | - | - |
| | Successful completion of drug treatment - non-opiate users | 30.9% | 58 | 39.2% |
| Smoking | Successful quitters at 4 weeks (rate per 100,000 population) | 3,489 | 627 | 2,892 |
| | Smoking prevalence | 23.4% | - | 18.0% |
| | Smoking in pregnancy | 18.1% | - | 11.4% |
| Diet and nutrition | Increase in breastfeeding initiation rates | 13% | - | - |
| | Consuming 5 portions or more of fruit and veg per day | 43.8% | - | 52.4% |
| Obesity | Referrals to Exercise for life programme or to health trainers | - | 1,232 | - |
| | Obese adults | 32.7% | - | 24.0% |
| Sexual health | Reduction in under 18 conceptions | 50% | - | - |
| | Under 16 conceptions | 8.6 | - | 4.4 |
| Physical inactivity | Increase in adult participation in 3 x 30 mins moderate exercise per week since 2005 | 41.3% | - | - |
| | Physically active adults | 51.2% | - | 57% |
| **Illness and death** | | | | |
| Cancer | Engaged with the Tees Health Awareness roadshow | - | 300 | - |
| | Die each year due to cancer | - | 300 | - |
| Cardiovascular disease | Eligible population aged 40-74 who received an NHS Health check | 18.6% | 4,256 | 18.6% |
| | Under 75 mortality rate from all cardiovascular diseases (rate per 100,000 population) | 90.1 | 210 | 75.7 |
| Diabetes mellitus | Diabetes prevalence | 6.3% | - | 6.4% |
| | People with undiagnosed diabetes | - | 1,700 | - |
| Injuries | Injuries due to falls in people aged 65 and over (rate per 100,000 population) | 1,975 | 351 | 2,125 |
| | Hospital admissions caused by injuries in children 0-14 years (rate per 100,000 population) | 137.4 | 227 | 109.6 |
| Mental and behavioural disorders | Diagnosed with dementia | - | 1,200 | - |

| Topic | Indicator | Hpool %/rate | Hpool no. | England %/rate |
|---|---|---|---|---|
| Oral health | Children with one or more decayed, missing or filled teeth | 19.6% | - | 27.9% |
| Respiratory disease | Lung Health Check assessments | - | 6,562 | - |
| | The number estimated to be living with chronic obstructive pulmonary disease (COPD) without knowing it | - | 1,250 | - |
| Self-harm and suicide | Suicide rate (per 100,000 population) | 225.9 | - | 191.4 |

## Summary of Health and Wellbeing in Hartlepool (2015)[19]




| Domain | | Indicator | Local No Per Year | Local value | Eng value | Eng worst | Eng best |
|---|---|---|---|---|---|---|---|
| Our communities | 1 | Deprivation | 44,642 | 48.2 | 20.4 | 83.8 | 0.0 |
| | 2 | Children in poverty (under 16s) | 5,315 | 29.8 | 19.2 | 37.9 | 5.8 |
| | 3 | Statutory homelessness | 33 | 0.8 | 2.3 | 12.5 | 0.0 |
| | 4 | GCSE achieved (5A*-C inc. Eng & Maths)† | 618 | 55.1 | 56.8 | 35.4 | 79.9 |
| | 5 | Violent crime (violence offences) | 1,078 | 11.7 | 11.1 | 27.8 | 2.8 |
| | 6 | Long term unemployment | 1,233 | 21.2 | 7.1 | 23.5 | 0.9 |
| Children's and young people's health | 7 | Smoking status at time of delivery | 181 | 18.2 | 12.0 | 27.5 | 1.9 |
| | 8 | Breastfeeding initiation | 505 | 47.8 | 73.9 | | |
| | 9 | Obese children (Year 6) | 245 | 24.4 | 19.1 | 27.1 | 9.4 |
| | 10 | Alcohol-specific hospital stays (under 18)† | 11.7 | 54.2 | 40.1 | 105.8 | 11.2 |
| | 11 | Under 18 conceptions | 58 | 33.0 | 24.3 | 44.0 | 7.6 |
| Adults' health and lifestyle | 12 | Smoking prevalence | n/a | 24.0 | 18.4 | 30.0 | 9.0 |
| | 13 | Percentage of physically active adults | 214 | 47.1 | 56.0 | 43.5 | 69.7 |
| | 14 | Obese adults | n/a | 30.6 | 23.0 | 35.2 | 11.2 |
| | 15 | Excess weight in adults | 164 | 68.5 | 63.8 | 75.9 | 45.9 |
| Disease and poor health | 16 | Incidence of malignant melanoma† | 10.7 | 13.2 | 18.4 | 38.0 | 4.8 |
| | 17 | Hospital stays for self-harm | 273 | 294.9 | 203.2 | 682.7 | 60.9 |
| | 18 | Hospital stays for alcohol related harm† | 750 | 831 | 645 | 1231 | 366 |
| | 19 | Prevalence of opiate and/or crack use | 1,018 | 17.0 | 8.4 | 25.0 | 1.4 |
| | 20 | Recorded diabetes | 4,730 | 6.2 | 6.2 | 9.0 | 3.4 |
| | 21 | Incidence of TB† | 5.7 | 6.1 | 14.8 | 113.7 | 0.0 |
| | 22 | New STI (exc Chlamydia aged under 25) | 423 | 711 | 832 | 3269 | 172 |
| | 23 | Hip fractures in people aged 65 and over | 129 | 757 | 580 | 838 | 354 |
| Life expectancy and causes of death | 24 | Excess winter deaths (three year) | 55.5 | 19.3 | 17.4 | 34.3 | 3.9 |
| | 25 | Life expectancy at birth (Male) | n/a | 77.8 | 79.4 | 74.3 | 83.0 |
| | 26 | Life expectancy at birth (Female) | n/a | 81.6 | 83.1 | 80.0 | 86.4 |
| | 27 | Infant mortality | 3 | 2.7 | 4.0 | 7.6 | 1.1 |
| | 28 | Smoking related deaths | 199 | 390.8 | 288.7 | 471.6 | 167.4 |
| | 29 | Suicide rate | 10 | 11.4 | 8.8 | | |
| | 30 | Under 75 mortality rate: cardiovascular | 70 | 91.7 | 78.2 | 137.0 | 37.1 |
| | 31 | Under 75 mortality rate: cancer | 136 | 175.9 | 144.4 | 202.9 | 104.0 |
| | 32 | Killed and seriously injured on roads | 26 | 28.5 | 39.7 | 119.6 | 7.8 |

19 Hartlepool JSNA

# Appendix C

**INTEGRATED SERVICES CURRENTLY PROVIDED IN HARTLEPOOL**

**Hartlepool Now -** The existing site has been further developed as an online system to support people who need advice and information and want to know about services in their local area.

**Assistive Technology -** Investment has enabled the number of people receiving support to grow on an annual basis for the last five years with over 2,200 people using assistive technology at the end of December 2015. How telehealth can be better utilised is now also being explored.

**Support for Carers -** Funding has been used to fund carers support services, including Direct Payments that provide carers with a break from their caring role.

**Information and Advice -** A bank of essential information for older people in the community (available on paper and electronically) has been developed, covering local activities, classes and community and interest groups.

**Low Level Support -** Provided for individuals with low level needs (one to one, over a 6 week period) to promote independence and enable people to get on with their lives:

- Telephone calls to enquire after someone's wellbeing;
- Assisted visits to community groups, activities and other locations in order to build people's confidence; facilitate connections to social/educational and other activities; and encourage them to get out and about;
- Support to get to important appointments; and
- Assistance to do one or two shopping visits and information and encouragement.

**Luncheon Clubs (Plus) -** Operating in a variety of settings, to provide an opportunity to buy lunch and enjoy an informal social atmosphere, including gentle exercise classes, wellbeing sessions, guest speakers and handicrafts

**Social Inclusion -** Centre based, available for frail elderly people for whom other elements of the service identified above would not be suitable to meet their needs. The service provides stimulating activities such as gentle exercise classes, wellbeing sessions, visits to places of interest, guest speakers, gardening, films and drama, handicrafts etc.

**Single Point of Access (SPA) -** Work to co-locate and integrate services continues to provide a single point of access for every person with whom health and social care engage.

**Adult Services First Contact Team (co-located with the NHS Single Point of Access (SPA)) -** The first step towards an integrated health and social care single point of access. Further work is underway to establish how these teams work more cohesively and how capacity is enhanced, including a proposal for clinical input to SPA.
A Clinical Triage Function (within the SPA).

**Weekend Working Pilot -** From October 2015 to March 2016 social workers have been available from 10.00-4.00 during weekends and bank holidays, focused on facilitating hospital discharges. This was supported by additional weekend capacity commissioned from independent home care providers for the same period using system resilience funding.

**Daily Discharge Planning Meetings -** Bring together professionals from a range of disciplines (such as nurses, social workers and therapists) to discuss every person requiring discharge from either social care, community services, direct care and support, acute beds or reablement/rehabilitation. This allows for joined up planning to take place, to ensure that the right professionals are working with the right person in the most effective way.

Enhanced pharmacy support for care homes and domiciliary care providers.

**Dementia Advisory Service -** To empower people who are affected by and/or suffering from dementia to be able to "live well with dementia". The service complements health and social care services provided to people living with dementia and their carers by providing named contacts and a single point of access for the provision of information and support about dementia, and the range of services, activities and benefits available in Hartlepool.

**Dementia Friendly Hartlepool -** The Working to Build a Dementia Friendly Hartlepool project has been successful in gaining the first level of accreditation which enables all interested parties that pledge their support to be able to register as part of the Dementia Friendly Community.

**The Bridge -** A drop-in and information centre for those living with dementia and their carers.

## OTHER SERVICES ALSO PROVIDED IN HARTLEPOOL

Low risk inpatient surgery (hip and knee, general surgery) overnight stay
Holdforth Unit (a rehabilitation ward for people recovering from the acute phase of their illness or injury to be cared for locally)

Medical rehabilitation day unit
Bowel screening
Breast screening
Day case surgery
Birthing centre
Maternity day assessment unit
Assisted reproduction unit (fertility)
Community services
Wheelchair services
Physiotherapy
Cardiac investigations unit
Respiratory investigations unit
Orthopaedic outpatients
General outpatients
Women's outpatients
Children's outpatients
Children's day unit
MRI and CT scanning
X-ray and ultrasound
Chemotherapy day unit

# Appendix D

**INDIVIDUAL MEETINGS WITH THE INDEPENDENT CHAIR – ORGANISATIONS AND SPECIAL INTEREST GROUPS**

**Clinicians Nursing Staff – North Tees and Hartlepool Foundation Trust**
Julie Gillon, Chief Operating Officer/Deputy Chief Executive
Dr Jean MacLeod, Consultant Physician in General Medicine and Diabetes/Associate Medical Director for Transformation and Integrated Care Services
Dr Deepak Dwarakanath, Consultant Physician/Clinical Director – In-hospital services
Mr Anil Agarwal, Consultant Surgeon/Associate Medical Director – Clinical Governance
Dr Bruce McLain, Consultant Paediatrician/Clinical Director – Paediatrics
Mr Pud Bhaskar, Consultant Surgeon/Clinical Director – General Surgery
Linda Hunter, Business Manager – Out of Hospital Care
Matthew Wynne, Service Lead – Physiotherapy / Occupational Therapy - Integrated Care Services
Vicky Blakey, Senior Clinical Professional – Integrated Care Services
Dr Dolon Basu, Consultant Obstetrician & Gynaecologist
Lindsey Robertson, Professional Lead Nurse – Out of Hospital Care

**Healthwatch:** Ruby Marshall, Margaret Wrenn, Evelyn Leck, Judy Gray, Stella Johnson, Gordon Johnson, T Leighton, M Metcalf and Zoe Sherry

**Town of Hartlepool Challenge:** Julie Clayton, Gordon Goddard, Stan Cronin, Steve Cronin

**Save our Hospital:** Keith Fisher

**Hartlepool Carers:** Karen Gibson

**GP Federation:** Paul Williams (Stockton GP who is lead of the Hartlepool and Stockton GP Federation (HASH). By video link from holidaying in the south of France) and Hartlepool GPs Boleslaw (Poz) Posmyk (Chair Hartlepool and Stockton-on-Tees Clinical Commissioning Group), Nick Timlin and Salvi Patel.

**Youth Council**:
Dyke House Youth Councillors - Eve Cooper, Adam Shillow and Joshua Scott
Manor Academy Youth Councillors - Daniel Measor, Callum Reed and Caitlin Amy Towers
English Martyrs Youth Councillors - Jack Palmer
Cultural Seats Youth Councillors - Sara Razzaq and Janat Khanum
Children in Care Youth Councillors - Chloe Vickers, Caitlin Laybourn
St Hild's Youth Councillors - Mathew Childs, Steffi Ellison, Abby Wallace and Chelsea Aveyard
Hartlepool 6th Form Youth Councillor and Member of Youth Parliament (MYP) for Hartlepool - Lauren Howells
Hartlepool College of FE Youth Councillor - Emma Jenner
Hart Gables (LGBT) Youth Councillors - Ben Marshall
SEN / Catcote Youth Councillors - Luke Wray

# Appendix E - Summary of Working Group Issues

| PRIORITIES SHARED ACROSS THE SERVICE THEMES | FRAIL AND ELDERLY | PRIMARY AND COMMUNITY SERVICES | URGENT AND EMERGENCY CARE SERVICES | MATERNITY, EARLY YEARS, CHILDREN'S HEALTH AND WELLBEING SERVICES | MENTAL HEALTH SERVICES | FOCUS GROUP / YOUTH COUNCIL VIEWS |
|---|---|---|---|---|---|---|
| **COMMUNICATION AND INFORMATION SHARING** | Clarity around what and how services were available.<br><br>To map needs and develop a directory of community resources to ensure when individuals were faced with choices, they were fully aware of what options were available.<br><br>Integrated records and shared information, especially around out of hours services;<br><br>Information sharing across organisations and ensuring first point of contact for both health care professionals and patients was with fully trained staff. | Information sharing utilising IT to improve communication should be a priority. | People were confused of where to go and get help and support through a single point of access.<br><br>Information should be shared more effectively with improved communication. | Better communication around the services provided to ensure patients were able to make informed decisions.<br><br>Communication around the services available in Hartlepool needs to be improved to raise awareness of what was available.<br><br>Ensuring parents and the workforce, including multi-disciplinary teams, were educated around the services available. | Increase and improve navigation to services and ensure they were facilitated, raising awareness of services available including online and face to face. | Better communication of future plans to the public. Often informed after the event.<br><br>Don't assume young people prefer electronic communication – traditional means are just as good. |

| PRIORITIES SHARED ACROSS THE SERVICE THEMES | FRAIL AND ELDERLY | PRIMARY AND COMMUNITY SERVICES | URGENT AND EMERGENCY CARE SERVICES | MATERNITY, EARLY YEARS, CHILDREN'S HEALTH AND WELLBEING SERVICES | MENTAL HEALTH SERVICES | FOCUS GROUP / YOUTH COUNCIL VIEWS |
|---|---|---|---|---|---|---|
| **SERVICE DELIVERY:**<br><br>**-INTEGRATION**<br><br>**-DEVELOPMENT OF COMMUNITY ASSET**<br><br>**-PROVISION OF SERVICES LOCALLY**<br><br>**-TRANSPORT**<br><br>**-STAFFING, EDUCATION AND TRAINING** | Extended access to health and social care professionals through a single point of contact to enable quick access to professional advice to deal with an individual's care when required.<br><br>Developing community assets such as a community hub to provide information and advice for carers as well as service users.<br><br>Transport.<br><br>Domiciliary care and the need to value the role, give respect and recognition to care staff.<br>Introducing an education and training programme for individuals and carers in the management of long term conditions;<br><br>To develop a leadership, education and training programme to invest in the workforce with the aim of achieving the desired outcomes. | The importance of building on existing community assets was emphasised along with the need to focus on those who were more isolated.<br><br>One contact providing the right service, at the right time, with the right expertise.<br><br>Better co-ordination of a single point of delivery/expertise.<br><br>Signposting to the right service at first point of contact, and improved communication between hospital/ community.<br><br>Transport services within localities needed reviewing to develop community based/ primary care services in relation to spending review cuts in health and social care.<br><br>Consistency – ensure a high service/standard of response with highly trained advanced care practitioners to meet the community's needs. | A mix of staff should include multi-disciplinary teams to ensure right care, right place, at the right time.<br>One service, one place, with one provider should be a key priority.<br><br>The provision of one emergency service 24 hours a day, 7 days a week in Hartlepool, with the Urgent Care Centre providing rapid response from a base within the University Hospital of Hartlepool, including an Emergency Assessment Unit.<br><br>There was a need for 24 hours a day access to a walk-in centre in Hartlepool as that had been the expectation when the One Life Centre was established - one place to meet a whole range of needs.<br><br>24 hours a day/7 days a week service required with the ability to walk in as there remained some confusion over what was available and some people do not like to access 111 directly.<br><br>The above should be provided within the Hartlepool boundary, preferably at the University Hospital of Hartlepool.<br><br>Transport was highlighted as a challenge for accessing services at the University Hospital of North Tees.<br><br>Should be more senior consultants/ matrons through a big recruitment drive to address emergencies, especially around specialist service. | Improvement of local co-ordination of specialised services to avoid appointments at numerous different hospitals and to ensure information was shared between doctors effectively. Need to ensure pathways of care were clear for families in order to minimise disruption where possible.<br><br>Ensure appropriate qualified and experienced staffing with the right expertise were in place where needed, and that they were accessible to maximise the support role where needed.<br><br>Transport was highlighted as a particular issue that needs to be improved for patients who need to attend North Tees Hospital, including the awareness of transport services available.<br><br>Improved workforce planning to ensure the number and skills of the workforce meet future needs of patients on both sites.<br><br>Improved education around the national childhood measurement programme, breastfeeding, inter-generational patterns and cycles, and how we can break into those including the public perception of social workers. The key being education in the right place to the right age group. | Better integration with health services and local authority services.<br><br>Better use of community and voluntary sector as they have a key role to play to support individuals in their home and help patients navigate services.<br><br>Education, training and raising awareness with professionals and public and ensuring easy access as early as possible to make certain that the first assessment counts with all options available being considered, including self help and IT solutions, not just prescribing medication. | Clear view that services need to be integrated to improve patient/ service user outcomes and efficiencies.<br><br>Shortness of community based beds.<br><br>Review the urgent care services at the One Life centre as they are perceived to be poorly integrated and there is too low a threshold for referral to North Tees. Hartlepool hospital offers a better site for these services and would lend itself to 24 hour availability.<br><br>Lack of 24/7 pharmacy at the One Life centre yet pharmacy in the hospital.<br>Need a strong Hartlepool focus for services as currently no clear focus.<br><br>Hartlepool hospital should host services such as elective care, chronic lung disease, pain services, birthing.<br><br>A telephone care service is needed.<br><br>Transport to North Tees including lack of clarity about the shuttle service. Problems compounded by low car ownership and discharge from North Tees at 'unsocial hours'.<br><br>Increase the numbers of GPs with a general satisfaction with GP services and a positive view of GPs. |

| PRIORITIES SHARED ACROSS THE SERVICE THEMES | FRAIL AND ELDERLY | PRIMARY AND COMMUNITY SERVICES | URGENT AND EMERGENCY CARE SERVICES | MATERNITY, EARLY YEARS, CHILDREN'S HEALTH AND WELLBEING SERVICES | MENTAL HEALTH SERVICES | FOCUS GROUP / YOUTH COUNCIL VIEWS |
|---|---|---|---|---|---|---|
| **PROVISION OF PATIENT FOCUSED CARE:**<br><br>**-PREVENTION**<br><br>**-TACKLING SOCIAL ISOLATION**<br><br>**-CLEAR CARE PLANS** | Making sure every individual has a tailored assessment plan with a single named co-ordinator upon discharge from hospital.<br><br>Social isolation and loneliness, especially for older people and informal carers. One way of improving this may be through the introduction of an App which would show what services were available to signpost people, including professionals. | Consistency across care whilst recognising personal care.<br><br>Improvements in relation to carer and support around hospital discharge. Tackling isolation and loneliness.<br><br>More proactive approach to predicting needs and risks to people in the community and the importance of targeting resources in relation to prevention along with the need to improve the promotion of public health messages within the community. | | | | |
| **STRONG LEADERSHIP / MANAGEMENT AND SERVICE CONFIDENCE** | | Confidence – as a result of training / services being implemented effectively. | Strong leadership is required to move forward through unbiased leadership and accountability. | Improve the involvement of young people including the Youth Parliament and Youth Council. | | A view that hospital Trust management focuses on North Tees.<br><br>A near universal feeling that since North Tees and Hartlepool hospitals merged in 1999 there has been a steady withdrawal of valid services from Hartlepool. The latest flashpoint, although not integral to this report, has been the removal of fertility services.<br><br>Stockton has better community services and concern was expressed that the Clinical Commissioning Group do not focus enough on Hartlepool issues. |

| PRIORITIES SHARED ACROSS THE SERVICE THEMES | FRAIL AND ELDERLY | PRIMARY AND COMMUNITY SERVICES | URGENT AND EMERGENCY CARE SERVICES | MATERNITY, EARLY YEARS, CHILDREN'S HEALTH AND WELLBEING SERVICES | MENTAL HEALTH SERVICES | FOCUS GROUP / YOUTH COUNCIL VIEWS |
|---|---|---|---|---|---|---|
| **OTHER** | | | There were concerns about the pressure placed on the Ambulance Service at the current time.<br><br>The preference was for the return of services locally including the provision of Accident and Emergency in Hartlepool. Further discussion ensued on the isolation of the current arrangement and the impact this had on families. | | Working together for change document to be considered in developing the Local Health and Social Care Plan Working Group. | There should be a public review of progress of Hartlepool services no later than a year after this report.<br><br>The SeQIHS (now the Better Care Programme) project presentation according to a member of the public was not focused on, and was patronising to, Hartlepool residents. Healthwatch members thought it provides an opportunity for specialised care to come to Hartlepool. |

HARTLEPOOL BOROUGH COUNCIL

NHS
Hartlepool and Stockton-on-Tees Clinical Commissioning Group