HARTLEPOOL MATTERS
DRAFT IMPLEMENTATION PLAN

HARTLEPOOL BOROUGH COUNCIL

NHS

Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Content

Message from the Council Chief Executive and Clinical Commissioning Group Chief Officer

Hartlepool Borough Council and Hartlepool and Stockton-on-Tees Clinical Commissioning Group continue to face unprecedented challenges, with continued funding reductions, increasing demands on health and social care services and nationally driven system change. Over the coming years we will see significant changes in the way our health and social care services are provided.

However, in Hartlepool we find ourselves in a favourable position, with the ability to build on the work undertaken by Professor Colin-Thomé in the formulation of the 'Hartlepool Matters' Plan. The Plan sets out a clear ambition and framework for making sure that any future changes around health and social care integration are delivered for the benefit of the people across Hartlepool.

We are committed to responding to the challenges we face, providing services that meet the needs of our population and delivering the best possible outcomes both now and in the future. The integration of our services across health and social care, the continued improvement in how we work with our partners across all sectors, and the support of our residents, are the key ingredients for success.

Gill Alexander
Chief Executive- Hartlepool Borough Council

Ali Wilson
Chief Officer - NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Vision for Hartlepool

During 2015/16 Hartlepool Council, in partnership with the CCG, commissioned Professor Colin-Thome (via the Northern Clinical Senate) to undertake a detailed piece of work to develop a model for the integration of health and social care services in Hartlepool. Professor Colin-Thome's findings are contained within the 'Hartlepool Matters' Plan and include a new care model for Hartlepool.

Based on the priorities identified by the Local Health and Social Care Plan Working Group, our new model 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 co-ordination 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 over-arching principles, we are committed to the provision of integrated services in Hartlepool wherever possible and appropriate, with recognition that specialist acute services (i.e. trauma) need to be provided centrally at James Cook University Hospital to ensure the best possible outcomes for patients.

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.

Hartlepool faces demographic challenges in terms of deprivation as well as in relation to an ageing population and increasing numbers of people with disabilities.

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

Prevention

The Council and the local NHS both have a statutory duty to take steps to improve and protect the health and wellbeing of all of our residents and to reduce health inequalities. We know that we have very significant health and well-being issues in Hartlepool, with the second worst healthy life expectancy in the country for women and the tenth worst for men. That means that, as well as far too many of our residents dying much earlier than they should, very large numbers are living for many years with a significant medical, physical or mental disability or long-term condition like diabetes and high blood pressure.

We have ambitious plans to improve the health and well-being of all our residents by focussing as much effort as we can on preventing ill health or disability in the first place (through vaccinations or screening perhaps), on trying to reduce the impact of ill health or disability once it has started (through reducing weight for those with diabetes or stopping smoking for those with chest conditions like bronchitis or asthma perhaps) and on trying to maximise recovery after a major event (through rehabilitation after stroke or heart attack perhaps).

We will also focus our efforts on reducing the sense of isolation that so many older residents tell us about and seek to help them to maintain their independence.

What have we achieved?

Established a Handyman Service to undertake minor repairs and adaptations for residents.

Established a Falls Prevention Service, based at University Hospital of Hartlepool.

Appointed Care Co-ordinators or Navigators to help the frail elderly get maximum benefit from available services.

Opened 3 Community Hubs in areas of greatest need to provide access to many services, such as smoking cessation, adult education, community activities and financial advice under one roof.

Provided support for a wide range of voluntary and community groups, such as the Dementia Day Service, Stroke Navigation Service, Blind Welfare, Deaf Centre and Hartlepool Befriending Network.

Integrated health and social care teams for children & young people working from 4 locations across the Borough offering support from the most appropriate professional based on need not diagnosis.

Reduced the number of adults smoking in Hartlepool from 30% to 19% in the last 10 years.

Opened the Centre for Independent Living which houses a number of voluntary and community sector organisations providing advice, information, advocacy and practical help for people with a disability.

What will we do next?

We will review Hartlepool Now and Family Services Directory, including an improved website and mobile app, to include health and lifestyle advice as well as more information on practical support services.

We will join Wave 3 of the National Diabetes Prevention Programme to identify people at imminent risk of developing diabetes and help minimise this risk by reducing obesity and increasing physical activity.

We will review and improve our current smoking cessation and tobacco harm reduction services to support the Smoke Free NHS Programme and to reduce the numbers of adults smoking overall to 5% by 2025.

We will work with pharmacies and GPs to improve effectiveness and uptake of NHS Health Checks (available every 5 years if aged 45-70) and increase the opportunities for people to care for themselves better.

We will work with the Youth Council, schools and colleges to promote mindfulness and better mental health and improve understanding of health promotion issues like alcohol and tobacco harm reduction.

How will we know that we are successful?

The number of adults smoking or drinking harmfully will reduce.

Older people will feel less socially isolated and more independent.

The number of people using Community Hubs and accessing services will increase.

The number of people with poorly controlled diabetes or complications of diabetes will reduce.

Primary, Community and Social Care

The Council, CCG and our partners are key to the development and implementation of a health and social care model that can provide integrated primary, community and social care services to meet the changing needs of our residents. The involvement of all partners is essential to the successful delivery of the model based upon the advice of Professor Colin-Thome and the views and comments of our residents.

In implementing this model, the Council, CCG and partners are committed to the delivery of ambitious plans. We aim to ensure that by working in health and care we integrate care records and services both within and outside of normal working hours (focusing on admission prevention and supporting independence), improve timely diagnosis and treatment of long term conditions, better use assistive technology; extend care services through general and community pharmacies and GP practices, and integrate social care/ health services for both children and adults, including mental health services, as well as those provided by the voluntary sector.

Whilst creating a model that meets current need, we also need to ensure that it will respond to the changing face of our communities and organisations. Whilst we aim to make services more accessible to our population, we are committed to developing individual and community assets that will ensure that our communities are robust and resilient. We will achieve this together, building on the strengths of each partner and overcoming the challenges we face in terms of organisational change and ongoing financial challenges. The ultimate aim is the delivery of the best possible outcomes for the health and wellbeing of our residents.

What have we achieved?

Co-location of health and social care staff in single point of access for referrals/triage.

Established an Integrated Discharge Team.

Locality teams and health visitors working together.

GP extended hours (7 day access).

Technology pilot to help people remain in their own homes.

Hubs established (Primary Care Pilot at McKenzie House GP practice / Multi Agency Children's Hub / Hartlepool Council Community Hubs).

'Trusted Assessor' pilot on Elective Care Ward at the University Hospital of Hartlepool.

Children's and Adolescent Mental Health Services (CAHMS) 24/7 crisis service.

Improved substance misuse service (tied to mental health services).

Centre for Independent Living created.

Established a Befriending Network.

Worked with Cleveland Fire Brigade to maximise benefits of home fire safety checks, and link to other services.

Supported the development of the Dementia Advisory Service at The Bridge.

Provided support to care homes including education, training and enhanced pharmacy support.

What will we do next?

Identify workforce requirements (including training) to deliver integrated services and a strategic workforce plan, highlighting duplication and gaps/opportunities for new roles.

Provide 7-day access to GP Services for people with long-term conditions and ensure that when patients leave appointments they are signposted effectively to other services.

Share electronic patient records (Great North Care Record) and co-ordinate data to identify needs/trends - where necessary delivering services differently to most effectively meet need within existing resources.

Fully implement new models (i.e. single point of access and trusted assessor), including the co-location of mental health and other services to improve access.

Develop the One Life Centre to deliver integrated health and social care services, create two fully functioning primary care hubs and expand the multi-agency children's hub.

Develop an integrated model for intermediate care services.

Promote closer working between primary care, community services and social care to support the frail elderly and prevent avoidable admissions to hospital and to care homes.

Review our approach to supporting carers to maintain their caring role.

How will we know that we are successful?

There will be seamless transition between services (from prevention right through to primary care), with clear advice and guidance.

There will be improved patient outcomes and effective self management of conditions (long term and other).

People are able to remain in their homes for longer, with reduced hospital admissions and shorter hospital stays.

No one has to tell their story twice!

There will be less duplication with services that meet changing professional standards and financial/demographic pressures.

There will be increased satisfaction and confidence in the services that are provided where and when they are needed, by the most appropriate professional.

Feedback from people who use our services and carers.

There will be a reduction in emergency admissions to hospital.

There will be a reduction in delayed discharges from hospital.

Local Hospital - Acute and Urgent Care

A key part of the 'Hartlepool Matters' vision for the integration of health and social care services in Hartlepool is the way in which we provide our acute and urgent care services. In achieving this, significant challenges face all partners. We will continue on our journey to provide services outside of hospital for those with urgent, but non-life threatening needs, that are highly responsive, effective and personalised. Services will be delivered in or as close to people's homes as possible, with a reliance on admission only when necessary, thus providing local and convenient access for patients and their families.

With the recent successful opening of the Integrated Urgent Care Services at the University Hospital of Hartlepool, a range of services such as minor illnesses, minor injuries, GP walk in and out of hours, is provided 24 hours per day in the local hospital. This is in line with the aim to provide local access to services, where safe to do so. This is supported by Professor Colin-Thome's conclusion that urgent cases could be fully dealt with in Hartlepool and that only rarer emergency problems need to travel further.

Building upon this, importance has been placed upon the need to maintain a fully functional One Life Centre for scheduled care, to increase levels of planned surgery from the local hospital, to provide an ongoing mental health service support for urgent and emergency services and to improve plain English guidance for new mums in Hartlepool.

We remain committed to listening to the needs and concerns of residents in the development of services that are fit for purpose now and in the future.

What have we achieved?

NHS 111 (single number for all urgent health needs) is integrated across three urgent care services.

An urgent Care Service (combining minor injury/ GP Out of Hours/Walk in services) is now delivered from the University Hospital of Hartlepool.

One Life Centre continues to provide scheduled care, day operations, musculo-skeletal services (MSK), audiology, speech and language therapy, podiatry/podiatric surgery and primary care.

Approximately 40% of all elective inpatient/day case activity, across both the North Tees and Hartlepool hospital sites, is now being delivered from the University Hospital of Hartlepool.

Newly commissioned 24/7 mental health crisis team through urgent/emergency services, with the ability to self refer – improving the response for the people in Hartlepool.

What will we do next?

Further integrate the One Life Centre to the development of primary care hub(s).

Provide all information and guidance in plain English.

Audit children's non-elective admissions to hospital, identifying trends and developing a more targeted/proactive way of partnership working.

Be actively involved in the strategic plans through the Sustainability and Transformation Plans and Better Health Programme to ensure that the needs of Hartlepool residents are reflected in the way services are developed, including further increases in the amount of planned care and other services from the Hartlepool locality.

Further develop community health and social care services in Hartlepool to deliver integrated support to keep people safe and well where they live.

How will we know that we are successful?

There will be improved patient outcomes and public acceptance that services can be provided safely, closer to home in locations outside of hospitals.

There will be reduced duplication of services, delivering a service that is 'fit for the future' and meets ever increasing professional standards and financial and demographic pressures.

There will be a motivated, happy and settled workforce.

There will be shorter hospital stays and improved transfer of care arrangements.

Patients receive services where and when they need them, provided by the most appropriate professional where safe to do so.

Implementation of Hospital@Home for people with chronic obstructive pulmonary disorder - to support timely access to clinical services supporting people in Hartlepool and reduce the need to go to hospital where appropriate.

Integrated Discharge Team – multilink between health and local authority services

People and Places

Over and above the recommendations of the Hartlepool Matters Plan, residents identified during the course of Professor Colin-Thome's work a number of concerns that we also need to address in delivering our new model for the provision of integrated services. It won't be possible to achieve our ambitions without ensuring that we are mindful of a range of supporting factors. These include the physical infrastructure, public transport, ambulance availability, appropriate staffing levels, a fully trained workforce (recruitment and retention), and confidence in the services we provide.

We will need to work closely with the Local Workforce Boards, universities and colleagues to ensure we have the right mix of skills and experience to deliver the new services we will be putting in place. We are already making good progress with technologies. Many of our most vulnerable members of the community have telecare or telehealth services that ensure no one is alone in a time of need and help those with chronic ill health to better manage their own condition.

Our new Great North Care Record will help to provide the right information to the health and care professionals at the right time, helping to individualise the care that our local people receive and ensuring that health and care professionals can make more speedy decisions about someone's care when they most need help.

We are reviewing our physical assets so that services are provided in the right place i.e. within local communities, using health and care hubs to consolidate those services that need to work together.

Our people are our greatest asset and through leadership and organisational development we will equip them with the right skills, expertise and attitudes to deliver an ambitious programme of work over the next several years.

These issues are fundamental to the success of the delivery of the model and whilst ll are within the remit of the Council, partnership working and a commitment to delivering change is to be key as we go forward.

What have we achieved?

Local Estates Forum established.

Transport - shuttle bus provided between the University Hospital of Hartlepool and North Tees.

Staffing:
- International recruitment and retention of GPs is underway.
- Developed plans for education and training for specialist teams who have been commissioned with the support of Education North East.
- Recruited paramedics to meet a shortfall.

Developed plans to ensure we have the right leadership and management skills for future.

Enabled GPs to make relevant medical information from GP records available to other healthcare professionals who are providing direct care.

What will we do next?

Plan the estate required to provide services to the population, through the Local Estates Forum, to maximise the use of the estate we hold and get the best value for money through either increased utilisation or disposing of the estate that is surplus to requirements and supporting the provision of services in community settings closer to people's homes.

Develop Integrated Community Hubs to provide services in the community as part of the New Models of Care.

Implement the Great North Care Record.

Work with further education providers to develop career pathways within health and social care, supported by relevant qualifications.

How will we know that we are successful?

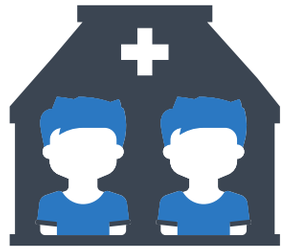
Physical infrastructure will be in place to provide services where they are required, in the most effective way.

Services will be accessible to members of the public who do not have access to private transport.

Staff will have been recruited, and retained, to provide services to the required high standards.

What we have achieved in 2017...

Launched a **24/7 Integrated Urgent Care Centre** at the University Hospital of Hartlepool.



Opened **three new Community Hubs** and the North of Tees Children's Hub.

Launched the Centre for Independent Living

Implemented the **Hospital at Home**.

Improved services for those living with long term conditions.

Created an **Integrated Discharge Team** to reduce delayed discharges from hospital.

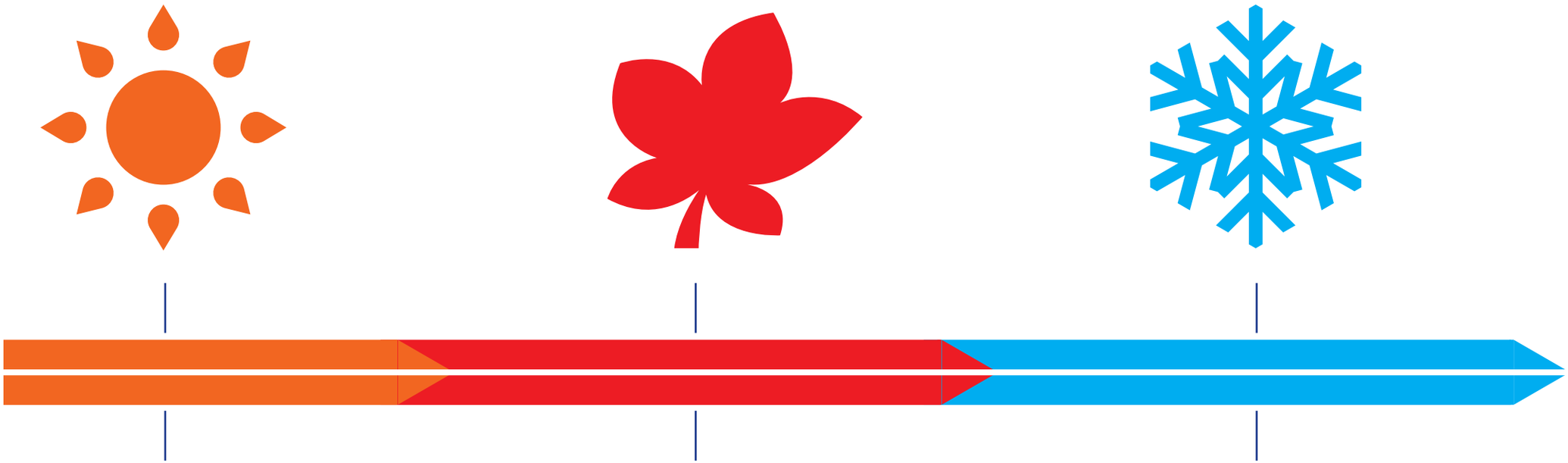
Located Care Co-ordinators in each GP surgery to prevent avoidable hospital admissions.

Brought back services to the University Hospital of Hartlepool, including the Pain Services Centre of Excellence.

GP hours extended for planned care.

What we will achieve in 2018/19...

- Continue to update Hartlepool Now and Family Services Directories.
- Deliver a mental health Pilot with the Hartlepool Youth Council.
- Increase the number of patients using online GP services.
- Further develop the Integrated Discharge Team.



- Work to personalise care to meet the specific wishes of individuals, initially targeting patients with chronic respiratory disorders.
- Review the community nursing service to deliver care closer to home.
- Improve proactive engagement with palliative patients and their families.
- Seven day access to GP services, ensuring patients leaving an appointment are signposted to other services.

- Deliver mindfulness and other mental health programmes in schools.
- Establish a total of three Primary Care hubs.
- Share electronic records.
- Implement an integrated single point of access for health and social care referrals.

- Explore opportunities to deliver further integration of health and social care services at the One Life Centre.
- Wider availability and better uptake of NHS Health Checks.
- Promote independence through closer working with GPs and community services.
- Strengthen support available for carers.

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