HEALTH AND WELLBEING BOARD

AGENDA

HARTLEPOOL BOROUGH COUNCIL

Monday 5th March 2018

at 10.00am

in Committee Room 'B'
Civic Centre, Hartlepool.

MEMBERS: HEALTH AND WELLBEING BOARD

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors C Akers-Belcher, Buchan, Clark and Thomas
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group – Dr Timlin and Alison Wilson
Interim Director of Public Health, Hartlepool Borough Council - Dr Paul Edmondson-Jones
Director of Children's and Joint Commissioning Services, Hartlepool Borough Council – Sally Robinson
Director of Adult and Community Based Services, Hartlepool Borough Council, Jill Harrison
Representatives of Healthwatch (2). Margaret Wrenn and Ruby Marshall

Other Members:
Chief Executive, Hartlepool Borough Council (1**)** – Gill Alexander
Director of Regeneration and Neighbourhoods, Hartlepool Borough Council – Denise Ogden
Representative of the NHS England – Dr Tim Butler
Representative of Hartlepool Voluntary and Community Sector – Tracy Woodhall
Representative of Tees, Esk and Wear Valley NHS Trust – Dominic Gardner
Representative of North Tees and Hartlepool NHS Trust – Deepak Dwarakanath / Julie Gillon
Representative of Cleveland Police, Jason Harwin
Representative of GP Federation – Fiona Adamson
Representative of Headteachers - Julie Thomas

Observer – Statutory Scrutiny Representative, Hartlepool Borough Council - Vacant

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

   3.1 To confirm the minutes of the meeting held on 19th February 2018

4. **ITEMS FOR CONSIDERATION**

4.1 Pharmaceutical Needs Assessment 2018 (*Interim Director of Public Health*)

4.2 Child Protection - Information Sharing Project (*Director of Children's and Joint Commissioning Services)*

4.3 SEND (Special Educational Needs and Disabilities) Improvement (*Director of Children's and Joint Commissioning Services)*

4.4 Health and Wellbeing Strategy (2018-2025) - Monitoring of the Implementation Plan (*Interim Director of Public Health*)

4.5 Hartlepool Matters Plan (*Chair of Health and Wellbeing Board) (to follow)*

4.6 Review of Mental Health and Wellbeing Services for Children and Young People *(Hartlepool and Stockton-on-Tees Clinical Commissioning Group)*

5. **ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT**

Date of next meeting – To be confirmed

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

19th February 2018

The meeting commenced at 9.00 am in the Civic Centre, Hartlepool

Present:

Councillor C Akers-Belcher, Leader of Council (In the Chair)

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillor Buchan
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group – Dr Andrea Jones
Director of Children's and Joint Commissioning Services, Hartlepool Borough Council – Sally Robinson
Director of Adult and Community Based Services, Hartlepool Borough Council, Jill Harrison
Representatives of Healthwatch - Margaret Wrenn and Ruby Marshall

Other Members:
Representative of the NHS England – Dr Tim Butler
Representative of Hartlepool Voluntary and Community Sector – Karen Gibson as substitute for Tracy Woodall
Representative of Tees, Esk and Wear Valley NHS Trust – Dominic Gardner
Representative of North Tees and Hartlepool NHS Trust – Julie Gillon
Representative of Cleveland Police, Jason Harwin

Also in attendance:- L Allison and J Gray, Healthwatch

Officers: Joan Stevens, Statutory Scrutiny Officer
Amanda Whitaker, Democratic Services Team

38. Apologies for Absence

Councillor Thomas
Interim Director of Public Health, Hartlepool Borough Council - Dr Paul Edmondson-Jones
Representative of GP Federation – Fiona Adamson

Cllr Ray Martin-Wells, Chair of Audit and Governance Committee (minute 43 refers)

39. Declarations of interest by Members

Councillor Christopher Akers-Belcher reaffirmed his interest as Manager of Healthwatch Hartlepool.

40. Minutes

(i) The minutes of the meeting held on 4 December 2017 were confirmed. There were no matters arising from the minutes

(ii) The minutes of the meeting of the Children's Strategic Partnership held on 22 November 2017 were received

41. CQC Local System Review – Action Plan *(Director of Adult and Community Based Services)*

The report provided the Board with an update regarding the Care Quality Commission's Local System Review in Hartlepool, which was published in December 2017, and the action plan that had been developed in response to the identified areas for improvement within the report.

Following the announcement of additional funding for social care in the Spring 2017 budget, work had been undertaken nationally to develop performance measures associated with this allocation, which would form part of the Improved Better Care Fund. The measures, which included Delayed Transfers of Care, aimed to assess patient flow and how the interface between health and social care services was managed. A notification had been received on 4 July 2017 advising that Hartlepool had been identified as one of the first twelve areas to be reviewed.

The Board was advised that the review process had involved submission of a Local System Overview Report, a two day on-site visit from members of the review team in September 2017 and a five day on-site visit from the whole review team in October 2017. A wide range of system leaders and partners had been involved in the review process including health and social care commissioners and providers, Healthwatch and voluntary sector organisations. The draft report had been shared with system leaders in late November to provide an opportunity for any factual accuracy issues to be addressed. A Local Summit had been held on Thursday 7 December 2017 where the CQC had presented the report and work had began to develop an action plan in response to the areas for improvement that had been identified. The final report had been published on the CQC website on Friday 8 December 201, a copy of which was appended to the report. Following the review, partners within the local system were required to develop an action plan for submission to the Department of Health. It was expected that implementation and monitoring of the action plan would be overseen by the local Health & Wellbeing Board. The action plan for Hartlepool had been developed by key partners and submitted to the Department of Health in January 2018. A copy of the action plan was appended to the report.

Following presentation of the report, the Chair expressed appreciation, on behalf of the Board, to those who had been involved in the Local System Review.

Decision

The Board:

- noted the outcome of the Care Quality Commission local system review for Hartlepool;
- noted the agreed action plan that has been developed in response to the report; and
- agreed to receive an update on implementation of the action plan at the first meeting of the Health & Wellbeing Board in the 2018/19 municipal year.

42. Better Care Fund 2017/18: Quarter 3 Update *(Director of Adult and Community Based Services)*

The report provided the background to the National Conditions and performance measures associated with the Better Care Fund. Performance reports were submitted to NHS England on a quarterly basis. The Q3 return (covering the period October – December 2017) had been submitted in January 2018 and had confirmed that all national conditions continued to be achieved, as well as providing analysis of performance data which was summarised in the report.

The Chair highlighted that the report referred to data indicating that approximately 75% of people had no ongoing social care needs after a reablement intervention. Clarification was sought on how that data compared to previous data. The Director undertook to include trend data in the quarter 4 update to the Board.

With regard to the reduction in non-elective admissions from care homes, a Board Member sought clarification of the impact of winter pressures. The Director advised that quarter 3 information was not yet available from the NHS but would be included in the next update report.

Decision

The Board noted progress made since the last update in terms of performance.

43. Delayed Transfers of Care *(Audit and Governance Committee)*

The Board received an update on information presented to the Audit and Governance Committee regarding the current position in relation to Delayed Transfers of Care.

Board Members were reminded that on 19 September 2016, the Board had been notified of North Tees and Hartlepool Foundation Trust's (FT) intention to review the way in which monthly delayed transfers of care were recorded following a review of NHS England guidance on 'Monthly Delayed Transfers of Care: Situation Reports' and direct discussions with NHS England. The Board had referred the matter to the Audit and Governance Committee for further investigation.

Between the period October 2016 - December 2016, the Committee had considered the referral and on the 8 December 2016 had agreed that actions taken had satisfactorily resolved the initial concerns raised by the Board and that the matter required no further exploration It was, however, agreed that an update would be provided to the Audit and Governance Committee in March 2017 regarding each of the actions taken. This update had been presented to the Committee on the 23 March 2017, with confirmation that overall performance in relation to delayed transfers of care had improved significantly in recent months. It was also noted that the position was expected to improve further over the next year as two proposed new care home developments become operational. On this basis, the Committee had agreed that no further action was required in relation to the referral at this time. It was noted also that returns would continue to be reviewed on a monthly basis, with the Council monitoring of all delays that are attributed to social care, to ensure that all possible actions are taken to facilitate timely and safe discharges from hospital. The Committee's decision had been noted by the Board at its meeting on the 26 June 2017, with a request that a further report be submitted to the Board on the outcome of the Committee's monitoring of delayed transfers of care (minute no. 4 refers). In accordance with this request, a copy of the update report, considered by the Committee at its meeting on the 24 January 2018, was appended to the report, details of which were noted by the Committee (Minute No. 89 refers).

The Chair suggested that future updates could be included in update reports relating to the Hartlepool Matters Action Plan.

In response to concerns expressed by a Healthwatch representative regarding transfers of care to West View Lodge, the Director of Adult and Community Based Services explained that rehabilitation and transitional beds were commissioned at West View lodge as part of intermediate care pathways. The Healthwatch representative highlighted an example of when a patient had not been given a choice in relation to their transfer from hospital to West View Lodge. The Chair highlighted the patient choice policy and the Director and North Tees and Hartlepool Trust representative undertook to investigate the issue and feedback to the Healthwatch representative outside of the meeting.

Decision

The Board noted the current positive position in relation to Delayed Transfers of Care and agreed that future updates would be included in Hartlepool

Matters Plan reports to the Board.

Meeting concluded at 9.20 a.m.

CHAIR

HEALTH AND WELLBEING BOARD

5nd March 2018

Report of: Interim Director of Public Health

Subject: PHARMACEUTICAL NEEDS ASSESSMENT 2018

1. TYPE OF DECISION/APPLICABLE CATEGORY

Key Decision (test (i)(ii))

2. PURPOSE OF REPORT

2.1 To seek approval of the final draft of the Hartlepool Pharmaceutical Needs Assessment (PNA) 2018.

Copies of the PNA can be accesses via the below link and will be available at the meeting. In addition to this, should a paper copy of the Draft PNA 2018 be required, please contact Joan Stevens (email: joan.stevens@hartlepool.gov.uk or telephone: 01429 284142).

Link to PNA:

https://www.hartlepool.gov.uk/downloads/download/779/pharmaceutical_needs_assessment_pna_2018

3. BACKGROUND

3.1 The National Health Service (NHS) (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 ("the Regulations"), set out the minimum requirements for the Hartlepool Health and Wellbeing Board (HWB) PNA, produced under this duty. These requirements include the provision of data on the health needs of the population, current provision of pharmaceutical services, and gaps in current provision. The PNA must also consider the potential need for future provision of pharmaceutical services.

3.2 It may be helpful to know that the PNA has very specific applications:-

i) NHS England must use it to guide the commissioning of pharmaceutical services in the area e.g., when responding to applications either to join the 'Pharmaceutical List' or to amend conditions or characteristics of being included in it (such as location or opening hours) or making arrangements for pharmacies to open on Bank Holidays.

ii) Additionally, in 2016, new regulations were introduced to allow two pharmacies to apply to NHS England to merge or 'consolidate' rather than simply to close. NHS England must seek the opinion of the HWB on whether or not a gap in service provision would be created by the consolidation. The PNA will therefore also now be used by the HWB in inform this decision.

iii) It may also be used to inform the commissioning (either directly or under sub-contracted arrangements) of some local services from pharmacies by Hartlepool Borough Council and NHS Hartlepool and Stockton on Tees Clinical Commissioning Group.

3.3 These purposes, and the legislative framework that covers both what must be included in the PNA, and how NHS England will use it, greatly influences the content and some of the language used, which reflects that used in the legislation and decision-making processes.

3.4 The 2013 Regulations outline the basis for the updating of PNA's, including the duty of HWB's to publish a statement of its revised assessment within 3 years of its previous publication of a PNA'[1]. It also requires that the HWB keep the PNA up to date in the intervening period by:

- Maintaining the map of pharmaceutical services;
- Assessing any on-going changes which might impact pharmaceutical need or require publication of a Supplementary Statement;
- Publishing a full revised assessment before the 25 March 2018.
- Considering 'Supplementary Statements' when changes take place to provide updates to the Pharmaceutical Needs Assessment (only in relation to changes in the availability of pharmaceutical services; and
- Reviewing the Pharmaceutical Needs Assessment where there are updates in pharmaceutical need.

3.5 Further details of actions required to maintain the current PNA and the planning process for the publication of a fully reviewed PNA are outlined in **Appendix A** of this report.

4. HARTLEPOOL'S PNA 2018

4.1 Hartlepool HWB published its first PNA on the 25 March 2015 and in accordance with the requirements of the Regulations has now carried out a full review. A summary of the timetable undertaken for the review is outlined in **Appendix B.**

4.2 The revision of the PNA was informed by a two stage engagement / consultation process, involving statutory consultees[2], residents, patients and stakeholders at both stages.

[1] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (Regulation 6(1))

[2] Statutory consultees - Local Pharmaceutical Committee, Local Medical Committee, persons on the pharmaceutical lists and any dispensing doctors list for its area; LPS chemist, Healthwatch, NHS trust or NHS foundation trust, NHSCB and neighbouring HWB (The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 - Part 2, Regulation 8)

4.3 The Engagement Exercise (Stage 1)

4.3.1 The engagement exercise, undertaken between the 23rd August and the 18th September 2017, helped gain an understanding of patient experiences, pharmacy contractor views and public views of pharmacy services. In total, 338 patients/members of the public, 19 stakeholders and 16 pharmacy contractors participated in the engagement survey.

4.3.2 The results of the survey have been used to inform the draft PNA 2018, circulated for formal consultation, and showed that community pharmacy services are:

- Valued;
- Well located;
- Generally easy to access;
- Have generally suitable opening times; and
- Patients and health professional awareness of the services available has improved in recent years.

4.4 Formal Consultation (Stage 2)

4.4.1 The 60 day statutory consultation was undertaken between the 15th November 2017 and the 13th January 2018. A total 121 patients/members of the public and stakeholders took part in the consultation process, with the majority of responses indicating that:-

i) The PNA:
   - Explains its purpose;
   - Accurately outlines pharmacy need, and the range of pharmaceutical services available in Hartlepool (in accordance with the Regulations); and
   - Covers all pharmacy services, with nothing to add.

ii) The process followed in developing the PNA was appropriate;

iii) There are currently no unmet needs for pharmaceutical services in Hartlepool; and

iv)There is no awareness of unmet future need (within the next 3 years).

4.4.2 A full breakdown of the results of the consultation is attached at **Appendix C** of this report, for reference. This information has also been appended to the finalised PNA 2018 (at Appendix 3) as supporting documentation.

4.4.3 In relation to general comments, a number of specific issues were raised:-

i) The complexity and length of the PNA;

ii) The PNA should:
   - Reference to rural need;
   - Reference national and local commissioning guidance, particularly in relation to minor ailments and self-limiting conditions, and gluten-free foods;
   - Reflect the recent restructure of emergency care across the Hartlepool and Stockton-on-Tees geography;
   - Consider the impact of the withdrawal of bus services on resident's ability to access services; and
   - Reference the quality of services provided.

iii) Other comments:

- Hours of service recorded don't take into account the limited service (i.e. insufficient staffing);
- There is a lack of awareness of late / out of hour's pharmacy opening times and how to complain about bad services / what to expect when complaints are made;
- A locally commissioned service for minor ailments is not a pharmaceutical need;
- There should be longer opening hours at pharmacies, especially over weekends and bank holidays;
- Pharmacies are under constant pressure and the impact of any closures on patients and other pharmacies would be unacceptable;
- There needs to be an option for students to share records and dispensing with a named establishment in both their home and student town;
- There is a lack of supplies in pharmacies and a lack of communication between services (e.g. script going electronically from GP); and
- Patients may have intermittent, undiagnosed symptoms which do not present whilst at the GP's or hospital. Quickly available tests at a pharmacy could resolve this without having to bother paramedics.

4.4.4 In responding to the issues raised during the consultation, comments regarding the size and complexity of the PNA are recognised and an easy read (executive summary) is in the process of being developed. In terms of the frequency of review of the PNA, the 2013 Regulations[1] state that the HWB is required to publish Supplementary Statements to update the PNA, relating to changes in the availability of pharmaceutical services. However, these cannot be issued to update on pharmaceutical need and in those instances a review of the PNA would be undertaken before the 3 year duration period of the PNA. On this basis, the HWB complies with the requirements of the 2013 Regulations.

4.4.5 In relation to the inclusion of specific information in the PNA, as suggested in Section 4.4.3(ii) of this report, the 2013 Regulations[1] clearly define what must be included (as detailed in **Appendix D**). On this basis, the suggestions made for additions to the content of the PNA are noted and have been reviewed, where appropriate, with specific responses outlined in Appendix C.

4.4.6 With reference to the 'Other Comments' made as part of the consultation process, some are relevant to the PNA and responses are also included in Appendix C. Others are not, and will be shared with appropriate professions / bodies locally.

4.5 The formal response from NHS England (Cumbria and North East) as a statutory consultee, is also attached at **Appendix E**. It is noted that the letter contains positive comments, and notes to include, with no specific actions to address. Particular reference was, however, made to need to inform the HWB of below and reference to them has been included in the PNA:

- Approval of a new pharmacy (unforeseen benefit) application – within 100 meters of the retail parade, Middle Warren Local Centre – extant grant until 9 May 2018; this was approved during the consultation period; and

- The application for relocation from 99A York Road to 107 York Road – Extant grant until 2 August 2018.

4.6 A second letter (**Appendix F**), sent to all HWBs, requested removal of reference to the NHS Urgent Medicine Supply Advanced Service (NUMSAS) as this is only a pilot service, operational until September 2018 (now extended to December 2018) with no certainty that this will become a permanent service thereafter. However, advisers in Tees have challenged this request, and the service remains referred to in the PNA, clearly identified as a point. This has been amended in the PNA.

4.7 The PNA is first and foremost a statutory, formal requirement of the Health and Wellbeing Board. As indicated, the consultation process has identified some areas of change and the responses received have been considered when compiling the final draft, now presented to the HWB for approval.

4.8 The final version remains substantively unchanged from the draft document. However, changes have been made to account for updates, errors or omissions identified since the draft was published in November 2017. The majority of respondents who could be sure, indicated that due process has been followed.

5. PROPOSALS

5.1 Full details of the conclusions of the PNA 2018 can be found at pages 13 to 20 of the finalised PNA, available via the link provided in Section 2 of this report. By way of assistance, without prejudice to the full content of the PNA, a summary of the conclusions is provided at **Appendix G** for easy reference.

5.2 As indicated, a full copy of the PNA 2018 is available via the link provided in Section 2 of this report.

6. RISK IMPLICATIONS / LEGAL CONSIDERATIONS

6.1 PNA's are used by NHS England for the purpose of determining applications for new premises. It is anticipated that many decisions made will continue to be appealed and that eventually there will be judicial reviews of decisions made by NHS Resolution. It is therefore important that PNAs comply with the requirements of the regulations, due process is followed in their development and that they are kept up-to-date.

6.2 The HWB have a statutory duty to publish a PNA by 25 March 2018 and to maintain in accordance with the Regulations.

7. RECOMMENDATIONS

7.1 That the Health and Wellbeing Board:-

i) Approve the final version of the PNA for publication on the Council's website before 25 March 2018, subject to minor errata identified before the publication date.

ii) Continue to delegate authority to the Director of Public Health (in conjunction with the Chair of the HWB) to approve as required:

- Publication of minor errata/ service updates as on-going notifications that fall short of formal Supplementary Statements to the PNA (for example changes of ownership, minor adjustments to opening hours and service contracts that do not impact on need);

- Any response on behalf of the Hartlepool HWB to NHS England (42 day) consultation on applications to provide new or amended pharmaceutical services, based on the PNA;

- Any response behalf of the Hartlepool HWB in relation to an application to consolidate two pharmacies, and make a statement or representation, to NHS England (within 45 days) stating whether the consolidation would, or would not create a gap in pharmaceutical services provision;

- Following determination on an application to consolidate two pharmacies by NHS England, publication of a supplementary statement reporting that removal of the pharmacy (which is to close from the Pharmaceutical List) will not create a gap in pharmaceutical services and update the map of premises where pharmaceutical services are provided (Regulation 4(2)); and

- Any initial determination with respect to the potential for either a Supplementary Statement or need for full review. Publication of Supplementary Statements to be ratified by the HWB at suitable periodic intervals (e.g. annually) as required.

iii) Acknowledge the responsibility of the HWB for maintenance of the PNA including the need to assess on-going changes which might impact on pharmaceutical need and the assessment thereof and respond by initiating early review or publishing a Supplementary Statement to the 2018 PNA as required.

iv) To continue delegation of authority to Director of Public Health (in conjunction with the Chair of the HWB) as above, to make initial assessments with respect to potential Supplementary Statements or need for full review.

8. REASONS FOR RECOMMENDATIONS

8.1 Statutory duty to publish a PNA by 25 March 2018.

9. BACKGROUND PAPERS

- National Health Service (NHS) (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 SI 2013/349

The Hartlepool Pharmaceutical Needs Assessment published 25 March 2015

The National Health Service (Pharmaceutical Services, Changes and Prescribing)(Amendment) Regulations 2016

Reports and agendas:
- Health and Wellbeing Board (16 June 2017)
- Audit and Governance Committee (15 November 2017 and 6 December 2017)

10. CONTACT OFFICER

Dr Paul Edmondson-Jones, Interim Director of Public Health,
Hartlepool Borough Council
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Joan Stevens, Statutory Scrutiny Officer
Chief Executive's Department – Legal Services
Joan.Stevens@hartlepool.gov.uk

Appendix A

ACTIONS REQUIRED TO MAINTAIN AND MONITOR THE CURRENT PNA

The requirement to assess any change which might impact on pharmaceutical need and the assessment thereof is acknowledged. If the Hartlepool HWB identifies changes to the need for pharmaceutical services which are of a significant extent then it must publish a revised assessment (PNA) as soon as reasonably practicable after identifying these changes, unless it is satisfied that making a revised assessment would be a disproportionate response to those changes.

In making an assessment of changes to need in its area, the HWB will have regard in particular to changes to the:

- Number of people in its area who require pharmaceutical services;
- Demography of its area; and
- Risks to the health or well-being of people in its area.

On 1st June 2017, under delegated authority, the Interim DPH in conjunction with the Chair, authorised publication of a statement to confirm that the Hartlepool HWB had commenced the process towards publication of its next PNA by 25th March 2018.

In accordance with the Regulations, as the HWB is now in the course of making its revised assessment for 2018, it will need to continue to monitor any changes to availability of pharmaceutical services. The HWB will publish a Supplementary Statement on the changes (to availability) where it is satisfied that immediate modification of its PNA is essential in order to prevent significant detriment to the pharmaceutical services in its area.

In support of on-going maintenance and use of the PNA, it is noted that authority should continue to be delegated to the current Interim Director of Public Health, in conjunction with the Chair of the HWB, to approve as required:

- Publication of minor errata/ service updates as on-going notifications that fall short of formal Supplementary Statements to the PNA (for example changes of ownership, minor relocations of pharmacies, minor adjustments to opening hours or locally commissioned services that would impact neither market entry nor pharmaceutical need);

- Any response on behalf of the Hartlepool HWB to NHS England (42 day) consultation on applications to provide new or amended pharmaceutical services, based on the PNA;

- Any initial determination with respect to the potential for either a Supplementary Statement or need for full review. Where required, any consequent Supplementary Statements to be ratified for publication by the HWB on a periodic basis, not less than annual; and

- Approval for publication of the Consultation Draft version of the PNA for Hartlepool 2018 (a new delegation).

National funding for community pharmacy was recently reduced by 6% and it is anticipated that some pharmacies might close as a result. To encourage mergers or

consolidations of closely located, "surplus" pharmacies, some new amendments to the Regulations[3] were introduced in December 2016. This would allow two pharmacies to make an application to merge and provide services from one of the two current premises.

HWB's have now been given two new statutory duties:

- When NHS England notifies a HWB about an application to consolidate two pharmacies, the HWB must respond and make a statement or representation to NHS England within 45 days stating whether the consolidation would or would not create a gap in pharmaceutical services provision NHS England will then convene a panel to consider the application to consolidate the two pharmacies, taking into account the representation made by the HWB.

- Once NHS England has made a determination on the application to consolidate two pharmacies, it will inform the HWB. The HWB must then:

  - Publish a supplementary statement[4] reporting that removal of the pharmacy which is to close from the Pharmaceutical List will not create a gap in pharmaceutical services; and then

  - Update the map of premises where pharmaceutical services are provided (Regulation 4(2)).

PLANNING FOR THE PUBLICATION OF A FULL REVISED PNA IN 2018

Planning for publication of a full review of the PNA should be in good time ahead of the statutory due date, which is 3 years since the publication of the current PNA (i.e. by 25 March 2018). It is widely acknowledged that the process towards a revised assessment will usually take no less than 12 months to complete, not least because there are statutory requirements for extensive consultation on a draft assessment, at least once and for a minimum of 60 days.

It is therefore recommended that the HWB now acknowledge initiation of the process towards publication of its next revised assessment. As the PNA is used by providers and others (including NHS England), in accordance with delegations agreed at the HWB meeting on the 2 March 2015, a Statement of Intent reporting this, has been published on the Hartlepool Borough Council website as follows:

"Hartlepool Health and Wellbeing Board understands its statutory duties in relation to the Pharmaceutical Needs Assessment (PNA) and intends to publish its full review of the current PNA within the required timeframe. Notwithstanding any changes to pharmaceutical services and related NHS services that have taken place since first publication and without prejudice to the assessment of needs described in the existing PNA, the HWB for Hartlepool formally reports that the Pharmaceutical Needs Assessment for 2015 is under review. Hartlepool HWB has commenced its process leading to publication of a revised assessment / second PNA, with a publication date before 25 March 2018."

[3] The National Health Service (Pharmaceutical Services, Changes and Prescribing)(Amendment) Regulations 2016

In the intervening period, the HWB is still required to:

- Respond to any consultation request from NHS England for representations in respect of pharmacy applications;

- Undertake the decision-making required in relation to the publishing of any associated Supplementary Statement and maintain and publish an up to date map as required; and

- Respond, when consulted by a neighbouring HWB on a draft of their PNA. In doing this, the HWB is required to consult with the Local Pharmaceutical Committee (LPC) and Local Medical Committee (LMC) for its area (unless the areas are served by the same LPC and/or LMC) and have regard for the representations from these committee(s) before making its own response to the consultation.

RISK IMPLICATIONS / LEGAL CONSIDERATIONS.

PNAs are used by NHS England for the purpose of determining applications for new premises. It is anticipated that many decisions made will continue to be appealed and that eventually there will be judicial reviews of decisions made by the NHS Litigation Authority's Family Health Services Appeal Unit. It is therefore important that PNAs comply with the requirements of the regulations, due process is followed in their development and that they are kept up-to-date.

Appendix B

Date	Action
June - July 2017	Published a statement to confirm that the Hartlepool HWB had commenced the process towards publication of its next PNA.
26 June 2017	Health and Wellbeing Board.
23 August - 18 September 2017	Engagement (Stage 1) - Engaged with and gathered data and evidence from a wide range of stakeholders, including (but not limited to) those included in the required Statutory Consultation, patients and the public, commissioners, providers and their representatives to contribute to the revised Needs Assessment. 338 patients/members of the public and 19 stakeholders (a good response). Details of those consulted and results are outlined in PNA.
August - September 2017	Draft PNA 2018 produced.
15 November 2017 - 13 January 2018	Consultation (Stage 2) (including statutory consultees - NHS England, HAST CCG, Local Pharmaceutical Committee, Local Medical Committee, NHS Trusts and Healthwatch) for a minimum of 60 days* *A&G included as a consultee on the basis of its health scrutiny responsibilities. 121 patients/members of the public and stakeholders responses / comments received.
January 2018	Revise and update following consultation.
5 March 2018	HWB - Final approval.
12 March 2018	Finance and Policy Committee
Publication before the due date of the 25 March 2018.	

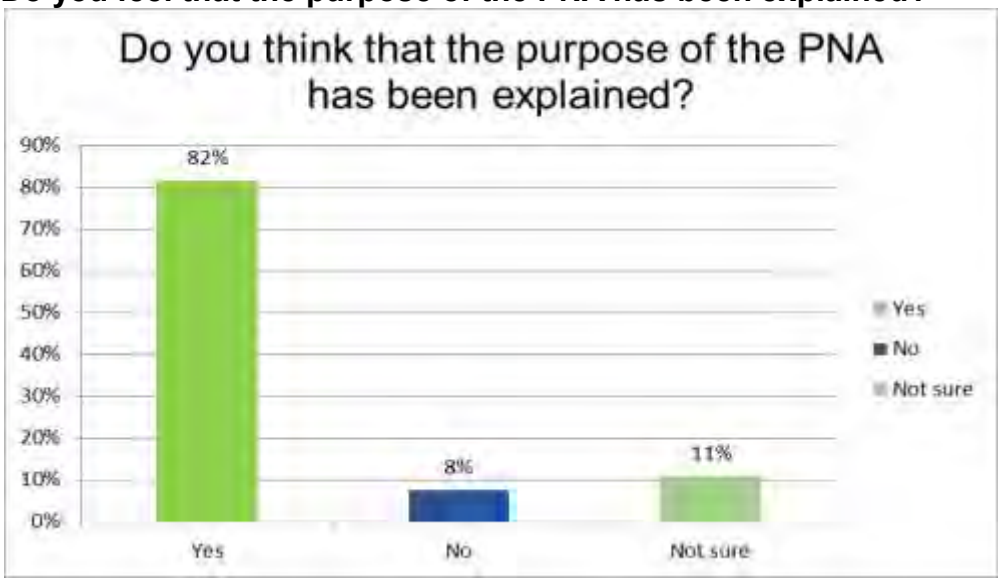
Appendix C

Hartlepool HWB Pharmaceutical Needs Assessment
60-day Formal Consultation from 15th November 2017 Summary and Feedback

Total number of responses received = 121[1] via the online consultation response form, plus 1 written response from NHS England.

- Comments received are quoted verbatim.
- It is not possible to link individual respondents across questions.
- Response to comments, on behalf of Hartlepool HWB are shown in italics.
- Where a consultation comment was considered to raise a query or require reflection on the content of the draft PNA, the response has included action taken to address this, or reasons why no amendment has been made.
- Where respondents skipped questions, this will be identifiable from the count reported for questions answered.

1. Do you feel that the purpose of the PNA has been explained?



n=119 responses

HWB response: this feedback is positively acknowledged

2. Do you have any further comments to add with regards to the purpose of the PNA?

N=10 respondents made free text comments other than answering that they had nothing to add, shown boxes below.

Please would this document include separate provision for the administration of Methadone/ needle exchange because it is very distressing for customers to listen to the foul and abusive language.
To justify a deteriorating service to the p*eople that pay for it whilst improving that for drug addicts.*

[1] N.B There were six responses to the PNA public consultation in 2011 and 14 responses in 2015

Commercial interests must play a large part in the delivery of services, but pharmacies can cherry pick the tasks they want to offer.
Appears to be little/no reference to quality of services provided. Named pharmacy is not fit for purpose due to serious delays in service (even when the pharmacy is devoid of any other patients), surly staff (I have twice witnessed customers being told to go elsewhere if they did not like the service provided) and prescriptions rarely completed in one visit (even though it is well past the prescription renewal date). *It is possibly not the purpose of this document to state the quality of service to be provided but I feel some standards need to be inserted.*
***Five** responses referring to the length of the document and/ or the need for a more accessible version.*

HWB response: responses acknowledged.
After publication, the HWB continues to seek and evaluate updated information by which it may identify and re-assess the impact of any potential changes to need, or the meeting of those needs.

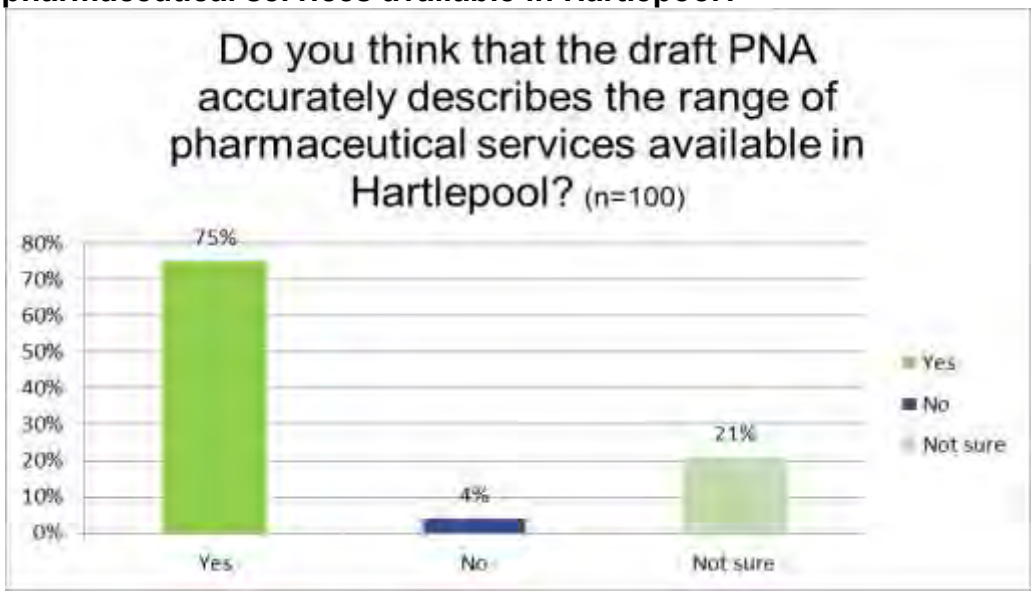
On-going work may seek a more detailed understanding of the views and experiences of patients, carers and their representatives as part of wider quality management and enhancement of local pharmaceutical and other services.

For the avoidance of doubt, it is not the main focus of this document to assess the quality of services provided; professional standards of pharmaceutical services are established by the General Pharmaceutical Council and contractual service specifications for essential services such as dispensing are monitored by NHS England. However, some aspects of service delivery could be considered to affect whether or not pharmaceutical needs continue to be met. Comments will be communicated to the profession locally.

The PNA is concerned with NHS services and local government contracted services considered to be equivalent for the purposes of the PNA. Financial viability may understandably influence service uptake of locally contracted services and may influence nationally contracted NHS services in all areas of primary care. However, the availability, or otherwise, of any locally contracted service is perhaps more likely to be influenced by commissioners' offer than the contractors' choice.

Comments on the length of the document are noted and understood; required content of the PNA is set out in legislation, and cannot be compromised. Nevertheless, it has been recognised that an accompanying guidance document that is shorter and more accessible, would be a valuable addition.

3. **Do you think that the draft PNA accurately describes the range of pharmaceutical services available in Hartlepool?**



4. **If no, please indicate and provide evidence where possible of any discrepancies.**
N=5 respondents made free text comments (other than N/A or similar) shown in boxes below.

Based on my own particular (and necessarily limited) experience
Hours of service recorded don't take into account the limited service such as standing outside at a window because the establishment has only 1
I am not aware of any pharmacies open after 5pm on a Saturday in Hartlepool
***Two** responses referring to the length of the document and/ or the need for a more accessible version.*

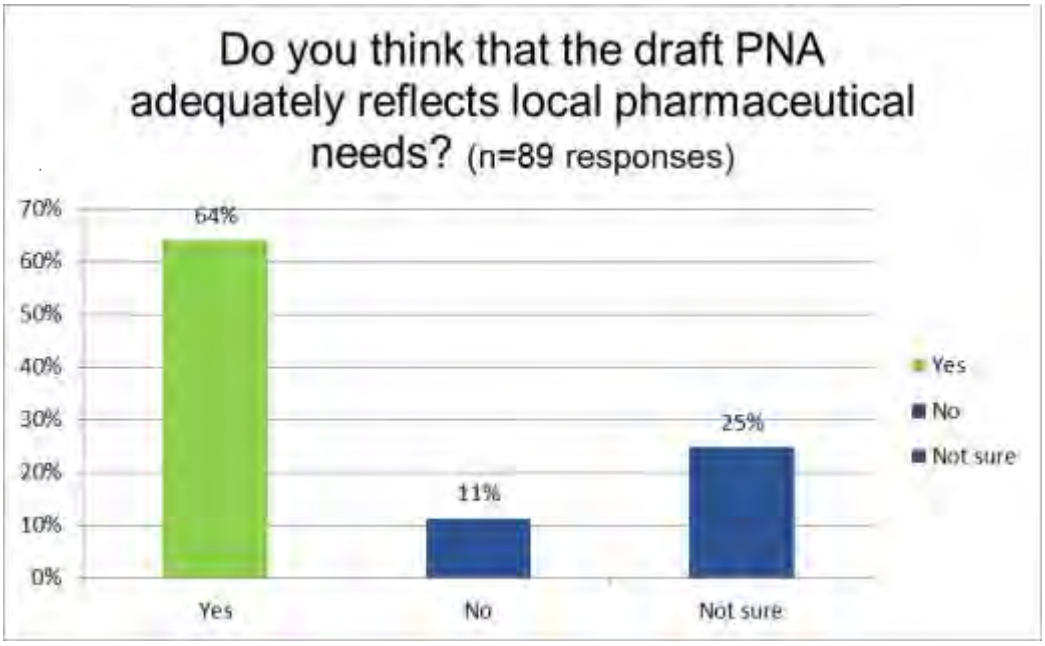
HWB response: this feedback is acknowledged.

After publication, the HWB continues to seek and evaluate updated information by which it may identify and re-assess the impact of any potential changes to need, or the meeting of those needs. Some aspects of service delivery could be considered to affect whether or not pharmaceutical needs continue to be met. Comments will be communicated to the profession locally.

As there are pharmacies providing services after 5pm on a Saturday in Hartlepool, this response may indicate that patient/ public understanding of the availability pharmacy services could be improved.

Comments on the length of the document are noted and understood as per response to question 2.

5. **Do you think that the draft PNA adequately reflects local pharmaceutical needs?**



6. **If not, what needs for pharmaceutical services should be included?**
N= 10 respondents made free text comments (other than N/A or similar, or repeating a statement exactly) shown boxes below.

We feel the current provision of pharmaceutical services within Hartlepool is adequate.

We do not agree that a locally commissioned service for minor ailments is a pharmaceutical need. The NHS is currently trying to reduce spend on treating conditions that are self-limiting or which lend themselves to self-care, to free resource to be used for other higher priority areas that have a greater impact for patients, support improvements in services and deliver transformation that will ensure the long-term sustainability of the NHS.

NHS England has recently launched a consultation on guidance with regards to the cessation of prescribing of medicines for self-limiting conditions which can be purchased over the counter. Hartlepool and Stockton-on-Tees CCG, in collaboration with CCGs across the region has developed guidance for prescribers in the form of a grey list and do not prescribe list to reduce prescribing of a number of products available to purchase over the counter.

We do not believe a locally commissioned service for gluten-free food is a pharmaceutical need. Gluten-free foods are now readily available from retail outlets who offer a range of products for purchase. The increase in demand has seen a significant reduction in cost to patients. The total cost to the NHS for these products can be up to ten times the price of a similar product in local shops. Hartlepool and Stockton-on-Tees CCG, in collaboration with CCGs across the region have implemented guidance which only supports prescribing of a specific number of units of staple gluten-free items for appropriate patients. All other gluten-free products, including luxury items should be purchased. NHS England undertook a national consultation on prescribing of gluten-free products in 2017.

Easier access to non prescription medicines. Stop the limit on paracetamol, etc.
Longer opening hours at pharmacies especially over weekends and bank holidays.
24 hour availability so Taxpayers (sic) can be supported whilst depriving access to….
Out of hours
If more pharmaceutical locations were available it may reduce the pressure on GP's and Hospital visits if people were encouraged to consult a pharmacist first.
Seems to dismiss rural need - although high car ownership the elderly most in need may not own car - and public transport patchy - Greatham well served but bus only passes through one end of village - some properties about a mile from stops.
Most of the pharmacies are under staffed and average wasting time for receipt of medcine from handing the prescription to receiving the medicine should be measured. My lastwo experiences cost me approx an hour each. Certain categories of service users are given precedence at the till e.g. drug addicts. Basically, until the actual customer service becomes more efficient and surgeries and pharmacists can both work together then much of what has been discussed in the draft proposal will have little effect.
***Two** responses referring to the length of the document and/ or the need for a more accessible version.*

HWB response: this feedback is acknowledged.

Comments on local commissioning of services to support patient self-care and management of minor ailments are acknowledged.
With respect to consideration of pharmaceutical need for these services; Pharmaceutical services identified as enhanced services in The Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013 (as amended) must be included in the PNA.

Both the “Gluten Free Food Supply Service, the underlying purpose of which is for P to supply gluten free foods to patients” and the “Minor Ailment Scheme, the underlying purpose of which is for P to provide advice and support to eligible patients presenting with a minor ailment, and where appropriate to supply drugs to the patient for the treatment of the minor ailment” are included in these Directions. They are pharmaceutical services that may be provided by pharmacy contractors and that the NHSCB (NHS England) is authorised to arrange for the provision of (with a pharmacy contractor).

It is reasonable to identify patients’ needs in respect of being able to access advice and treatment for minor ailments, and to access gluten free foodstuffs if their medical diagnosis requires that, wherever that advice and treatment is provided from i.e. from an NHS general practice or an NHS pharmacy contractor, or elsewhere.

As pharmaceutical services are included in Directions which might be commissioned to meet those needs, then those needs are correctly identified as pharmaceutical needs.

What must be assessed by the PNA is whether or not those pharmaceutical needs are met in a given area, taking into account (where applicable) those factors included in Schedule 1 to the 2013 Regulations i.e.,

- the different needs of different localities in its area
- the different needs of people in its area who share a protected characteristic and having regard to
- any other NHS services provided or arranged by a local authority, NHS England, a CCG, an NHS trust or an NHS foundation trust which affect

a) the need for pharmaceutical services, or pharmaceutical services of a specified type, in its area; or
b) whether further provision of pharmaceutical services in its area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area.

It is correct that NHS England undertook national consultation on prescribing of gluten-free products in 2017 (this was already referred to in the draft) and that they have also launched consultation on the prescription of medicines for self-limiting conditions or which can be purchased over the counter which will conclude in March 2018.

It is also true that there is now guidance for prescribers on issuing prescriptions for these products and those prescriptions will be more expensive for the NHS than patients purchasing their own, where they have the means to do so. These aspects fall under consideration of 'any other NHS services provided or arranged by NHS England…which affect the need for pharmaceutical services…of a specified type' in the area. Any reduced availability on prescription, for sound justification, might also affect 'whether further provision of pharmaceutical services …. would secure improvements, or better access, to ….pharmaceutical services of a specified type' in the area, particularly when having regard to the 'different needs of different localities, or the different needs of people who share a protected characteristic'. There is also a need, nationally identified, to encourage patients to self-care and to visit a pharmacy first in support of conditions that can be managed without the need for a visit to general practice (whether in hours or extended hours), or to an Urgent Care facility or (elsewhere other than Hartlepool) to call NHS111 or potentially to visit A&E.

This is what has been assessed in the PNA. It is for commissioners, national and local, to decide where their resources are allocated.

The assessment has considered hours of availability of pharmaceutical services, by locality, and found them to meet the needs of the population. Truly urgent needs for medicines in the hours when pharmaceutical services are not available are met in other ways. Again, better understanding of current opening hours may support this.

Bank holiday opening times are commissioned by NHS England.
Comments on waiting times will be communicated to the profession locally.
Pharmacies are already available in more locations and for longer hours than general practices. However, encouraging patients to visit a pharmacy first is to be supported.

The comments about rural need are acknowledged. The HWB is required to seek and evaluate updated information by which it may identify and re-assess the impact of any potential changes to need, or the meeting of those needs, after publication of the PNA. Updates and progress of construction against Local Plans are of particular import at this time of activity.

7. Are you aware of any pharmaceutical services provided in Hartlepool that are not currently included in the PNA?

Answer	% of answered	Count
Yes	5%	4
No	73%	61
Not sure	23%	19
Answered	-	84
Skipped	-	37

8. If yes can you please tell us what they are?
There was just one free-text comment other than N/A:

Only quickly read through very long document but are prescription deliveries considered - very important in rural area

HWB response: pharmaceutical services for prescription deliveries (current available as a non-NHS service) are included in the assessment.

9. Is there any other information which you feel should be included in the PNA?

Answer	% of answered	Count
Yes	12%	10
No	59%	50
Not sure	29%	25
Answered	-	85
Skipped	-	36

10. If yes please tell us what type of information...
N= 8 respondents made free text comments (other than N/A or similar, or repeating a previous statement exactly) shown boxes below.

We feel the PNA should reference national and local commissioning guidance as previously stated, particularly in relation to minor ailments and self-limiting conditions, and gluten-free foods.
How to complain about bad services and what to expect when you do complain.
Commercial interests and owners of individual pharmacies with costings for individual items of service.
How are you going to prevent comment suppressed and drug users getting their fix
Number of drug users who are putting particular pharmacists under pressure. Staffing. Customer service.
a list of pharmacists with a specialism/medical interest eg one who could discuss with confidence the side effects of certain medications
***Two** responses referring to the length of the document and/ or the need for a more accessible version.*

HWB response: feedback is acknowledged.

Specific reference to national and local commissioning guidance for prescribers has been included in the PNA, in relation to minor ailments and self-limiting conditions, and gluten-free foods.

It is not a requirement of the PNA to include how to complain about NHS services. The NHS Choices website has information about how to do this and any pharmacy will also offer advice on how to do this, even if it is about them.

Commercial interests are not required to be included in the PNA.

With regards to specialisms or medical interest, all pharmacies will be able to support patients with advice on any medicine-related issues, particularly if the issues are related to a condition that an individual patient has. An additional NHS Medicines Use review is available at virtually all pharmacies where a sit-down consultation can be provided.

11. Do you think that the process followed in developing the PNA was appropriate?

Answer	% of answered	Count
Yes	71%	60
No	4%	3
Not sure	25%	21
Answered	-	84
Skipped	-	37

12. Do you have any further comments on the process?

N=4 respondents made free text comments (other than N/A or similar) shown boxes below.

Stop the politically correct rhetoric
Very detailed
Only time will tell but I'm inclined to believe some systems are breaking down
not well enough publicised

13. Are there any current needs for pharmaceutical services that you consider are unmet?

Answer	% of answered	Count
Yes	16%	12
No	56%	43
Not sure	29%	22
Answered	-	77
Skipped	-	44

14. Do you have any further comments about current unmet pharmaceutical needs?

N=4 respondents made free text comments (other than N/A or similar) shown boxes below.

Pharmacies in Hartlepool need to be available overnight in addition to bank holidays and on Sundays as at present, pharmacies shut early on a Sunday and shut at 10pm on bank holidays

24 hour service for hard working families
Out of hours
Separate building for addics. Instead of preferential treatment (queue jumping).
Treatment services for Opiate dependent people could be more pro-active in engaging with those in need.
Option for students to share records and dispensing with a named establishment in both home and student town
There is insufficient provision of Pharmaceutical services gnerally in comparison to Stockton. In particular service at the Fens is lacking. The pharmacy at the Fens is overloaded with dispensing to the older population of the area which includes the Fens, Owton Manor estates etc.
Patients may have intermittent, undiagnosed symptoms which do not present whilst at the GP's or hospital. Quickly available tests at a Pharmacy could resolve this without having to bother paramedics etc.. For example a test for low blood sugar WHILST the symptoms are presenting would be really useful, even if a small charge was needed. I am sure that there are other examples.
The ability to fill out a prescription with more than one item fully and completely
I find a lack of supplies, lack of communication between service (eg script going electronically from GP) is a bad service and often wrong
Waiting times

HWB response: feedback is acknowledged.

Similar comments relating to opening hours were reflected in response to question 6.

With regard to students, aspects of the newly upgraded Summary Care Record access in pharmacies may support this.

Reference to diagnostic test-type services such as referred to above are included in the PNA and could offer improvement or better access.

Comments regarding waiting times and medicines shortages were also included in question 2; responses provided there apply. Comments will be communicated to the profession locally.

With respect to the Fens, again, after publication, the HWB continues to seek and evaluate updated information by which it may identify and re-assess the impact of any potential changes to need, or the meeting of those needs. On-going work may seek a more detailed understanding of the views and experiences of patients, carers and their representatives as part of wider quality management and enhancement of local pharmaceutical and other services.

15. Are there any 'near future needs' (within the next 3 years) unmet?

Answer	% of answered	Count
Yes	15%	12
No	42%	33
Not sure	43%	34
Answered	-	79
Skipped	-	42

16. Do you have any other comments with regards to near future unmet needs?

N=7 respondents made free text comments (other than N/A or similar) shown boxes below.

Out of hours
24 hour service for hard working families
The ability to fill out a prescription with more than one item fully and completely.
more separate areas for those with drug addiction problems
People using more medications will mean a better greater service needs to be offered
Must be reviewed every year to include new needs that may, and will, crop up.
As above, an extra pharmacy is required say at the St.Patrick`s Church area. The individual name suppressed is overloaded with trying to deal with the regular medication requirements of the Fens/Owton Manor. The addition of further housing at Caxton will exacerbate the problems.

HWB response: feedback is acknowledged.

Similar comments relating to opening hours were reflected in response to question 6. It is true that the trend is likely to continue for more people to use more medicines.

The PNA is subject to on-going review for assessment of new needs as previously described. Comments about the Fens area are also responded to for question 14 and are included in this.

17. Do you have any other comments about the Hartlepool Health and Wellbeing Board draft PNA?

N=8 respondents made free text comments (other than 'none'); shown boxes below.

We do not feel information in the draft PNA reflects the recent restructure of emergency care across the Hartlepool and Stockton-on-Tees geography.
In Autumn 2017, Stagecoach withdrew the bus service which was formerly routed along Elwick Road, providing access to the Town Centre. Given the demographic profile of the Burn Valley (North) Ward - where I myself live - do you consider this impacts the ability of residents (particularly the elderly and/or physically disabled) to access pharmaceutical services ?
Total and utter waste of money. It is an embarassment
The document produced is very comprehensive however it is a very long document to fully digest so the Executive Summary really needed to be more succinct.
Going to collect prescriptions from the chemists has become extremely stressful and certainly does Not improve my health and well being. Stop number crunching and get out there to appreciate the true issues
Purely on a cosmetic basis some of the headings need realigning and also pages 161 & 164 are virtually blank but appear to have been 'Page Break inserted' in error.
The Pharmacy at individual name suppressed is under constant pressure. If it were to close the impact on both patients and other pharmacies would be unacceptable.
NOT PEOPLE/READER FRIENDLY but not surprised by this

HWB response: these comments are acknowledged, cosmetic issues have been addressed.

There is no requirement for community pharmacy-based pharmaceutical services in relation to emergency care. The CCG was asked to clarify how the recent re-structure of emergency care across the HAST geography would be better represented in the PNA. Following their response, it was acknowledged that there is no option for patients to attend A&E in Hartlepool, but in Urgent Care, prescriptions that might be dispensed in a community pharmacy could be issued. Consequently, where the draft PNA had made reference to the possibility that a patient might inappropriately choose to attend A&E to be able to access a medicine for a minor condition free at the point of supply, this has been changed.

A service which better manages suitable low acuity conditions via pharmacy avoids the need for vulnerable groups to make an appointment with a GP, call NHS 111, or inappropriately attend Urgent Care (or in other areas even A&E) just to access such medicines for free. The patient survey for the PNA, although not a representative sample, did again indicate that financial constraints had sometimes required patients to use a GP/'A&E' unnecessarily.

Comments on the length of the document were noted and addressed in earlier responses.

The PNA is subject to on-going review for assessment of new needs as previously described. Comments about the Burn Valley and Fens area are noted.

18. I am answering these questions as: N= 74 answered of which:

- 64 patients (86% of responses)
- 1 pharmacy contractor
- 1 individual pharmacist i.e. not a representative of pharmacy contractor
- 1 local councillor in this HWB area
- 1 CCG representative
- 1 NHS Trust/NHS Foundation Trust representative
- 5 'any other health or social care professional'
- 3 'any other group/organisation not listed above'

Additionally, NHS England provided a response in the form of a letter, copied on the next page, and their feedback is acknowledged.

Appendix D

THE NATIONAL HEALTH SERVICE (PHARMACEUTICAL AND LOCAL PHARMACEUTICAL SERVICES) REGULATIONS 2013 – SCHEDULE 1 - REGULATION 4(1) - INFORMATION TO BE CONTAINED IN PHARMACEUTICAL NEEDS ASSESSMENTS

Necessary services: current provision

1. A statement of the pharmaceutical services that the HWB has identified as services that are provided—
(a) in the area of the HWB and which are necessary to meet the need for pharmaceutical services in its area; and
(b) outside the area of the HWB but which nevertheless contribute towards meeting the need for pharmaceutical services in its area (if the HWB has identified such services).

Necessary services: gaps in provision

2. A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied—
(a) need to be provided (whether or not they are located in the area of the HWB) in order to meet a current need for pharmaceutical services, or pharmaceutical services of a specified type, in its area;
(b) will, in specified future circumstances, need to be provided (whether or not they are located in the area of the HWB) in order to meet a future need for pharmaceutical services, or pharmaceutical services of a specified type, in its area.

Other relevant services: current provision

3. A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are provided—
(a) in the area of the HWB and which, although they are not necessary to meet the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area;
(b) outside the area of the HWB and which, although they do not contribute towards meeting the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area;
(c) in or outside the area of the HWB and, whilst not being services of the types described in sub-paragraph (a) or (b), or paragraph 1, they nevertheless affect the assessment by the HWB of the need for pharmaceutical services in its area.
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Improvements and better access: gaps in provision

4. A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied—
(a) would, if they were provided (whether or not they were located in the area of the HWB), secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area,

(b) would, if in specified future circumstances they were provided (whether or not they were located in the area of the HWB), secure future improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area.

Other NHS services

5. A statement of any NHS services provided or arranged by a local authority, the NHSCB, a CCG, an NHS trust or an NHS foundation trust to which the HWB has had regard in its assessment, which affect—
(a) the need for pharmaceutical services, or pharmaceutical services of a specified type, in its area; or
(b) whether further provision of pharmaceutical services in its area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area.

How the assessment was carried out

6. An explanation of how the assessment has been carried out, and in particular—
(a) how it has determined what are the localities in its area;
(b) how it has taken into account (where applicable)—
(i) the different needs of different localities in its area, and
(ii) the different needs of people in its area who share a protected characteristic; and
(c) a report on the consultation that it has undertaken.

Map of provision

7. A map that identifies the premises at which pharmaceutical services are provided in the area of the HWB.

Appendix E

NHS England

North (Cumbria and North East)
Waterfront 4,
Goldcrest Way,
Newburn,
Newcastle Upon Tyne,
NE15 8NY

10 January 2018

Private and Confidential
FAO: Joan Stevens, Statutory Scrutiny Officer
Statutory Scrutiny Officer
Hartlepool Borough Council
Civic Centre,
Victoria Road,
Hartlepool
TS24 8AY

Dear Joan

Ref: Feedback on Hartlepool Health and Wellbeing Board's PNA

Thank you for inviting NHS England (Cumbria and the North East) to comment on Hartlepool's Pharmaceutical Needs Assessment (PNA).

NHS England (Cumbria and the North East) recognises the work undertaken by Hartlepool's Health and Wellbeing Board in producing the draft PNA.

Upon NHS England (Cumbria and the North East) review of the draft PNA, it is noted that Hartlepool Health and Wellbeing Board has concluded the following points:

1. There is a good provision of opening hours offering essential pharmaceutical services available seven days a week with no gap in service that cannot be met from pharmacies located within the HWB area.
2. The range of core hours must be maintained, the two pharmacies that open for 100 hours per week are necessary providers of core hours, particularly at evenings and weekends.
3. Patient choice can only be made if patients are aware of those choices available to them. The PNA suggests that public information on pharmacy hours, services and location could be improved.
4. Local health needs of the Hartlepool area indicate that programmes to encourage behaviour change in terms of attitudes towards smoking, breast feeding, diet, alcohol and sexual should be an important feature of public health plans in the immediate and short term future.

NHS England would also like to bring to your attention two recent applications that have been approved in Hartlepool:

- Approval on appeal of a New Pharmacy Unforeseen Benefits Application - Within 100 metres of the retail parade, Middle Warren Local Centre, Hartlepool TS26 0BF - extant grant until 9 May 2018.
- Approval of a Relocation Application from 86a York Road, Hartlepool, TS26 9DA to 107 York Road, Hartlepool, TS26 9DH – extant grant until 2 August 2018.

I would like to add that NHS England (Cumbria and North East) looks forward to working closely with all other commissioners of NHS services in Hartlepool to ensure that community pharmacies continue to play their part in delivering high quality services and advice to all patients.

Yours sincerely

pp

Mrs Denise Jones
Head of Primary Care

North – Cumbria and North East
Waterfront 4
Goldcrest Way
Newburn Riverside
Newcastle upon Tyne
NE15 8NY

BY EMAIL ONLY TO:
All Health and Wellbeing Boards
in Cumbria and the North East *(see overleaf)*

23 January 2018

Dear Health and Wellbeing Board Colleague

Re: YOUR 2018 PHARMACEUTICAL NEEDS ASSESSMENT

NHS England North (Cumbria and the North East) is currently responding to all consultation drafts of the Pharmaceutical Needs Assessment (PNA) produced by the Health and Wellbeing Boards in the CNE area. This process has highlighted reference to the **NHS Urgent Medicine Supply Advanced Service (NUMSAS)** – to a greater or lesser extent – in PNAs.

Having sought advice from the national team of NHS England, we would like to remind local authorities that NUMSAS is only a **pilot service,** operational until September 2018. There is no certainty that this will become a permanent service thereafter.

Accordingly, we would respectfully suggest that you review your PNA and remove all reference to the service. However, should your Health and Wellbeing Board insist that NUMSAS is referenced in the PNA, please ensure that a qualifying statement is included regarding its pilot status.

Of course, if NUMSAS subsequently becomes a national, rather than pilot service, an update to the PNA could be made.

It would be helpful if you could acknowledge receipt of this letter by email, which should be sent to: ENGLAND.Pharmacyandoptometry@nhs.net).

Yours sincerely

Kenneth Youngman
Primary Care Commissioning Manager

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Joan Stevens	Hartlepool
Sue White	South Tyneside
Christine Jordan	North Tyneside
Catherine Scott Sue White	Gateshead

Appendix G

Extract from pages 14 – 20 of PNA 2018 - Without prejudice to the full content of the PNA, the summary conclusions are:

Following this assessment, the HWB considers that:

- the range of services provided and access to them is good; there are pharmacies within a few miles of the areas where people live, work or shop; there are some differences between localities which reflect the nature of their populations and environment.

- this good provision of essential pharmaceutical services is available seven days a week.

- the number of current providers of pharmaceutical services, the general location in which the services are provided, and the range of hours of availability of those services are necessary to meet the current and likely future pharmaceutical needs for essential pharmaceutical services in all localities of the Hartlepool HWB area. The dimensions of the existing service provision described above are also considered to meet the need in all localities, other than where described below.

- the pattern of opening hours are necessary and the HWB does not seek to change the pattern. In particular, for pharmaceutical needs to continue to be met, the range of core hours currently provided before 9 am and after 6pm on week days and all core hours on Saturday and Sunday must be maintained; the two pharmacies that open for 100 hours per week are necessary providers of core hours, particularly at evenings and weekends. They provide a substantial contribution to opening hours stability, and provision of locally contracted services; the HWB would not wish to see any of their opening times altered or reduced.

- the HWB considers that there is sufficient choice of both provider and services available to the resident and visiting population of all localities of Hartlepool including the days on which, and times at which, these services are provided

- having regard to all the relevant factors there are no current gaps in provision of necessary pharmaceutical services or other relevant services that could not be addressed through the existing contractors; no likely future needs have been identified that could not also be similarly addressed. There is therefore **no current or known future need for any new pharmacy contractor or appliance contractor** provider of pharmaceutical services in Hartlepool (other than the extant grant at Middle Warren).

The HWB further considers that:

- some few providers of pharmaceutical services outside the HWB area provide improvement and or better access in terms of choice of services, but these are not necessary services i.e. there is **no gap** in service that could not be met from pharmacies located within the HWB area.

With regards to advanced services commissioned by NHS England:

- an advanced pharmaceutical service for NHS seasonal flu vaccination is commissioned by NHS England. This service provides improvement or better access and additional choice for NHS patients who elect to attend a pharmacy for this service

- the advanced services for Medicines Use Review (MUR), New Medicines Service (NMS), Appliance Use Reviews/ Stoma Customization (AUR) and pilot NHS Urgent Medicine Supply Advanced Service (NUMSAS; subject to national evaluation) all provide improvement or better access to these pharmaceutical services

No gaps are identified in the provision of these advanced services.

With regards to other enhanced or locally commissioned services:

- extended hours for bank holidays are commissioned locally by NHS England and are currently **necessary**; **no gaps** are identified. Their on- going availability should be secured with regular and timely review to ensure the hours and services needed are commissioned, by direction if necessary

- antiviral distribution systems must be available in the event of a pandemic. NHS England may choose to use pharmacy or non-pharmacy providers but some planned service availability is **necessary** to meet the needs of the population of Hartlepool; **no gaps** are identified as current pharmacy contractors are willing to provide

- emergency hormonal contraception through pharmacies is a **necessary** pharmaceutical service; current and anticipated future population **needs are met** by the existing provision of a locally commissioned service (commissioned by Public Health via a sub-contracted arrangement)

- supervised self-administration of medicines for the treatment of drug mis-users, provided in pharmacies), is a **necessary** pharmaceutical service; current and anticipated future population **needs are met** by the existing provision of a locally commissioned service (commissioned by Public Health)

- with the configuration of the existing commissioned services to support individuals with their attempts to quit, the 'one stop' stop smoking service through pharmacies is a **necessary** pharmaceutical service providing choice alongside the specialist hub service; current population **needs are met** by existing provision of a locally commissioned service (commissioned by Public Health); **improvement or better access** is also achieved via established dispensing voucher pathways in pharmacies

- given the volume of activity in 2016-17, needle exchange via pharmacies is a **necessary** pharmaceutical service; current population **needs** are considered to be **met** by the existing provision of a locally commissioned service (commissioned by Public Health). Commissioners should monitor and evaluate capacity and service-user experience to ensure sufficient access and choice to accommodate future needs

- the locally commissioned Healthy Start Vitamin Service (commissioned by Public Health) is a **necessary** service which meets a statutory requirement and pharmaceutical need to make these vitamins available to eligible pregnant women and children aged 6 months to four years; current population **needs are met** and existing pharmacy contractors will be able to meet future demand

- the current locally commissioned pharmacy-based chlamydia testing service is considered to currently provide a **necessary** service for the population of Hartlepool. However, performance is currently low. Improvement or better access to this service could be afforded in the future by adding pharmacological 'treatment' in a pharmacy setting to the 'test only' current provision.

- there are opportunities for improvement or better access to the pharmaceutical services or other relevant locally contracted services that are offered, or could be offered, by existing community pharmacy providers. Such services could be locally commissioned as enhanced services by NHS England on behalf of other commissioning agencies, or they may be directly commissioned as locally contracted services should any commissioner elect to do so having identified a suitable resource allocation.

- the current locally commissioned C-Card condom distribution service re-launched with new formal sub-contracting arrangements following a recommendation in PNA 2015 has delivered **improvement or better access** to this service. Activity could be increased with additional promotion and service support.

- the CCG commissioned service which provides 'on demand' availability of specialist drugs (largely for palliative care) **provides improvement or better access** for patients; current population **needs are met** by existing provision but resilience should be assessed since the loss of contractor providers

- the Healthy Living Pharmacy (HLPs) initiative on Tees has enabled participating pharmacies to more actively engage with the public health agenda and provide improvement or better access to the essential pharmaceutical services that relate to this i.e. public health (via brief interventions, sometimes known as MECC, Making Every Contact Count) and support for self-care in a preventative context. The culture of HLP in supporting health improvement and developing health communities suggests further **improvement or better access** to a range of pharmaceutical services (commissioned locally) could be provided via pharmacies as HLP is now embedded and accredited at a national level.

- several other pharmaceutical services have been identified in section 11.6 as having the potential to provide improvement or better access to pharmaceutical services in response to current or likely future needs should a commissioner elect to commission them in the evolving climate of the FYFV and service integration under STPs.

- there is potential to provide improvement or better access to the support provided to patients in the borough to manage low acuity conditions or minor illnesses. A recent publication indicates which minor ailments may be

appropriate to be directed for management within community pharmacy. (Nazar H N. Z., 2018). The study reported that approximately 35,000 patients (11.5% of total) could have been shifted away from the higher cost settings in the North East region alone during February-August 2016. This shift may be particularly possible in Hartlepool where levels of deprivation impact significantly on individuals' ability to look after their own health and well-being.

- Where there is no service pathway outside of general practice or urgent care to support this, a current gap in provision in this 'other relevant service'[4] is identified. Meeting this potential gap would not require any new pharmacy premises, but some form of commissioned service whose scope may be determined for at least some conditions, on some days or times and at some locations in Hartlepool, particularly for those of the population whose needs are greatest or most urgent and where those needs could be justifiably managed by community pharmacy. The assessment is complicated as

    - in 2016, NHS England stated that "minor ailments services are already commissioned by clinical commissioning groups (CCGs) across many parts of the country and ultimately NHS England will encourage all CCGs to adopt this joined-up approach by April 2018, building on the experience of the urgent and emergency care vanguard projects to achieve this at scale" (NHS England, 2016).
    - NHS England also have initiated a consultation on-going to March 2018 on reducing access on prescription to medicines that are available at 'low cost' to purchase over the counter. However, guidance following this is consultation is some time away at this stage, and the impact on minor ailments services is uncertain.

- HAST CCG Operational Plan 2016 includes a statement to "review current service provision for minor ailments". Their response to the draft PNA indicated they did not consider that a pharmacy minor ailments service was a pharmaceutical need.
    - this overlapped in time with NHS England reported intent to "test the technical integration and clinical governance framework for referral to community pharmacy from NHS 111 for people who need immediate help with urgent minor ailments where this is appropriate for community pharmacy" (NHS England, 2016).
    - testing began in the north east (commissioned by NHS England) in December 2017 so the future availability of this particular 'other relevant service' will depend on commissioning decisions made once the outcome of the service test is known; evaluation may support further understanding of local issues involved in the implementation of such a scheme. Any new information which may affect the assessment of need in the PNA will need to be considered at that point.

Additionally, to maximize the potential for pharmacy to impact on reducing the substantial health inequalities of the people of Hartlepool, commissioners should seek to be assured of the highest standards of quality and performance from all pharmacies providing, or intending to provide, existing pharmaceutical services or locally contracted services. To do this requires all local partners, commissioning organisations and other agencies to:

- improve public and professional access to accurate and timely information on pharmacy opening hours, services and location including the widespread availability of confidential consultation facilities
- continue to seek opportunities to promote underused essential services including NHS repeat dispensing, support for self-care and brief advice, signposting and public health campaigns

- seek to work more closely with all providers of pharmaceutical services to improve or provide better access to such services via new or improved service pathways e.g., hospital referral to pharmacy schemes (Transfer of Care) and opportunities arising from Sustainability and Transformation Plans

- continue to seek to maximize benefit from all the advanced services, including those at the pilot or testing stage

- continue to review and maintain accreditation processes for locally contracted services to ensure flexibility and fitness for purpose

- make best use of opportunities for quality improvement, audit and evaluation, contract management and performance monitoring including the national Contractual Framework; sharing both best practice and lessons learned from patient safety incidents across all pharmaceutical services and locally commissioned equivalents

- maintain opportunities to incorporate the Royal Pharmaceutical Society Professional Standards for Public Health Practice for Pharmacy into public health services, kitemarks and contracts to support public confidence in service provision.

Realising the benefits of community pharmacy services to meet the needs of the population will depend on the availability of sound evidence, service evaluation, fair cost-effectiveness comparisons and close working between all local commissioners i.e. NHS England, CCGs, local authority public health teams and ultimately Sustainability and Transformation Partnerships (STPs) as Accountable Care Systems (ACS). There is an opportunity to develop a rolling programme of engagement and evaluation of the potential contribution of pharmaceutical services to supplement the statutory processes and support commissioning decisions.

It may be helpful to produce an easy read guide to the PNA in due course to better enable the content of the PNA to be used by anyone (including LA or NHS officers, any healthcare or other professional, other stakeholders, patients or members of the general public) that may wish to know or understand more about the need and provision of pharmaceutical services to the population of Hartlepool.

Finally, Hartlepool Health and Wellbeing Board recognises the requirement to maintain processes to manage

- the response to requests from NHS England for representation on applications to provide new pharmaceutical services, or amend existing

provision, including the potential application for consolidation of pharmacy contractors[5]

- the activity that supports on-going maintenance of the PNA, including the publication of Supplementary Statements and subsequent timely reviews, including, where necessary, in response to identified changes in need.

How will it be used?

Once published, this PNA will be used by NHS England in their decision-making process when applying the Regulations to the process of application to, and management of, the Pharmaceutical List. PNAs are the basis for determining market entry to NHS pharmaceutical services provision. The Cumbria and North East Sub Region of NHS England undertake these statutory processes and the HWB must make the PNA and associated Supplementary Statements available to them.

There are also new duties introduced since the 2015 PNA. National funding for community pharmacy was recently reduced by 6% (NHS England, 2016) and it is recognised nationally that some pharmacies might close as a result. Some new amendments to the Regulations were introduced in December 2016 (Department of Health, 2016) to allow two pharmacies to make an application to merge and provide services from one of the two current premises.

As a result, HWB's have also now been given two new statutory duties:

1. When NHS England notifies a HWB about an application to consolidate two pharmacies, the HWB must respond and make a statement or representation to NHS England within 45 days stating whether the consolidation would or would not create a gap in pharmaceutical services provision. NHS England will then convene a panel to consider the application to consolidate the two pharmacies, taking into account the representation made by the HWB.

2. Once NHS England has made a determination on the application to consolidate two pharmacies, it will inform the HWB. The HWB must then
   (a) publish a supplementary statement reporting that removal of the pharmacy which is to close from the Pharmaceutical List will not create a gap in pharmaceutical services; and then
   (b) update the map of premises where pharmaceutical services are provided (Regulation 4(2)).

The PNA may be used by anyone (including LA or NHS officers, any healthcare or other professional, other stakeholders, patients or members of the general public) that may wish to know or understand more about the need and provision of pharmaceutical services to the population of Hartlepool.

HEALTH AND WELLBEING BOARD

5th March 2018

Report of: Director of Children's and Joint Commissioning Services

Subject: CHILD PROTECTION – INFORMATION SHARING PROJECT

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1. PURPOSE OF REPORT

1.1 To brief Health and Wellbeing Board on the Child Protection – Information Sharing (CP-IS) project and plans for implementation in Hartlepool.

2. BACKGROUND

2.1 The CP-IS system is designed to improve information sharing between local authorities and health service providers to protect vulnerable children. It was developed in response to learning from serious case reviews which identified that information sharing is critical to the protecting children from harm.

2.2 There are 152 local authorities and more than 1,200 unscheduled healthcare settings in England (such as emergency departments, walk-in centres, and maternity units) using more than 75 different computer systems. The CP-IS system connects these systems helping organisations to improve business processes so essential information can be shared securely.

2.3 The CP-IS system works by ensuring that health and social care staff are notified when a child or unborn baby with a child protection plan (CPP) or looked after child (LAC) status is treated at an unscheduled care setting. On a daily basis information is uploaded automatically from children's social care systems to the NHS Spine. This means that when a child is booked in at an unscheduled health care setting that has CP-IS, staff are alerted that the child is either looked after or subject to a protection plan and provides health staff with contact details for the social care team responsible. Parallel to this, social care teams are automatically alerted that the child has presented at an unscheduled care setting and staff in all organisations can see details of the child's previous 25 visits to unscheduled care settings.

3. PROPOSALS

3.1 About four years ago, officers from Hartlepool Borough Council (HBC) met with the CP-IS implementation team regarding implementing CP-IS in Hartlepool. However, due to the social care system used in Stockton, which was not compatible with CP-IS, implementation in Hartlepool was not progressed to avoid the risk of a two tiered system for health providers.

3.2 In recent months, momentum for the implementation of the CP-IS system has picked up and HBC is being encouraged to implement the system as CP-IS is now part of the NHS Standard Contact and North Tees and Hartlepool NHS Foundation Trust (NTHFT) no longer need to wait for local authorities to go live.

3.3 In order to implement the CP-IS system, the council and health providers will need to work with the CP-IS implementation team and, as long as the IT systems are appropriate to support CP-IS, the process will take around six weeks.

3.4 Officers from HBC have met with NTHFT and Stockton Borough Council to begin planning for implementation of CP-IS. NTHFT have a contractual requirement to implement the system and can progress without impact on the Local Authorities. There will be regular meetings of NTHFT, HBC and SBC to progress implementation and this will be dependent upon a number of factors including the procurement of middleware by NTHFT which will support their implementation of CP-IS. Until this is achieved, no specific dates for Go Live can be agreed.

3.5 HBC will need to gather and record NHS numbers for at least 95% of the CP and LAC cohort prior to implementation of CP-IS.

4. RISK IMPLICATIONS

4.1 The implementation of the CP-IS system is designed to improve the arrangements for the protection of children at risk.

4.2 The CP-IS system has been implemented in a number of local authorities and health settings therefore the risk associated with implementation are low. Implementation will place additional pressure on management information teams to ensure the system is implemented and working correctly, therefore the timing of implementation needs to take into consideration other commitments.

5. FINANCIAL CONSIDERATIONS

5.1 There are no financial implications arising from this report. HBC's social care system has the functionality required for CP-IS, however, there will be an implementation cost from Liquidlogic.

6. LEGAL CONSIDERATIONS

6.1 There are no legal considerations arising from this report. All legal requirements in relation to implementing an information sharing system have been addressed by the CP-IS development team.

7. EQUALITY AND DIVERSITY CONSIDERATIONS

7.1 There are no equality and diversity considerations arising from this report.

8. STAFF CONSIDERATIONS

8.1 There are no staffing considerations arising from this report.

9. ASSET MANAGEMENT CONSIDERATIONS

9.1 There are no asset management considerations arising from this report.

10. RECOMMENDATIONS

10.1 Health and Wellbeing Board is asked to note the contents of this report and the plan to implement the CP-IS in Hartlepool

11. REASONS FOR RECOMMENDATIONS

11.1 The implementation of the CP-IS will strengthen the arrangements to safeguard children in Hartlepool.

12. BACKGROUND PAPERS

12.1 None

13. CONTACT OFFICER

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HEALTH AND WELLBEING BOARD

5th March 2018

Report of: Director of Children's and Joint Commissioning Services

Subject: SEND (SPECIAL EDUCATIONAL NEEDS AND DISABILITIES) IMPROVEMENT

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1. PURPOSE OF REPORT

1.1 To share with members of the Health and Wellbeing Board the progress of the SEND Improvement Plan following the Area SEND Inspection which took place in October 2017.

1.2 To ensure that all partners are committed to supporting the implementation of the statement of action.

2. BACKGROUND

2.1 The Special Educational Needs and Disability (SEND) provisions in the Children and Families Act 2014 were introduced on 1 September 2014. This act sets out duties for all partners with a particular focus on the local authority, CCG (Clinical Commissioning Group) and education providers. From September 2014, children or young people who are newly referred to a local authority for assessment are considered under the new Education, Health and Care (EHC) plan assessment process.

2.2 An EHC plan details the education, health and social care support that is to be provided to a child or young person who has Special Educational Needs (SEN) or a disability. It is drawn up by the local authority in consultation with relevant partners. The EHC plan sets out the child's needs and the extra help they should receive.

2.3 The legal test of when a child or young person requires an EHC plan remains the same as that for a statement under the Education Act 1996. Transferring children and young people with statements of SEN to EHC plans has had a phased approach with all transfers having to be completed by March 2018.

2.4 In addition, the previous 'School Action' and 'School Action Plus' categories have been replaced by a new category 'SEN support'. All transfers to this category had to take place by 2015. The children or young people identified in this category receive extra or different help from that provided as part of the school's usual curriculum. The class teacher and special educational needs co-ordinator (SENCO) may receive advice or support from outside specialists.

2.5 The SEND code of practice: 0 to 25 gives detailed information on the reforms. The Code of Practice provides guidance to help the Local Authority, schools, health services and social care more identify children with SEN.

2.6 A joint local area SEND Inspection took place 3rd October 2017 – 7th October 2017. The report sets out strengths and areas of development as attached as **Appendix A.** The Local Authority and CCG were notified in January 2017 that serious weaknesses had been identified within the inspection and the local area was required to produce a statement of action.

3. STATEMENT OF ACTION

3.1 The recommendations within the inspection letter were:

1. Inconsistencies in the timeliness and effectiveness of the local area's arrangements for identifying and assessing children and young people's special educational needs and/or disabilities
2. Weaknesses in providing the clear and timely information, advice and support that families need
3. Weaknesses in the strategic joint commissioning of services for children and young people who have special educational needs and/or disabilities
4. Weaknesses in the monitoring of the effectiveness of services in improving outcomes for children and young people who have special educational needs and/or disabilities

3.2 The action plan is attached as **Appendix B** which sets out the detailed actions and progress. The following sets out an …… update of the recommendations highlighted above:

1. Inconsistencies in the timeliness and effectiveness of the local area's arrangements for identifying and assessing children and young people's special educational needs and/or disabilities.

   The Code of Practice sets out that "the whole process of EHC needs assessment and EHC plan development, from the point when an assessment is requested until the final EHC plan is issued, must take no more than 20 weeks (subject to exemptions.)"

At the point of the inspection there were only …….% being completed within the 20 week timescale. Work has been undertaken to establish protocols with partners to ensure that agencies work together in a timely manner. These protocols have been put in place and the percentage of plans issued within the 20 weeks as at Dec 2017 was 61%. This continues to be monitored.

2. Weaknesses in providing the clear and timely information, advice and support that families need

   The inspection identified that there were some families that felt that the information they were provided about the support they could expect was lacking and felt that the offer was not clear.

   Work has been undertaken to review the Early Help offer to ensure that children with additional needs are identified at the earliest possible opportunity. This will allow parents to understand what support is available for them. Work is ongoing with the parent led forum to develop this information in an accessible format.

   Work is also ongoing to develop an ASD (Autistic Spectrum Disorder) Pathway which the CCG are leading on. This work is proving challenging and is being developed across Hartlepool and Stockton.

3. Weaknesses in the strategic joint commissioning of services for children and young people who have special educational needs and/or disabilities

   A joint commissioning statement of intent is currently being developed between the Local Authority, CCG and schools to be completed by the end of March. A questionnaire has been circulated to schools to identify areas that they feel should be priority for collaborative commissioning. A project group has been established to drive this area of work.

4. Weaknesses in the monitoring of the effectiveness of services in improving outcomes for children and young people who have special educational needs and/or disabilities.

   It was highlighted in the inspection that the local area did not have an effective process to capture information to inform whether provision was meeting children's needs and whether services were improving outcomes for children with additional needs. A number of pieces of work have been undertaken to improve this:
   - *The Local Authority, CCG and health providers have worked to develop information sharing protocols and processes to ensure that all providers now who has an EHC plan and can track this within their systems.*

- *The Local Authority has procured a children's system that can capture EHC information which will allow progress to be tracked. This system (EYES) is expected to be in place from April 2018.*
- *A review of the EHC plan paperwork has taken place with partners agreed to use the preparing for adulthood themes for the integrated outcomes framework*

4. RISK IMPLICATIONS

4.1 There is a risk that if partners do not work together to implement the recommendations that the Secretary of State will intervene.

5. FINANCIAL CONSIDERATIONS

5.1 There are no specific financial considerations within this report.

6. LEGAL CONSIDERATIONS

6.1 There are no specific legal considerations within this report, however all partners must ensure they are meeting their duties within the Children and Families Act 2014.

7. EQUALITY AND DIVERSITY CONSIDERATIONS (IMPACT ASSESSMENT FORM TO BE COMPLETED AS APPROPRIATE.)

7.1 The services discussed in this report support children with additional needs.

8. STAFF CONSIDERATIONS

8.1 There are no staff considerations within this report.

9. ASSET MANAGEMENT CONSIDERATIONS

9.1 There are no asset management considerations within this report.

10. RECOMMENDATIONS

10.1 That members of the Health and Wellbeing Board note the progress of the SEND Improvement Plan.

10.2 That members of the Health and Wellbeing Board reflect on their duties for children under the Children and Families Act 2014 to ensure that children with SEND are supported as appropriate.

11. REASONS FOR RECOMMENDATIONS

11.1 To ensure that children with SEND are appropriately supported.

12. BACKGROUND PAPERS

SEND Code of Practice
https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

13. CONTACT OFFICER

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10 October 2016

Ms Sally Robinson
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Ali Wilson, Hartlepool and Stockton-on-Tees clinical commissioning group chief officer

Danielle Swainston, local area nominated officer

Dear Ms Robinson

Joint local area SEND inspection in Hartlepool

During 3 October to 7 October 2016, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of the local area of Hartlepool to judge the effectiveness of the area in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014.

The inspection was led by one of Her Majesty's Inspectors from Ofsted, with team inspectors including an Ofsted Inspector and a Children's Services Inspector from the Care Quality Commission (CQC).

Inspectors spoke with children and young people who have special educational needs and/or disabilities, parents and carers, representatives of the local authority and National Health Service (NHS) officers. They visited a range of providers and spoke to leaders, staff and governors about how they were implementing the special educational needs reforms. Inspectors looked at a range of information about the performance of the local area, including the local area's self-evaluation. Inspectors also met with leaders from the local area for health, social care and education. Inspectors reviewed performance data and evidence about the local offer and joint commissioning.

As a result of the findings of this inspection, and in accordance with the Children Act 2004 (Joint Area Reviews) Regulations 2015, Her Majesty's Chief Inspector of Education, Children's Services and Skills (HMCI) has determined that a Written Statement of Action is required because of significant areas of weakness in the local area's practice. HMCI has also determined that the local authority and the area's clinical commissioning group (CCG) are responsible for submitting the Written Statement of Action to Ofsted.

This letter outlines the findings from the inspection, including some areas of strength and areas for further improvement.

Main findings

- The impact of leaders on the quality of services for children and young people who have special educational needs and/or disabilities in Hartlepool varies widely. Consequently, the experiences and outcomes for different groups of children and young people, and their families, in relation to education, care and health are too variable.
- Inspectors found some examples of effective practice in education, care and health services that enrich and enhance the lives of children and young people. Conversely, weaknesses in monitoring and evaluating the effectiveness of other aspects of the same services mean that leaders are, at times, not well enough informed to intervene quickly when improvement is needed.
- The needs of the youngest children and those who have complex health needs are identified and assessed effectively and in a timely way. Education, health and care provision for these children and young people is flexible and highly personalised. As a result, they are achieving better outcomes.
- Many families told inspectors that they do not know how to get the help and support their children need. Some families told inspectors that they find the local area's arrangements confusing and, at times, frustrating, as a result of long waiting times and because their views are not always heard or valued.
- Although, compared with the national picture, a high proportion of existing statements of special educational needs have been converted to education, health and care plans in a timely way, too few new assessments are completed within the required 20-week timescale.
- Health leaders' analysis of children and young people's needs is limited, and the local area's approach to jointly commissioning services is not focused on the difference these services will make to children, young people and their families.
- Leaders do not have a clear view of how well the local area improves outcomes for children and young people who have special educational needs and/or disabilities. This is because the outcome measures in plans focus on what services will be delivered and not on the difference these services will make.
- Inspection evidence indicates that children and young people who have special educational needs and/or disabilities are kept safe and protected from harm. However, leaders do not routinely evaluate the effectiveness of the local area's safeguarding arrangements for this key group of children and young people. Consequently, leaders do not know what is helping the children and young people to feel safe in Hartlepool and what could be improved.
- Inspectors recognised the deep commitment of frontline staff who work with children and young people who have special educational needs and/or disabilities. This was echoed by many families who shared their views with inspectors.

The effectiveness of the local area in identification of children and young people who have special educational needs and/or disabilities

Strengths

- The needs of the youngest children who have special educational needs and/or disabilities are identified quickly and accurately as a result of effective work in newly formed teams of community-based education, health and care professionals. The use of early help assessments provides these children with timely and well-targeted support.
- Children's centres provide the communities they serve with access to a range of services that support timely identification and assessment of children's needs. Effective training and development is helping staff to spot more quickly children whose development is atypical.
- Parents and carers report that children's education and care needs are identified and assessed effectively through the autism transition pathway. Much is done to work out how best to support Years 5 and 6 pupils so that they are ready for the move to secondary school.
- Children with complex health needs are identified effectively. Care coordination plans successfully capture the voice of children and young people, for example: 'I find lumpy foods difficult so please give me smooth food and thickened fluids.' This helps professionals to understand what is important to each child and know how best to support them.
- Professionals in schools and settings are knowledgeable about what makes children and young people who have special educational needs and/or disabilities vulnerable and how to protect them from harm and keep them safe and well.

Areas for development

- Leaders' understanding of families' experience of identification and assessment is limited. There are too few opportunities for families to be heard and not enough consideration is given to what they say, for example at the point of, or indeed following, diagnosis.
- Many families told inspectors that the systems for identifying and assessing children and young people's needs are confusing and hard to access. These systems were described by parents and carers as 'opaque' and needing to be 'simplified and explained'. Too often, families have to repeatedly 'tell their story' to health professionals in different settings.
- Too few assessments are completed within the statutory timescales. When compared to the national average, the proportion of assessments completed within the required 20-week period is low.
- The impact of training in the disability and special educational needs reforms is too variable. For example, while leaders are confident about the knowledge and skills of health services staff, they do not monitor the impact of training and

development on the identification of children and young people who have special educational needs and/or disabilities.

- The existing mechanism for sharing information about checks completed by early years practitioners and health visitors is not robust. This limits the effectiveness of the local area's arrangements for identifying children and young people's additional needs.
- Leaders in the local area do not evaluate the effectiveness or impact of arrangements for identifying and assessing the needs of specific groups of children and young people, for example those who have special educational needs and/or disabilities who are also looked after by the local authority.

The effectiveness of the local area in assessing and meeting the needs of children and young people who have special educational needs and/or disabilities

Strengths

- Jointly commissioned education, health and care services are effectively meeting the complex health needs of some individual children and young people.
- The range of short breaks provision is greatly valued by children and young people and their families because it is flexible, needs-led and highly personalised. Similarly, carers' grants are used creatively and flexibly to provide valuable help and support for families.
- In the 19 to 25 age range, well-planned and effectively coordinated learning programmes are helping some young people with severe and complex needs to develop their independence and work-related knowledge and skills. This includes work experience, work placements and supported internships. Expectations for these young people are high, and a determined and purposeful drive helps them to achieve better lives.
- The 'all about me' section of education, health and care plans is consistently and effectively co-produced with children, young people and their families. One parent told inspectors, 'It is like my son has written it himself ... it is not like a medical journal.' Children and young people themselves say that these plans help other people to understand what is important to them.
- Families who use the local area's special educational needs and disabilities information, advice and support service (SENDIASS) say that they have received invaluable help, enabling them to have a stronger and more influential voice.
- There are many good examples of schools working individually or together to develop new provision which meets children and young people's needs well, for example by using specialist training and support from speech and language therapists to develop staff knowledge and skills and improve children's learning and development.

- Children and young people who have special educational needs and/or disabilities are supported well by the occupational therapy and physiotherapy services to access the specialist equipment they need.
- Children and young people with diabetes are supported well by dedicated children's community nurses. Case studies show that children with diabetes and their families are supported effectively when they move from primary to secondary school and from children's to adults' services.

Areas for development

- The process for checking the quality of education, health and care plans is applied inconsistently. The health outcomes in these plans are imprecise and do not always link with the assessments of children and young people's needs. Plans for some of the children who have special educational needs and/or disabilities who are also looked after by the local authority do not align well with their personal education plans. Consequently, reviews of their plans are sometimes superficial.
- Of the families who spoke with inspectors, very few knew about the local offer or how to get help and advice in the local area. Many are heavily reliant on others to help them make sense of the resources and support that are available. Some parents and carers described feeling particularly vulnerable and isolated at the point of their child's diagnosis.
- Children with additional needs who receive care from a number of health services do not always benefit from a coordinated approach to assessing and meeting their needs. This episodic and condition-led approach inhibits the development of joined-up healthcare planning and leads to a lack of clarity for parents. For example, children and young people on the autism diagnostic pathway can wait for 10 to 12 months for a diagnosis, and too many families experience long waiting times for speech and language therapy or to see a paediatrician.
- Transition arrangements for children and young people who have special educational needs and/or disabilities moving from paediatric to adult health services are not always well supported. While there are strong arrangements for some children and young people, transition arrangements for others are less effective.
- Leaders do not make the best use of some of the strongest and most valuable resources in the local area to improve the quality of services. Highly effective practice resides within individual services, settings and schools and too little is done to help professionals 'learn from the best'. Similarly, leaders do not give sufficient prominence to the views of children, young people and families in evaluating what is working well and where improvement is needed.
- Inspectors identified weaknesses in leaders' understanding of the effectiveness and impact of specialist provision. The local area has been too slow to develop an approach to commissioning services which is sharply focused on improving outcomes for children and young people who have special educational needs

and/or disabilities. This includes poor arrangements for providing personal health budgets.

The effectiveness of the local area in improving outcomes for children and young people who have special educational needs and/or disabilities

Strengths

- Rates of progress of primary-aged children who have special educational needs and/or disabilities in reading, writing and mathematics are comparable with, and sometimes better than, those for other children nationally with similar starting points.
- Individual health services are working well to improve the health outcomes of children and young people who have special educational needs and/or disabilities.
- Services are provided sensitively and with care and compassion. Short breaks provision effectively helps children and young people to develop their confidence, independence and skills away from their families.
- Well-planned, coordinated and highly personalised learning programmes are effective in supporting young people in the 19 to 25 age range to develop their functional skills, lifeskills and work-related learning skills. This, importantly, improves their independence and employability.

Areas for development

- The outcome measures in education, health and care plans tend to focus on what services will do for children and young people and not on the difference these services will make. As a result, leaders do not know how well the local area improves outcomes for children and young people who have special educational needs and/or disabilities.
- Leaders in the local area do not analyse outcomes for children and young people who have special educational needs and/or disabilities rigorously enough. The learning and progress of children and young people with different needs, and those who are also looked after by the local authority, are not systematically analysed. This means that leaders cannot evaluate the effectiveness of provision on key groups of children and young people, which weakens future planning.
- Leaders' understanding about what is helping children and young people who have special educational needs and/or disabilities to feel safe in Hartlepool is not well developed because leaders do not routinely seek their views.
- The progress of children and young people who have special educational needs and/or disabilities in secondary schools is not as strong as it is in primary schools. While some young people achieve outcomes which help them to be well prepared for the next stage of their learning and their adult lives, others do not. Comparative analysis of the learning outcomes of young people who have special educational needs and/or disabilities in the 16 to 25 phase is lacking.

- Levels of absence, persistent absence and fixed-term exclusion for children and young people who have special educational needs and/or disabilities are too high, especially in the secondary phase, when compared with the national averages for all pupils. Leaders are not doing enough to increase levels of attendance and reduce fixed-term exclusions.
- The existing arrangement for the role of designated medical officer or designated clinical officer in the local area is not providing the influence needed to ensure better health provision and improved outcomes for children and young people who have special educational needs and/or disabilities.

The inspection raises significant concerns about the effectiveness of the local area.

The local area is required to produce and submit a Written Statement of Action to Ofsted that explains how the local area will tackle the following areas of significant weakness:

- inconsistencies in the timeliness and effectiveness of the local area's arrangements for identifying and assessing children and young people's special educational needs and/or disabilities
- weaknesses in providing the clear and timely information, advice and support that families need
- weaknesses in the strategic joint commissioning of services for children and young people who have special educational needs and/or disabilities
- weaknesses in the monitoring of the effectiveness of services in improving outcomes for children and young people who have special educational needs and/or disabilities.

The approach to responding to findings from inspections, including the production and review of the statement, is set out in Annex A of the local area SEND inspection handbook.

Yours sincerely

Nick Whittaker
Her Majesty's Inspector

Ofsted	Care Quality Commission
Cathryn Kirby HMI Regional Director	Ursula Gallagher Deputy Chief Inspector, Primary Medical Services Children, Health and Justice.
Nick Whittaker HMI Lead Inspector	Elaine Croll Children's Services Inspector
Liz Cornish Ofsted Inspector	

CC: Clinical Commissioning Group
Director, Public Health for the Local Area
Department for Education
Department of Health
NHS England

Hartlepool Borough Council & Hartlepool and Stockton-on-Tees Clinical Commissioning Group
SEND Action Plan UPDATE DECEMBER 2017

1. Develop an Integrated Early Help pathway that identifies needs at the earliest possible opportunity and where families are supported. Produce a visual representation of the pathway that parents understand and use to access the support they need when they need it.

Objective	Specific Actions	By Whom?	By When	Progress
1.Review and consolidate previous pathways/process maps and standardise a child's / parent's / carer's journey from early identification through to statutory support	Initial development session with Health Visitors, School Nurses and Family Nurse Partnership to ensure that LA are fully aware of all aspects of pathway (children's community health services transferring to LA)	Head of Service, Early Help	July 2017	**Complete** **(Information has been collated to use in multi agency sessions in Nov/ Dec)**
	Future in Mind workshop to take place to share best practice from first phase (2016/17) and identify the vision for emotional wellbeing for the whole town.	Senior Educational Psychologist	September 2017	**Complete** All information was presented to Children's Strategic Partnership on 26th Sept to be used to inform the review of the HWB strategy and Children and Young's People Plan
	Multi agency development sessions to write the universal	Assistant Director, CS	Dec 2017	9th November **completed** – draft universal pathway mapped

	pathway for children and identify the checkpoints on the journey to result in a mapped journey that can be shared with parents	Head of Service Early Help Senior Educational Psychologist		Sessions in diary for: 9th Nov, 16th Nov, 11th Dec, 19th Dec Including HV, FNP, Early Help, Small Steps, SALT, parents, SEND team, CCG, social care, **9th Nov – completed** **16th Nov – completed** **11th Dec – completed** Early thinking is a model of universal/ targeted workforce being supported by specialists Want to focus on: 1. Parenting support – education re: child's development and re-establish parenting support as universal/targeted support 2. Workforce strategy
	Share the draft mapped journey with workforce colleagues to commission the workforce development elements of the pathway	Assistant Director, CS Head of Service Early Help	February 2018	Workforce lead has attended each session.
	Share the draft mapped journey with parents to develop further and refine and identify ways to present to all parents.	Assistant Director, CS Head of Early Help, Chair of Parent Led Forum	February 2018	

	Communications team to develop the child and family's journey in a format that is accessible for all families.	Head of Service, Early Help	March 2018	
	Pathway to be published and distributed to parents.	Assistant Director, CS Head of Early Help, Chair of Parent Led Forum	March 2018	
	Early Help pathway to be published on local offer	Assistant Director, CS Head of Early Help, Chair of Parent Led Forum	April 2018	

2. To develop an ASD pathway that is shared with parents

Objective	Specific Actions	By Whom?	By When	Progress
	LA session externally facilitated to map LA functions/ services across ASD pathway	Head of commissioning and strategy(CCG)		
	ASD 3P event to be held to map ideal ASD pathway	Head of commissioning and strategy(CCG)		
	ASD project group established	Head of commissioning and strategy(CCG)		
	Understand current ASD service provision: 1) Data request to be sent to TEWV & NTHFT for utilization, capacity, pathways of support, frequency of support Understand level of resourcing within TEWV & NTHFT	Head of commissioning and strategy(CCG)	Request to be made 1st week in Jan – with expected submission date by 9.2.18 End Jan 18	
	Communication (ASD specific) 1) Review letters	Head of commissioning and	End Jan 18	

	issued by TEWV & NTHFT to parents 2) Work with Communication team to change to Easy Read if applicable 3) Work with Parent carer forum to develop some positive messages/case studies 4) Work with partners to dispel fact from fiction – are schools giving the right message 5) Develop a communication to parents on the waiting list around services which can be accessed 6) Develop an infographic to depict pathway for families	strategy(CCG)	9.2.18 9.2.18 End March 18 End Apr 18	**Meeting needs to be arranged for Jan – timeline to be developed in partnership** **Have to be assured that all teachers are aware that you do not need a diagnosis to have an ECHP or access funding** **To be completed following the analysis of data returned from TEWV & NTHFT**
	Waiting list 1) Data sharing agreement to be		End Dec 18	

	reviewed to ensure waiting list can be shared 2) Share waiting list with EP 3) Match waiting list to know SEN/EHCP CYP and determine if more from the list could apply for funding or have a EHCP 4) Cross reference into families in receipt of Early Help support 5) Profile those on the waiting list who have been waiting 18+months to see if any can be moved (age, severity) 6) Audit referrals 7) Consider introducing a single referral form		As soon as IG confirm As soon as IG confirm As soon as IG confirm End Feb 18	
	ASD Diagnostic Pathway			

	1) What tools can be rolled out to observe/identify developmental needs? What training can be provided for teachers etc? Can this become part of the pathway? What needs to be observed? Why, when and by whom? 2) Explore the roll of EP in the above process 3) Understanding of the Early Help offer – what are staff trained in to support the family – behaviour, parenting 4) Map the wider support services available to parents/CYP			

3. Development and implementation of a Communication Strategy to ensure that parents are provided with the clear and timely information, advice and support that they need.

Objective	Specific Actions	By whom?	By when?	Progress
Communication plan to be in place to ensure parents understand the work being carried out within this SEND Improvement Plan	Ensure that parent led forum chair is invited to the SEND Improvement Board	Assistant Director, CS	June 2017	**Completed**
	Communications to be shared with parents to explain work currently being undertaken	Information, Advice and Support Service for SEND	Dec 2017	Leaflet in draft – to be finalised with Parent Led Forum Chair beginning of January Liaise with comms team to ensure leaflet is accessible
Parents to carry out full review of the information, advice and support that families need at all stages and make proposals on any changes needed within the system	Local Offer to be reviewed through a peer review	Information, Advice and Support Service for SEND Parent Led Forum Chair	September 2017	**Completed**
	Develop peer review recommendations into a Local Offer Action Plan	Information, Advice and Support Service	September 2017	**Completed**

		for SEND Parent Led Forum Chair		
	Implement Local Offer Action Plan	Information, Advice and Support Service for SEND Parent Led Forum Chair	March 2018	**Part completed (see attachment)**

4. Develop a shared understanding of whether are children with SEND are achieving good outcomes

Objective	Specific Actions	By Whom?	By When?	Progress
1. Develop an initial performance framework using single agency cohort data to ensure that the partnership can track outcomes for children with SEND	Complete an initial performance data briefing with the information we currently collect - Education - Social Care - Health	SEND Manager Speech and Language Therapy Professional Lead	December 2017	Committee report being presented 13th December 2017 – **completed** **(gaps in education performance discussed at SEND Improvement Board and seeking further advice via other local areas)** Establish 6 monthly reporting to Children's Services Committee/ Children's Strategic Partnership – **completed**
	Data Set framework to be developed in order to report on single agency cohort data. Meeting to be arranged with school improvement, attendance to look at ways of collating data.	SEND Team	January 2018 Phased implementation SEND units to be completed by April 2018	Meeting held with Louise Allen to discuss data to be collected on a termly basis with the view to be reporting annually. Groups identified. EYES system being implemented currently – data migration currently taking place
	Establish a regular reporting mechanism to report to the SEND Improvement Board	SEND Team	September 2018	SEN Support Leaflets have been developed and sent to schools to inform parents of data sharing for pupils on SEN Support as at present schools hold this information. **Completed**

				Data to be collected from October census. Outcome template built into EYES System to track if outcomes have been achieved, partially achieved or not achieved. **Completed** Once data in input into EYES reports can be run quarterly to track outcomes of individuals and/or specific cohort groups.
2.Development of an outcomes framework for children with SEND	Review each agencies approach to capturing outcomes – identifying best practice to share across the partnership	Speech and Language Therapy Professional Lead		**Complete**
	EHCP to be redrafted to include: "All about me" section to include child specific outcomes linked to aspirations Section B – identifying the young person's primary areas of needs	Send Manager	October 2017	Partners have agreed to use the preparing for adulthood themes for the integrated outcomes framework EHCP paperwork has been redrafted **Completed**
	Annual review paperwork to be redrafted	SEND Manager	October 2017	Annual Review Paperwork has been redrafted to include outcomes and review of previous outcomes. **Completed**
	Consultation to take place with parents in relation to this	SEND Manager	October 2017	Consultations have taken place with parents and changes discussed. All

	change in the paperwork: Parent Led Forum session Individual workers to ask parents as reviews arise	Speech and Language Therapy Professional Lead		consulted were happy with new format. **Completed**
	Review the co-ordinated support plan alongside the Early Help Assessment to see if they can be merged/ aligned	SEND Manager	December 2017	Volunteers (PSAs and SENCOs) have been identified and meeting set for Jan 2018. Draft Coordinated support plan shared at parents during Parent Led Forum. Parents happy with format so far.
	EHCP case worker guidance handbook to be developed for the workforce	SEND Manager/ Children's commissioning	December 2017	EHCP case worker handbook is in the process of being developed. This will detail structure of meetings and EHC process – To be completed by December 2017. Also easy access guidance notes for professionals (Health and Social Care) are being developed– To be completed by December 2017 **In Progress**
	Development of a measurement scale for assessing outcomes consistently used by all partners – development session? - Awareness raising sessions with the workforce	Speech and Language Therapy Professional Lead		Outcomes measure built into electronic EYES system. Outcomes can now be recorded as achieved, partially achieved or not achieved. Drop down boxes allow workers to identify reasons and free text box for further information. Need to ensure drop down boxed are used so that reports can be pulled from the system. **Completed**

				Need development sessions/awareness raising sessions with the workforce
	Template document to be developed for services to use for contributions to meetings if they are unable to attend	SEND Manager	October 2017	Annual Review paperwork has been developed. This need to be shared with services and completed ready for Annual Review Meeting or send prior to meeting if unable to attend. **Completed**
	Framework to be approved by SEND Improvement Board	Head of SEND	January 2018	
	Share the new outcomes framework with the workforce so all understand the need to capture outcome measures and progress for individual children	SEND Manager	January 2018	
Established reporting mechanism which can be used to commission services	Establish reporting mechanism for the individual outcomes to be presented as cohort data	SEND Team	September 2018	Once all information is input into EYES, we will be able to run reports in order to inform commissioning using the drop down boxed built into the system.
	Use the outcome data to understand which services are working well or not so well to inform commissioning arrangements.	SEND Team	September 2018	Once all information is input into EYES, we will be able to run reports in order to inform commissioning using the drop down boxed built into the system.

5. Ensure that the area fully understands the needs of our SEND children and uses this to inform commissioning of services leading to the development of an integrated commissioning framework

Objective	Specific Actions	By Whom?	By When?	Progress
Establish data sharing processes which allow for - Basic capturing of the EHCP cohort across all agencies - Basic capturing of the SEN support cohort across all agencies - Allows all agencies to know who has an EHC to allow for agencies to be mindful of the needs of the child and family when they are supporting them - Establishes an	Phase 1 – EHCP cohort identified and shared with partner agencies to allow pseudonymised matching of data	Head of commissioning and strategy(CCG) Strategic Commissioner, Children's (HBC)	July 2017	**Completed**
	Submission of the IG Toolkit demonstrating information security arrangements	Head of commissioning and strategy (CCG) Strategic Commissioner, Children's (HBC)	July 2017	**Completed**
	Progress with Information Governance policy with all partners	Head of commissioning and strategy (CCG) Strategic Commissioner, Children's(HBC)	October 2017	
	Authorisation from	Head of	October 2017	

ongoing process for all agencies to know those who begins an EHC plan	NHS Digital for NECS to carry out pseudonymisation of data to support data analysis	commissioning and strategy (CCG)		
	TEWV and Foundation Trust provide NECS with details of children, young people on EHCP accessing services	Head of commissioning and strategy (CCG)	December 2017	
	Phase 2 – SEN support cohort identified and shared with partner agencies to allow pseudonymised matching of data	Head of commissioning and strategy (CCG) Strategic Commissioner, Children's(HBC)	January 2018	Consent being sought through SEND support paperwork
Complete a strategic needs analysis to inform the commissioning strategy	Map all services currently being commissioned – schools, CCG, LA	Head of commissioning and strategy (CCG) Strategic Commissioner, Children's(HBC)	December 2017	

	Carry out an ARP review – consultations with schools Phase 1 - implementation of PMLD Phase 2 – implementation SEMH	Strategic Commissioner, Children's(HBC) Strategic Commissioner, Children's(HBC)	Nov 2017 Sept 2018 Sept 2019	**Completed consultation.** **The consultation has highlighted some gaps – one to one meetings are taking place with schools to understand what they are proposing to deliver.** Commissioning to take place Jan onwards with places being redistributed from Sept 2018.
	Collate all needs information and review and amend the JSNA	Head of commissioning and strategy (CCG) Strategic Commissioner, Children's(HBC)	March 2018	
	Establish a joint commissioning working group with schools, LA and CCG Working group to	Head of commissioning and strategy (CCG) Strategic	Dec 2017	Meeting held with all Headteachers (November 2017) and CCG presented to start to explore joint commissioning Template sent to schools in November to explore services commissioned by schools

	explore priorities for joint commissioning	Commissioner, Children's(HBC)		and to establish who wants to be part of a project group to look at opportunities for joint commissioning. To date 13 schools have responded, 4 wish to be part of the joint steering group with LA and CCG. A further paper was tabled at meeting held with all Heateachers on 07/12/17 and the deadline extended until 22nd December 2017 to allow more schools to respond. The LA is meeting with CCG w/c 15th January 2018, to establish terms of reference for project group. Project group first meeting is w/c 29 January 201
	Develop a commissioning strategy based on the needs identified in JSNA	Head of commissioning and strategy (CCG) Strategic Commissioner, Children's(HBC)	April 2018	

6. Implementation of a Statutory assessment notification pathway

Objective	Specific Actions	By Whom?	By When?	Progress
1. Agreed pathway of notification of statutory EHC cohort into Foundation Trust, TEWV and social care	Phase 1 – EHCP cohort identified and shared with partner agencies to allow pseudonymised matching of data	Head of Service and Manager SEND service. Data team TEWV NTHT	May 2017	**Completed**
	Further update of data to be shared across agencies to ensure cohort is current with agreed transfer of data ongoing on a monthly basis subject to IG agreements.	Head of Service and Manager SEND Data team TEWV NTHT	October 2017	**Ongoing (linked to the data workstream 4)**
2. Enhanced 20 week pathway identifying notification points and clear flow of information requests	Re-mapping of 20 week timeframe with process including notification and decision making	Head of Service SEND	September 2017	**Completed** Completion rates have improved over last academic years:

with regard to statutory timescales	points being explicit.			14/15 – 22 out of 54 completed on time 40% 15/16 – 4 out of 52 completed on time 7% 16/17 – 42 out of 63 completed on time 67%
	Transfer all existing Statements of SEN to EHC Plans undertaking as new assessments.	Head of Service SEND SEND Manager SEN Officers	March 2018	**All but 7 have been transferred (Oct 2017)** **6 still to be transferred (Nov 2017) – all in progress.**
	Reviewed documentation to support the provision and collection of information to support the overall assessment of need.	SEND Manager	September 2017	All paperwork has been reviewed and circulated to schools and agencies. Awaiting feedback. **Completed**
3. Enhanced pathway for annual reviews giving clarity of notifications and information requests	Annual review paperwork has been developed in a multi agency arena.	Head of Service SEND SEND Manager	October 2017	Draft forms are now available to start consultation. Initial consultation has taken place with Parent Carer Forum.

				Completed
	Multi agency group to be convened to explore the annual review process.	Head of Service SEND SEND Manager	January 2018	**Completed**
4.Disemination of enhanced pathways for EHC needs assessments and annual reviews to parents/carers, CYP and the workforce.	Information to be cascaded through agencies, families and young people	Head of Service SEND SEND Manager	February 2018 Ongoing	Consultation has taken place with Parent Carer Forum. Shared with parents at review meetings Started consultation through SENDCo forum.

Owners: Danielle Swainston, Assistant Director, Children's Services, Hartlepool Borough Council
Jean Golightly, Director of Nursing and Quality, NHS Hartlepool and Stockton-on-Tees CCG

Last reviewed: December 2017
Next review: January 2018

HEALTH AND WELLBEING BOARD

5 March 2018

Report of: Interim Director of Public Health

Subject: HEALTH AND WELLBEING STRATEGY (2018 - 2025) – MONITORING OF THE IMPLEMENTATION PLAN

1. PURPOSE OF REPORT

1.1 The purpose of this report is to present to the Health and Wellbeing Board (HWB) a proposed process for the monitoring of the Implementation Plan for the Joint Health and Wellbeing Strategy (2018 – 2025) (JHWS).

2. BACKGROUND

2.1 Following an extensive engagement / consultation exercise, Hartlepool Health and Wellbeing Board's (HWB) has now completed the development of its JHWS (2018 – 2025). A copy of the JHWS is attached at **Appendix A**.

2.2 Final approval of the JHWS is to be sought from Full Council and the Hartlepool and Stockton Clinical Commissioning Group's Governing Body, on the 15th March 2018 and the 27 March 2018 respectively. Subject to approval by these bodies, the Strategy will be formally published on the 28th March 2018, monitoring of the work undertaken to achieve the aims and outcomes contained within it will then be undertaken by the HWB.

3. MONITORING AND IMPLEMENTATION OF THE JHWS

3.1 Contained within the JHWS (pages 12-17) is an Implementation Plan and consideration is now needed as to how the HWB will monitor progress against the actions and desired outcomes outlined in the Plan.

3.2 In order to monitor the implementation of the Strategy, it is suggested that progress be considered against each of the deep dive areas identified in the strategy and that this be reported to the HWB on area by area basis, as detailed below.

Health & Wellbeing Board Meeting	Deep Dive Project Areas
June 2018	Reduce Drug and Alcohol Harm
September 2018	Dying Well / Voluntary Sector and Community Assets
December 2018	Reduce Health Inequalities
March 2019	Improving Mental Health and Wellbeing

3.3 The proposed monitoring process will enable the HWB to look in greater detail at the actions allocated against each of the deep dive areas, and progress made towards achieving the outcomes outlined in the Implementation Plan. In addition to this, it is proposed that an annual 'baseline' report be presented to the HWB, to provide an overview of overall progress. Presentation of this 'baseline' report to be incorporated in to the HWB's Face the Public Event.

4. RECOMMENDATIONS

4.1 That the HWB approve the process for the monitoring of progress against the Implementation Plan for the JHWS, as detailed in Sections 3.2 and 3.3 of this report.

5. BACKGROUND PAPERS

Health and Social Care Act 2012

Report and minutes of the:
- Health and Social Care Act 2012
- Health and Wellbeing Board (13 March 2017, 26 June 2017, 4 Sept 2017 and 4 December 2017)
- Finance and Policy Committee (18 Sept 2017 and 8 January 2018)
- Audit & Governance Committee (20 Sept 2017 and 6 Dec 2017)
- Children's Strategic Partnership (26 Sept 2017)
- Hartlepool and Stockton CCG (26 Sept 2017 and 30 January 2018)

6. CONTACT OFFICER

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Hartlepool Joint Health and Wellbeing Strategy 2018 - 2025

Our Vision and Ambition

Our vision is that Hartlepool will develop a culture and environment that promotes and supports health and wellbeing for all.

Our ambition is to improve health and wellbeing outcomes and reduce inequalities for our population.

Our Purpose

Why do we need a strategy?

The Health and Social Care Act (2012) establishes Health and Wellbeing Boards as statutory bodies responsible for encouraging integrated working and developing a Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) for their area. Hartlepool Health and Wellbeing Board (HWB) is a committee of the Council with the mandate to address the health and wellbeing needs of Hartlepool and help reduce health inequalities. The JHWS is a strategic document outlining how Hartlepool Borough Council (HBC), NHS Hartlepool and Stockton Clinical Commissioning Group (HAST CCG) and other partners, through the HWB, will fulfil this mandate. The strategy is underpinned by the JSNA and views of our communities and will provide a foundation for strategic, evidence-based, outcomes-focused commissioning and planning for Hartlepool.

About Hartlepool

Background and Context

Hartlepool is one of the most deprived areas in England, ranked 18th out of 326 local authority areas and with 7 of the 17 wards in Hartlepool amongst the 10% most deprived in the country.

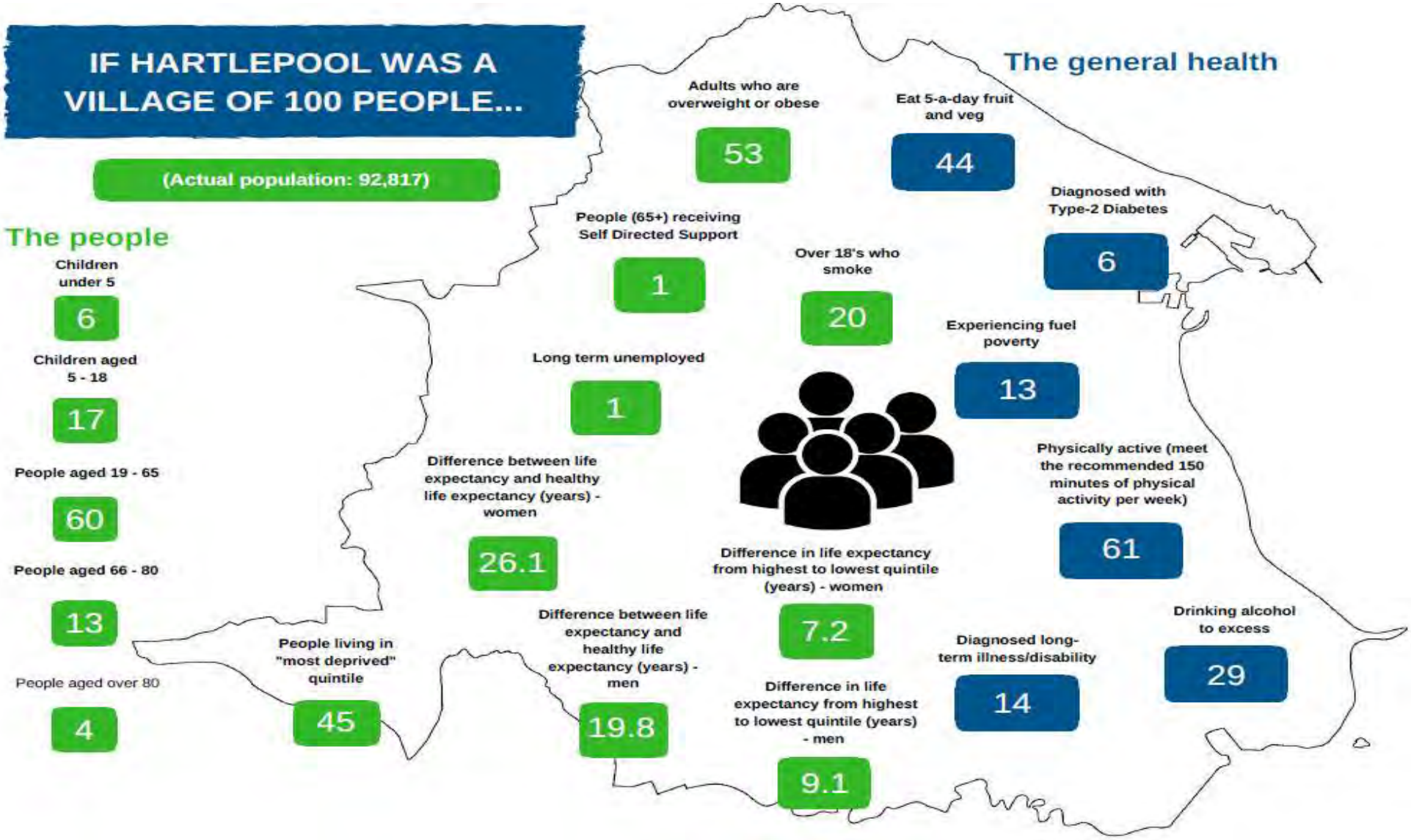
Hartlepool HWB is committed to working together with the people of Hartlepool to improve health and wellbeing of residents. At a time of increasing demand on services and pressures on funding, it is even more important to make sure we are a healthy Borough by supporting people to take responsibility for their health, and that services are delivered efficiently, targeting them towards those who need the most help. In Hartlepool, the areas where the most vulnerable members of our population live reflect the areas with the highest deprivation.

The HWB has previously had a JHWS that was jointly implemented by the partners and runs to an end in March 2018. The previous strategy was based upon the principles of the Marmot Review (2010) and focused on protecting and improving the health of the population through a range of evidence based interventions. In order to ensure that the strategy is fit for purpose and effectively reflects local priorities, the Board took the decision to revise the strategy. The Board intends to focus on a few key priorities that will make a difference to the lives of the people who live and work in the Borough, over the next seven years, in order to get it right for our population.

Hartlepool also has other key ongoing programmes such as 'Hartlepool Matters' and the 'Sustainability and Transformation Partnership (STP)' that are concurrently shaping the future of health and wellbeing in our Borough. The implementation of this revised strategy, together with these ongoing programmes and other projects that are led by the Voluntary and Community Sector (VCS) will contribute to achieve the priorities outlined in this strategy. However, we are mindful that our residents are our greatest assets and we will work in collaboration with our communities to make maximum use of our community assets and to help shape our local policies and planning levers to achieve improved health outcomes in the Borough.

4.4 Appendix A

Key Facts



Our residents

What do they say?

In developing this strategy, steps were taken to ensure that the strategy focuses on the issues that residents consider to be of importance to them. Findings from an online survey together with face to face workshops held in community venues and with bespoke groups were used to determine the actions that will be delivered through the strategy. We were keen to include the voice of marginal groups in our population. Separate workshops were therefore held with Asylum seekers, VCS organisations and members of the youth council to seek their views. In addition consideration was given to findings from various other pieces of work across the local authority and its partners. Examples of this work include:

- The Young Future's Project, undertaken by the Youth Parliament and Hartlepool Healthwatch in partnership with York University, that engaged with young people around their experiences of health and social care and to understand their experiences and expectations for ongoing development of services. The project focused on mental health and emotional wellbeing;
- Healthwatch Hartlepool survey (2017) on access to services for people with impaired hearing;
- A Consultation Workshop on 'Future in Mind', led by the Children's Strategic Partnership. The aim of the workshop was to develop an integrated mental health offer for children and young people that incorporate the five ways to wellbeing; and
- Asylum seeker and refugee consultation undertaken by Healthwatch Hartlepool (2015).

There was an acknowledgement by residents of the need to ensure that longer term and sustained prevention programmes are put in place and that collective action by residents, voluntary and community, private and public sector organisations should be promoted to implement the strategy. They also highlighted the importance to identify and target vulnerable and at risk groups in order to reduce inequalities and to use our current community assets for health, care and wellbeing to facilitate implementation.

Our Priorities

What we want to achieve and why?

The HWB considered our achievements from the previous strategy, findings from the JSNA and local intelligence from partners and agreed four main priority areas to focus on during the lifetime of this strategy – **Starting, Working, Ageing and Living Well**. After our consultation with the general public we have added an additional priority – **Dying Well**.

Starting Well – All **Children and young people** living in Hartlepool have the best start in life.

Children who grow up in loving and supportive families are most likely to be happy, healthy and safe. Life experiences involve critical transitions - emotional and physical changes in early childhood; moving from primary to secondary and tertiary education; starting work; leaving home and starting a family; and retirement. Each transition stage can affect health and wellbeing by pushing people into more or less disadvantaged paths. Children and young people who have been disadvantaged in the past are at the greatest risk and their children are more likely to be also disadvantaged. We want to ensure access to high quality universal services such as health care and education; early intervention when needed, and targeted support for those who are in difficulties. We want to prevent children and young people from developing emotional problems; having to live in poverty, or are affected by abuse, violence or misuse of substances, so that we prevent problems being passed from generation to generation.

Working Well - Workplaces in Hartlepool promote and support healthy living.

Access to fulfilling work has an impact on people's wellbeing. Economically, fulfilling work provides a secure income and can offer a sense of purpose and social connection. People who are economically less well-off have substantially shorter life expectancy and more illnesses than those in meaningful employment. In addition, supporting those who work to be healthy and well means they are able to better support and care for their dependents (children and/or the elderly). We want workplaces in Hartlepool to be healthy places with supportive practices and environments that enable employees to sustain healthy lifestyle choices. Hartlepool has a higher than average number of people with learning disabilities in employment. We want to sustain this achievement and we also want to work with our communities to support young people and people with limiting ill-health into fulfilling employment for positive health and wellbeing gains.

Ageing Well – **Older People** in Hartlepool live active and independent lives and are supported to manage their own health and wellbeing.

Similar to most areas in England, the proportion of older people in Hartlepool is increasing. For instance, the number of people who were aged 85 years or more in 2005 was 1,400; this increased to 2,100 by 2015 and will continue to increase to 3,330 by 2025 and to 4,700 by 2035. Although most people are living longer, the majority of their latter years (approximately 20years for males; and 26years for females) are lived with poor health and wellbeing. We want to support people to develop and maintain health and independence as long as possible. When people start to develop a long-term health problem, we want to focus on preventing them from developing further health and social problems. We want to see local services focused on those who have the greatest need, to reduce health inequality and to enable a greater focus on prevention of ill health.

Living Well –Hartlepool is a **safe and healthy place** to live with strong communities.

Enabling those who live in Hartlepool to be healthy and well for a lifetime involves much more than good health and social care services. Many different things impact on health and wellbeing – housing, jobs, leisure, sport & access to open spaces, education, health services and transport. We want Hartlepool to be a healthy place with supportive neighbourhoods and communities which are strong and resourceful, making best use of their community assets. We want to support people in Hartlepool to take steps to avoid premature deaths.

Dying Well – People in Hartlepool are supported for a **good death**.

Despite the fact that all of us will die one day, some of us will experience death suddenly or prematurely; others will die after a period of illness or frailty, which can sometimes be protracted over time. We want to engage our communities so that people from Hartlepool are supported to die with dignity, compassion and that relevant support is available to carers to deal with dying and death.

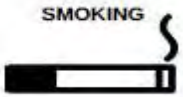
OUR STORY: WHAT DO WE NEED TO BE MINDFUL OF?

Green = progress | Blue = requires improvement

Living well

1 out of every 2 mothers initiate breastfeeding - up 6%

44 out of every 100 people eat five portions of fruit and veg a day - lower than the national average



1,922 per 100,000 successful quitters at 4 weeks in Hartlepool

1 out of every 5 adults over 18 smoke - higher than the national average

30 per 100,000 children killed or seriously injured in road traffic accidents

In 2015/16, 61 out of every 100 adults completed 150+ minutes of exercise per week

27 out of of every 100 adults is physically inactive

6 out of every 100 adults in Hartlepool has diabetes

1,700 Hartlepool people estimated to be living with diabetes, but remain undiagnosed

8,411 eligible people aged 40 - 74 received an NHS Health Check in 2013-16

An average of 221 people in Hartlepool aged under 75 die each year due to cardiovascular disease

Just 1 person per 1,000 homeless

1,900 successful lung health checks completed

1,250 people estimated to be living with COPD without knowing

36 per 100,000 under 18s admitted to hospital for alcohol specific conditions

62 per 100,000 alcohol-related mortality amongst Hartlepool residents

4.4 Appendix A

Starting well

SCHOOL READINESS

7 out of every 10 children achieve a good level of development by the end of reception

97 out of 200 pupils achieve 5 A* - C at GCSE - lower than the national average

SEXUAL HEALTH

The number of teenage conceptions has reduced significantlty since 2010

The rate of under 16 conceptions in Hartlepool is 5.9 per 100,000 - above the national average

Working well

EMPLOYMENT

32 out of every 200 adults with learning disabilities are in emplyment

5 out of every 100 of Hartlepool's 16-18 year olds not in education, employment or training - above the national average

INCOME

8,700 househods do not have a working adult

24 out of every 100 adults in Hartlepool experiencing income deprivation

Ageing well

VACCINATIONS

7 out of 10 adults over 65 receive the flu vaccination annually

6 out of 10 eligible people receive the pneumonia vaccination annually

INJURIES

321 emergency hospital admissions due to falls in people aged 65 and over - below the national average

Dying well

DEATHS

Excess winter deaths index = 25.9 compared to 24.6 in England

4 out of 10 deaths occur at home - lower than the national average

DEATHS FROM CANCER

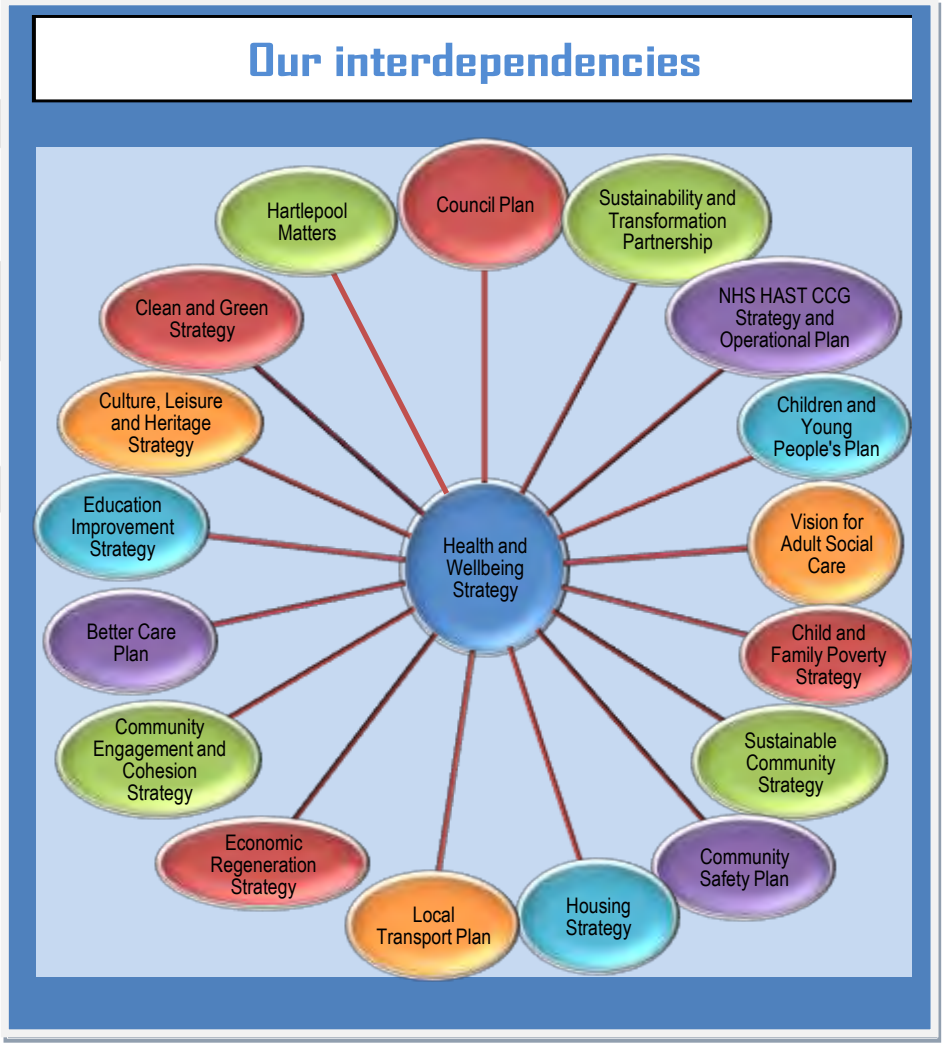
1345 per 100,000 rate of deaths from cancer aged 65+

784 per 100,000 rate of deaths from respiratory disease aged 65+

Our plan for delivery – Current and ongoing

Majority of the priority actions identified by our residents are already being worked on by partners and is inter-dependent on the delivery of a number of town wide/Tees/regional strategies, policies and plans. We will continue to align our business with implementation of these strategies, policies and action plans.

Priority Outcomes	Actions already in Progress		
	Improving Health and Care Services	Improving Health & Wellbeing	Protecting Health
Starting Well	*Improve access for emotional wellbeing and Child and Adolescent Mental Health Services (CAMHS)	*Implement programmes that promote emotional wellbeing and resilience *Improve school readiness, educational attainment and aspirations for children and young people *Implement parenting programmes	*Promote healthy relationships through education, early help and support *Promote uptake of childhood immunisations in deprived wards
Working Well	*Implement workplace based screening programmes to improve health and wellbeing and improve access to health services *Implement workplace wellbeing accreditation and charter schemes for businesses and organisations	*Improve training and employment for people with disability/mental health/long-term conditions *Provide training and employment for young people *Implement programmes to reduce poverty	*Promote uptake of vaccinations for at risk professional groups e.g. health and social care *Promote uptake of vaccinations for people with long-term conditions
Ageing Well	*Provide integrated health, care and wellbeing packages *Improve access to health, care, mental health and wellbeing services	*Implement networking initiatives to reduce social isolation and loneliness *Implement and strengthen programmes that provide support for carers	*Promote safer neighbourhoods and reduce crime and anti-social behaviour
Living Well	*Provide integrated care packages and to include prevention *Deliver the right care, at the right time, in the right place by working as locally as possible and shifting the balance of care out of hospital to community providers including Housing and VCS organisations	*Implement programmes to reduce drugs and alcohol harm *Implement programmes to reduce tobacco harm *Implement programmes to promote physical activity, improve diets and reduce excess weight *Implement programmes to improve emotional wellbeing and mental health	*Implement programmes to reduce impact of drugs and alcohol misuse on children and young people *Implement programmes to reduce tobacco harm in children and young people
Dying Well	*Implement evidence based end of life care packages in appropriate settings	*Implement bereavement and counselling services	*Promote uptake of 65+ flu vaccinations *Promote screening and early identification for preventable ill-health

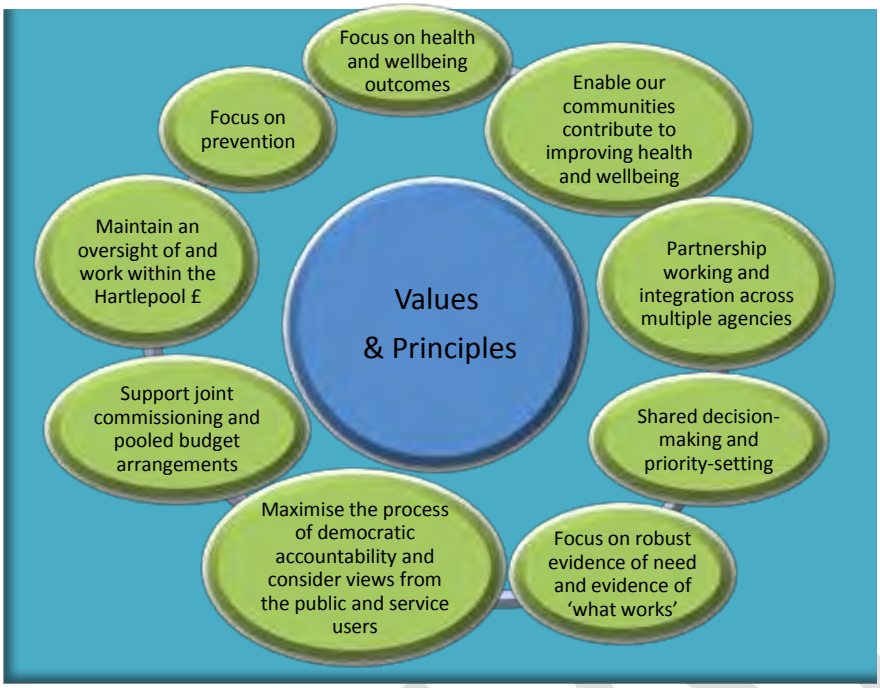


Our plan for delivery – Looking ahead

In addition, we want to do some things very differently from the way we have previously operated. This means that we will invest in the health and wellbeing assets in our communities to enable our residents to facilitate the desired cultural changes that will improve the health and wellbeing of our local area. The Board will also focus on a few deep dive projects across the life course and ensure that together with our wider community partners, we collectively deliver over the lifespan of this strategy to get it right for our population.

The detailed implementation plan for the deep dive projects is attached as appendix 1 of this strategy.

Our principles and values



The Health and Wellbeing Board operates within a set of principles and values. The Joint Health and Wellbeing Strategy implementation provides the opportunity to maximise partnerships and evidence base, generating new ways of tackling health and wellbeing challenges. This includes recognising and mobilising the talents, skills and assets of local communities to maximise health and wellbeing outcomes.

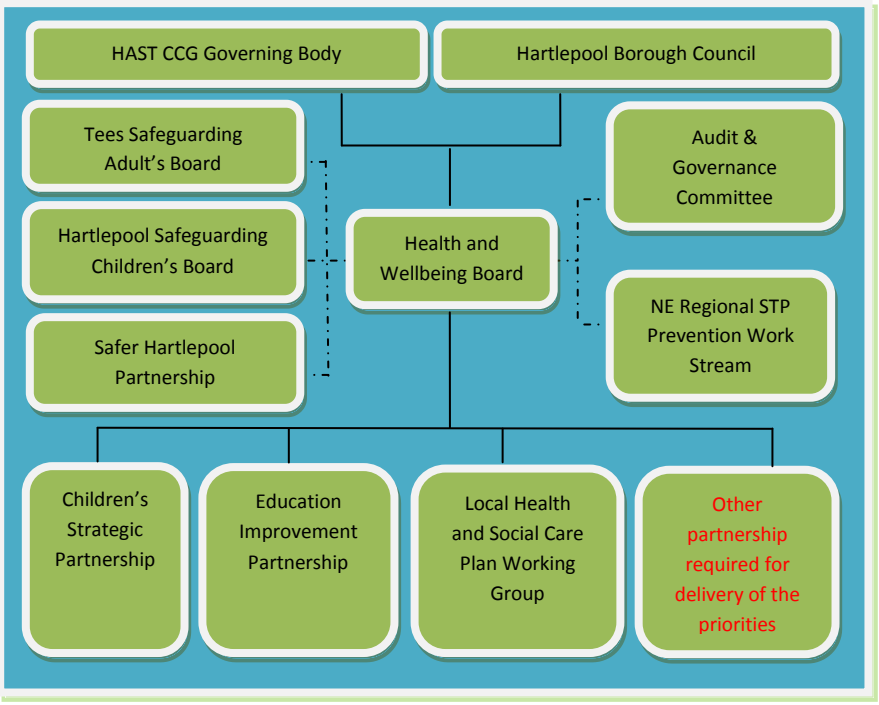
Our governance arrangements

Who will hold us accountable?

This Strategy is owned by the Health and Wellbeing Board and will be reviewed by the Board every 3 years to ensure that it remains relevant and continues to reflect local priorities.

Each year the Board will agree an action plan setting out how the Strategy will be delivered. The action plan will set out agreed timescales for delivery and clear ownership for the actions. The action plan will also include a number of performance indicators which will be used to assess the progress being made.

The key risks for implementing the Strategy will also be identified.



The Audit and Governance Committee of the Council will hold the Board accountable for implementing the Strategy. In addition there will be other Council/Borough-wide/regional partnerships whose work will help to deliver the Strategy.

Monitoring and evaluation

How will we know we have been successful?

In order to measure success, the Board will monitor progress through quarterly performance reports and seek to maximise resources and secure external resources into the Borough. We will embed a culture of evaluation by working better with the academic institutions to utilise an action research approach that will help test new models of delivery and embed a continuous improvement ethos. Below are the outline indicators that will be monitored for each priority theme.

Priority	Measures	
	What we hope to achieve (outcome of interest)	How we will know we are on the right path (process/output indicators)
Overarching	VCS is driving prevention programmes in communities.	✓ MECC training offer that includes brief intervention skills is produced with library service and delivered to staff of local agencies ✓ Comprehensive local directory of community assets and services is produced ✓ Hartlepool multi-agency health, care and wellbeing prevention model is developed and implemented
Starting Well	Number of children affected by inter-generational cycle of vulnerability e.g. poverty, domestic abuse, drugs and alcohol is decreasing.	✓ Reducing trend in LAC/child protection cases that result from domestic abuse/substance misuse is observed ✓ Increasing proportion of children on FSM achieving 5+ GCSEs (including Maths and English) is observed ✓ Increasing proportion of 11-16year olds are offered opportunities for work experience or apprenticeship
Working Well	Number of people from Hartlepool with a disability/long-term illness in employment is increasing. Number of young people from Hartlepool in employment is increasing.	✓ Increasing trend in % of people aged 16-64 in employment is observed ✓ Health-led employment initiative is piloted, evaluated and fully implemented ✓ Reducing trend in gap in employment rate between those with a long-term health condition/learning disability/mental health and the overall employment rate is observed
Ageing Well	Majority of older people in Hartlepool are independent and not socially isolated.	✓ Community peer support and networking model is developed and implemented ✓ Increasing trend in the % of adult carers who have as much social contact as they would like is observed ✓ Increasing trend in the % of adult social care users who have as much social contact as they would like is observed
Living Well	Hartlepool Borough provides an enabling environment that supports residents to take up and sustain a healthy lifestyle.	✓ Healthy Borough status is achieved ✓ Social value charter is developed and adopted for the Borough ✓ Increasing trend in % of people utilising outdoor space for exercise/health reasons is observed
Dying Well	Residents of Hartlepool and their carers/families are provided with appropriate support to deal with dying and death.	✓ Compassionate Borough status is achieved ✓ Dying Well community charter is developed and adopted by the Borough ✓ Integrated multi-agency support pathway for dying well is developed and implemented

4.4 Appendix A

Appendix 1: Joint Health and Wellbeing Implementation plan (2018 -2025)

Joint Health and Wellbeing Strategy (2018 - 2025) Delivery plan											
What	**Lead**	**Timescale**							**Outcome/Output measures**	**RAG**	**Risks/Barriers to delivery**
		Year									
		1	2	3	4	5	6	7			
1. **Voluntary Sector & Community Assets**											
VCS sector improvement • Develop virtual network of local VCS organisations with appropriate coordination to avoid duplication and coordinate provision • Utilise VCS organisations to facilitate targeted consultations/strategy and service development to relevant groups – place and person; and to secure insight into community specific issues • Work in partnership to secure inward investment through external bids. Communicate information on grants through newsletter /support to smaller organisations on bid writing.	Safer Hartlepool Partnership (SHP) - Community engagement lead, HBC	√	√	√					• Virtual network of VCS organisations developed • VCS leading community development and engagement activities		
		√	√	√	√	√	√	√			
		√	√	√	√	√	√	√			
Community development and Directory of community activities • Maximise opportunities for people to access information and support and participate within their local communities through promoting and continuing to further develop resources such as 'Hartlepool Now' and 'Family Services Directory' – provide group specific segments e.g. CYP, Family, free activities, place specific • Provide information and support to elected members to advocate for and champion bespoke health improvement initiatives in their wards	Hartlepool Matters working group Public health lead	√	√	√					• Directory of multi-agency services in the community refreshed, marketed and kept up to date • Annual ward profiles produced for elected members • Elected members leading on ward specific health improvement initiatives		
		√	√	√	√	√	√	√			

2. **Improve Mental Health & Emotional Wellbeing**											
Access to mental health services • Redesign care pathways to improve access to interventions for those people who fall below the specialist services threshold but require interventions other than universal programmes	Hartlepool Matters working group	√	√	√	√	√	√	√	• Improved public perception on accessibility of mental health services		
Children and Young People's health • Develop local CYP workforce (to help make every contact count) to identify emotional health issues and intervene early • Continue to develop and implement a multi-agency intervention model that incorporates the five ways to wellbeing and aligned with CAMHS and Future in Mind • Continue to develop intervention to address the needs of young carers with a focus on social isolation	Children's Strategic Partnership (CSP)	√ √ √	√ √ √	√ √ √	√ √	√ √	√ √	√ √	• CYP workforce development plan • Five ways to wellbeing model developed and implemented		
Employee health • Utilise the North East Better Health at Work Award to facilitate improved employer support for emotional wellbeing of employees	Public Health lead	√	√	√	√	√	√	√	• Checklist for promoting EWB in the workplace is adopted and shared with local employers • Mental health and wellbeing is addressed at each stage of the regional award scheme		
Older people's health • Continue to strengthen ongoing multi-agency work (e.g. Befriending Network, Project 65 etc) to tackle social isolation for older people. To include peer networks to facilitate improved access to community based activities.	Adult services committee	√	√	√	√	√			• Reported improvement in social isolation by residents		
Promoting emotional wellbeing • Implement community cohesion programmes to facilitate mutual acceptance and tolerance of people from different backgrounds • Improve access to ESOL classes to help reduce	(SHP) – Safer neighbourhoods group Adult	√	√	√					• Community cohesion strategy fully implemented • Observed increasing trend in number of people who use outdoor space for physical activity		

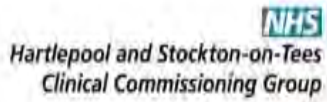
communication barriers and therefore help with better networking and engagement by asylum seekers • Raise awareness of and implement multiple interventions to improve access and facilitate increased uptake of physical activity to improve emotional wellbeing • Design and implement a social marketing campaign to help improve awareness and reduce stigma on mental health	learning and skills lead Healthy weight healthy lives strategy group Public Health/Comms lead (s)	√ √ √	√ √ √	√ √ √	√	√	√	√	• EWB social marketing campaign launched		
3. **Reduce Drug and Alcohol harm**											
Understanding needs and demand • Utilise multi-agency data, information and demographics across Hartlepool to provide a better overview of need to help redirect action through the JSNA. • Map current activity to help re-direct action to areas of most need through the development and implementation of a multi-agency Drug &Alcohol Harm Reduction delivery framework and to improve access to interventions – to include a focus on CYP misuse and parental impact.	SHP- Drugs & Alcohol Harm Reduction group	√ √	√						• Multi-agency Drugs and Alcohol Harm Reduction delivery framework developed and implemented		
Targeted awareness and social marketing • Design and launch a '**Hartlepool big conversation**' programme that will support multi-agency and town wide social marketing on drugs and alcohol harm (to include medicines waste) – use sport as an engagement tool for prevention and recovery	SHP- Drugs & Alcohol Harm Reduction group	√	√	√	√	√	√	√	• Drugs and alcohol marketing campaign launched		
Promoting behaviour change • Pilot a behaviour insight project to help understand behavioural barriers to assessing interventions and implement appropriate ethnographic interventions in response in order to improve uptake of services	SHP- Drugs & Alcohol Harm Reduction group	√	√	√	√	√	√	√	• Increasing trend in uptake of support by community based services		
Children and Young People's health • Develop local CYP workforce (to help make every	Children's Strategic								• CYP workforce development plan • Hidden harm identification		

contact count) to provide parental and CYP education and to identify Drug and Alcohol misuse issues and intervene early; and to support schools and colleges to play a lead role. • Design and implement a multi-agency model that will support early identification of 'hidden harm' and intervention in order to minimise the impact of drugs and alcohol on children and young people • Build and provide multi-agency integrated early help services for 'hidden harm'.	Partnership (CSP) Hartlepool Safeguarding Children's Board (HSCB)	√ √ √	√ √ √	√ √	√ √	√ √	√ √	√ √	framework developed and implemented • Integrated early help services support pathway for 'hidden harm' commissioned		
4. **Reduce Health Inequalities**											
Asylum seeker incl BME communities' health • Implement peer educator training for asylum seekers to raise awareness of education/information on health care systems/services/childhood communicable diseases and other community health and care services and how to access them • Provide health and care leaflets with different translations in order to reduce language barrier • Provide presentations on health, care and wellbeing initiatives to bespoke BME groups e.g. Chinese association in order to improve awareness.	SHP - Public Health lead/CCG lead/ HBC Community engagement lead	√	√	√	√	√	√	√	• Peer educator programme for asylum seekers implemented		
Interpreter service • Implement the recommendations from the Health watch (2017) survey in order to help reduce barriers to accessing health and care services for vulnerable groups e.g. deaf, asylum seekers	GP Federation/ TEWV/NTHFT	√	√						• Improved access to healthcare for those who require interpreter services		
Children and Young People's health • Provide awareness sessions to young people on their rights to access health care services independently e.g. contraception, alcohol etc; and interventions available in the Borough • Design and implement a multi-agency support model to improve the achievement of children	Children's Strategic Partnership (CSP)	√	√	√					• Improved awareness among young people on their rights to access services independently • Tobacco harm social marking campaign in schools launched • Reducing trend in number of CYP who are excluded from school		

and young people in school • Design and facilitate an awareness and social marketing approach on tobacco harm to be implemented by schools and colleges			√ √	√ √	√ √	√ √	√ √	√ √			
Health of the Armed Forces Community • Continue to implement actions to address the health and care needs of service and ex-service personnel as outlined in the Armed Forces Community Covenant	Hartlepool Armed Forces liaison group	√	√	√	√	√	√	√	• Health and Care needs of the Armed Forces community is considered in service design and implementation		
Financial improvement • Build on the work of the financial inclusion partnership and the Hartlepool action lab to improve income for disadvantaged groups • Pilot a health-led employment initiative for people with LTCs/disability	Financial inclusion partnership/ Hartlepool action lab NTHFT lead	√	√	√	√	√	√	√	• Increasing trend in rate of people with LTC/disability and Young People who are in employment		
Using policy and intelligence to drive change • Develop and adopt a multi-agency charter for Health in all policies (HiAP) • Utilise multi-agency data and intelligence to help redirect action through the JSNA to areas of most need by development and implementation of a tobacco harm reduction framework	Public Health lead/CCG lead	√	√	√	√	√	√	√	• Hartlepool charter for HiAP developed and signed up by all partners of the HWB • Multi-agency tobacco harm reduction framework developed and implemented		
Domestic Abuse • Develop and implement a programme of action to achieve a White Ribbon Town status in Hartlepool • Continue to implement social marketing campaigns to help reduce incidence of Domestic Abuse	SHP – Domestic violence and abuse group	√ √	√ √	√ √	√	√	√	√	• White Ribbon Accreditation achieved		
Make every contact count • Develop local workforce to identify health, care and wellbeing issues and intervene early	STP regional prevention group – PH lead	√	√	√	√	√	√	√	• MECC model implemented in Hartlepool		

Access to local health and care services • Continue to implement current actions to ensure appropriate health and care services are provided closer to home • Continue to implement the Better Care Fund Plan	Hartlepool Matters working group	√	√	√	√	√	√	√	• Better Care Fund Plan fully implemented		
Autism and Learning Disabilities • Continue to further develop and implement local strategies and programmes to address access to health and care services for people with Autism and Learning Disabilities	CCG lead/CSP								• Local strategy to improve access for people with Autism and Learning Disabilities implemented.		
Ex-Offender Health • Provide leaflets and education on local health and care services to ex-offenders to help improve access to services and integration	SHP - Public Health lead/CCG lead/ HBC Community engagement lead/Probation service lead	√	√	√	√	√	√	√	• Community health and care services introductory pack for ex-offenders developed • Local pathway for community re-integration for ex-offenders agreed and implemented		
5. Dying well											
Bereavement/palliative care support • Map current access to bereavement/palliative care support in Hartlepool and implement interventions to ensure easy access for those who require them • Develop and implement a model for advanced care planning for end of life that addresses preferred place of death– to include implications for carers and a focus on vulnerable groups e.g young carers, people with learning disabilities • Adapt local policies to help achieve a compassionate Borough status	Health watch/CCG lead/NTHFT lead	√ √	√ √	√ √ √	√ √ √	√ √	√ √	√ √	• Directory of bereavement/ palliative care support produced and marketed • Multi-agency advanced care planning toolkit developed and implemented • Compassionate Borough status achieved		
Key (RAG rating): Red = Not started; Amber = In progress; Green = Completed											


HARTLEPOOL
BOROUGH COUNCIL


NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group


CLEVELAND
POLICE


NHS
North Tees and Hartlepool
NHS Foundation Trust


Tees, Esk and Wear Valleys
NHS Foundation Trust
NHS


NHS
England


H&SH
Hartlepool & Stockton Health


healthwatch
Hartlepool

HEALTH AND WELLBEING BOARD

5 March 2018

Report of: Chair of the Health and Wellbeing Board

Subject: THE HARTLEPOOL MATTERS PLAN - IMPLEMENTATION UPDATE

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1. PURPOSE OF REPORT

1.1 The purpose of this report is to introduce an update in relation to the implementation of the Hartlepool Matters Plan.

2. BACKGROUND

2.1 Hartlepool Borough Council on 12th March 2015 established the Local Health and Social Care Working Group, with NHS Hartlepool and Stockton on Tees Clinical Commissioning Group (CCG), to identify health and social care planning priorities and inform the development of a Plan for the delivery of integrated health and social care services across Hartlepool (including the University Hospital of Hartlepool (UHH) site).

2.2 Key to the work of the Group was the involvement of partners from across health and social care and the appointment of Professor David Colin-Thomé OBE as the independent Chair.

2.3 In 2016 the Local Health and Social Care Working Group fulfilled its remit, with the publication of the 'Hartlepool Matters Plan' for the delivery of integrated health and social care services across Hartlepool. The Plan, a copy of which is attached at **Appendix A**, was approved by the Health and Wellbeing Board, Full Council and the CCG Governing Body in October 2016.

3. IMPLEMENTATION OF THE HARTLEPOOL MATTERS PLAN

3.1 It had been agreed that implementation of the recommendations of the Hartlepool Matters Plan would be monitored annually through the Hartlepool Matters Implementation Plan Working Group, as a sub group of the Health and Wellbeing Board.

3.2 Professor David Colin-Thomé chaired the first meeting of the Hartlepool Matters Implementation Plan Working Group which was held on the 2nd

October 2017. Progress against the recommendations of the Plan was reported to the Working Group, with the assistance of a document entitled the 'Draft Hartlepool Matters Implementation Plan', a copy of which is attached at **Appendix B**. Detailed presentations also outlined progress in relation to the areas of:

- Prevention;
- Primary / Community and Social Care;
- Local Hospital, Acute and Urgent Care;
- Children and Adults Services; and
- People and Places.

3.3 Following consideration of the information provided, and taking in to consideration views expressed by the Working Group on the 2nd October 2017, Professor David Colin-Thomé submitted a letter outlining his comments regarding the implementation of the recommendations of the Hartlepool Matters Plan. Professor David Colin-Thomé's letter reflects positively on the way in which partners are working together on the provision of integrated services and identifies areas for further progress. A copy of his letter is attached at **Appendix C** for the Boards information.

3.4 In addition to the information, and views on progress, appended to this report, a brief presentation summarising progress will be presented at today's meeting.

4. RECOMMENDATIONS

4.1 That the HWB notes:

i) Feedback following the meeting of the Hartlepool Matters Implementation Plan Working Group in October 2017;

ii) Progress 'headlines and highlights' presented at today's meeting; and

iii) That Hartlepool Matters Plan will continue to be monitored though the Hartlepool Matters Implementation Plan Working Group.

5. BACKGROUND PAPERS

Hartlepool Matters Plan
Draft Hartlepool Matters Implementation Plan

6. CONTACT OFFICER

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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

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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.

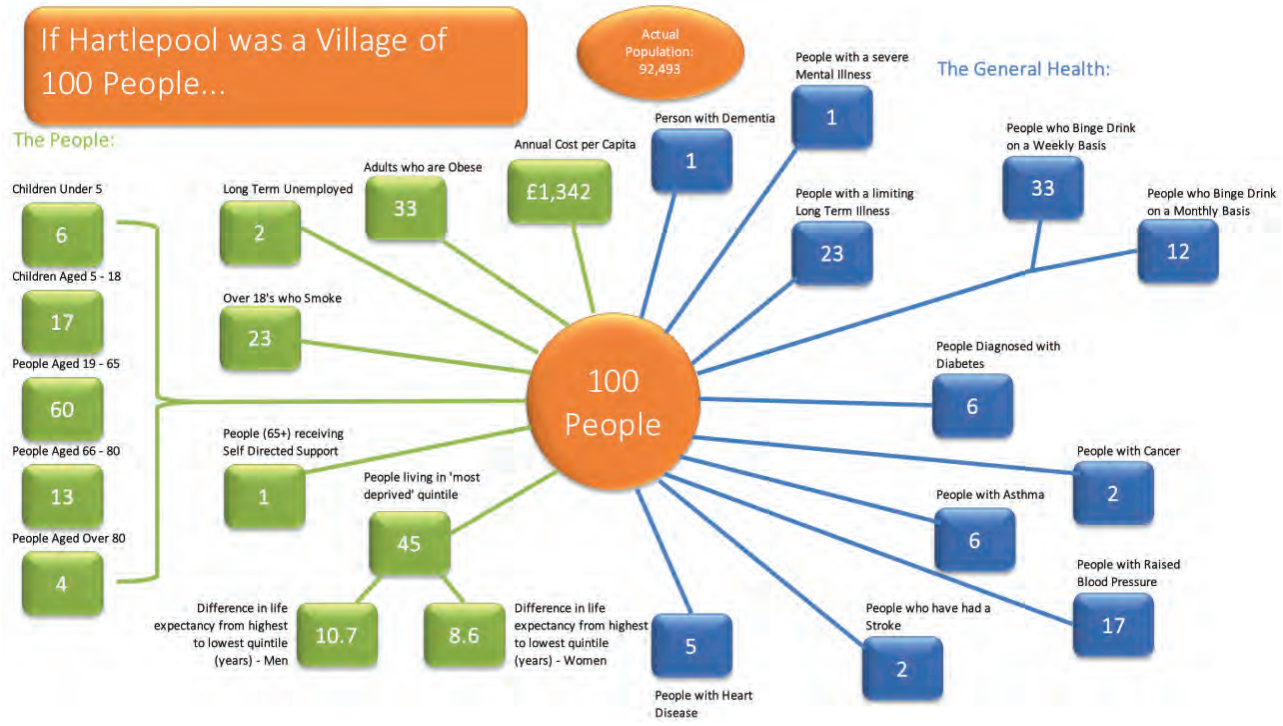
A full list of attendees can be found in **Appendix A**.

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]

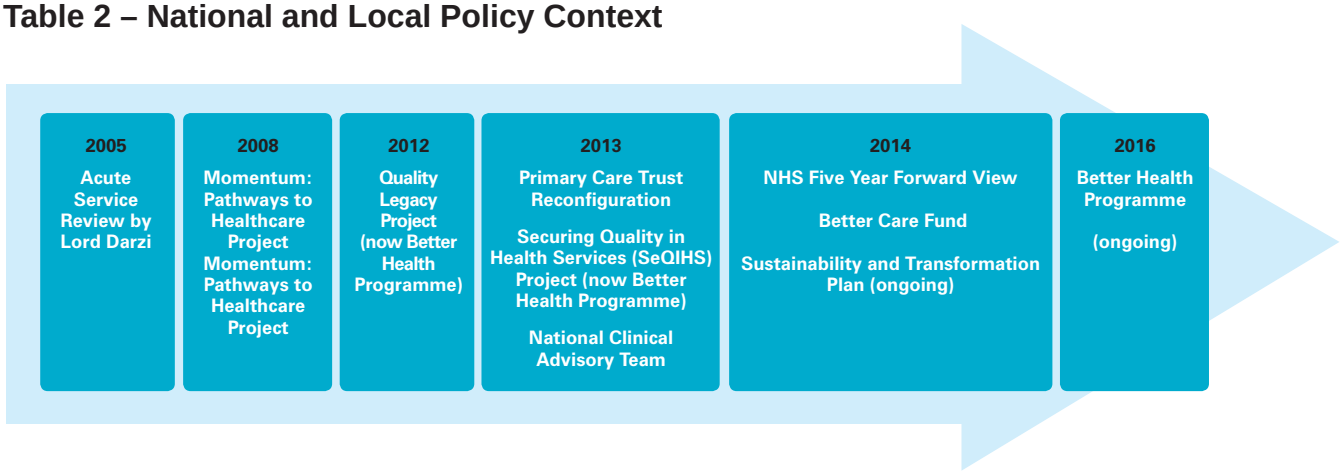
2 Hartlepool JSNA
3 Hartlepool Borough Council - Medium Term Financial Strategy
4 The Marmot Review 2010 - 'Fair Society, Healthy Lives',
5 Hartlepool Local Plan 2016

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

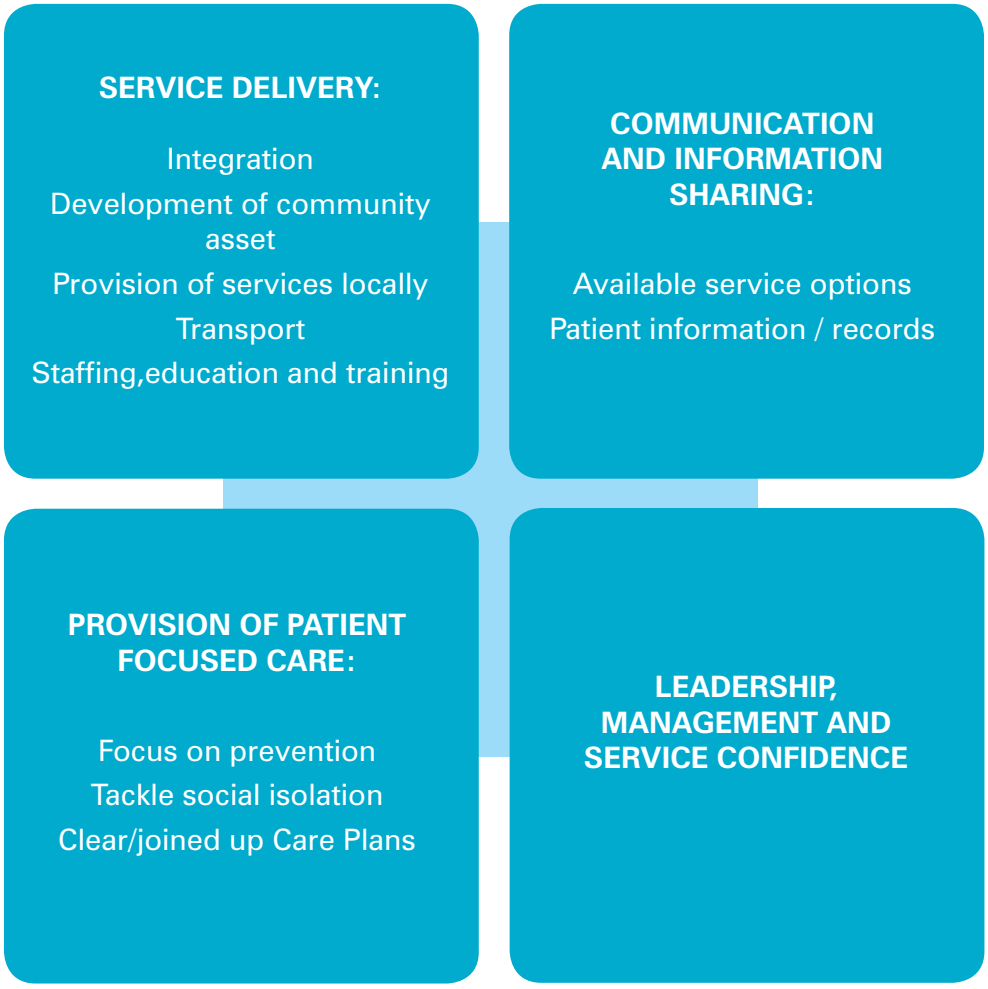
'A&E needs to be in Hartlepool, at the Hospital'

'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.

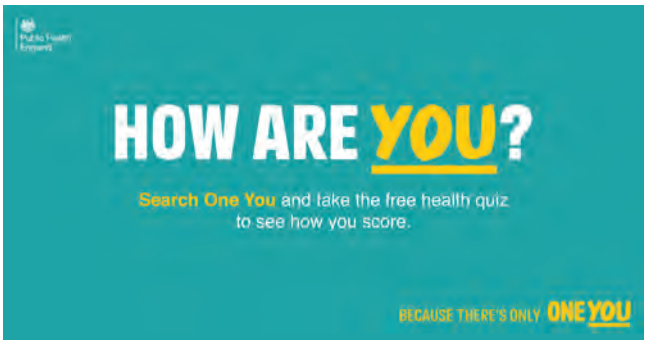


Photo © careimages.com

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.

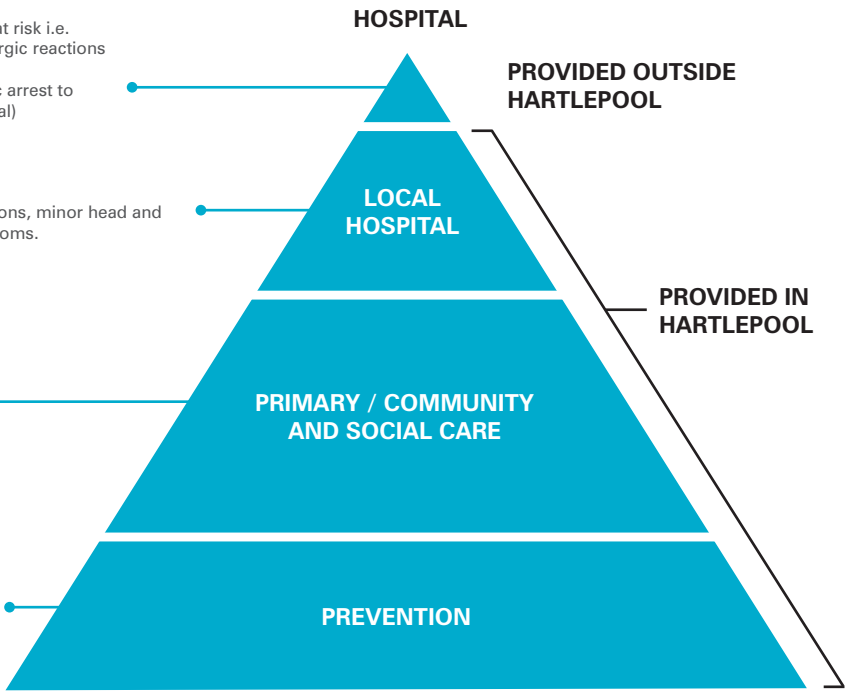
Table 4 - Operating Model

Services including:
- Accident and Emergency (Where life or long term health is at risk i.e. severe bleeding; severe chest pain, severe burns/scalds/allergic reactions and breathing difficulties.
- Acute and specialist services (i.e. trauma, stroke and cardiac arrest to continue to be provided from James Cook University Hospital)

Services including:
- Planned Surgery (i.e. orthopaedic, podiatry)
- Urgent Care (Non-life threatening i.e. sprains, strains, infections, minor head and eye injuries, some broken bones and a range of other symptoms.
- Rehabilitation
- Midwife led maternity and Fertility Services
- Outpatient services

Services including:
- GPs and other primary care
- Rehabilitation
- Speech and language therapy
- Continence services,
- Health visiting and family community nursing.

Services included span all sections of the model/ providing primary, secondary and tertiary prevention i.e.:
- NHS Health Check Programme, Health Trainer, Sport and Recreation and Get Active on Prescription services, national screening programmes
- Where appropriate, other GP services which go beyond the scope of the GP contract.



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]

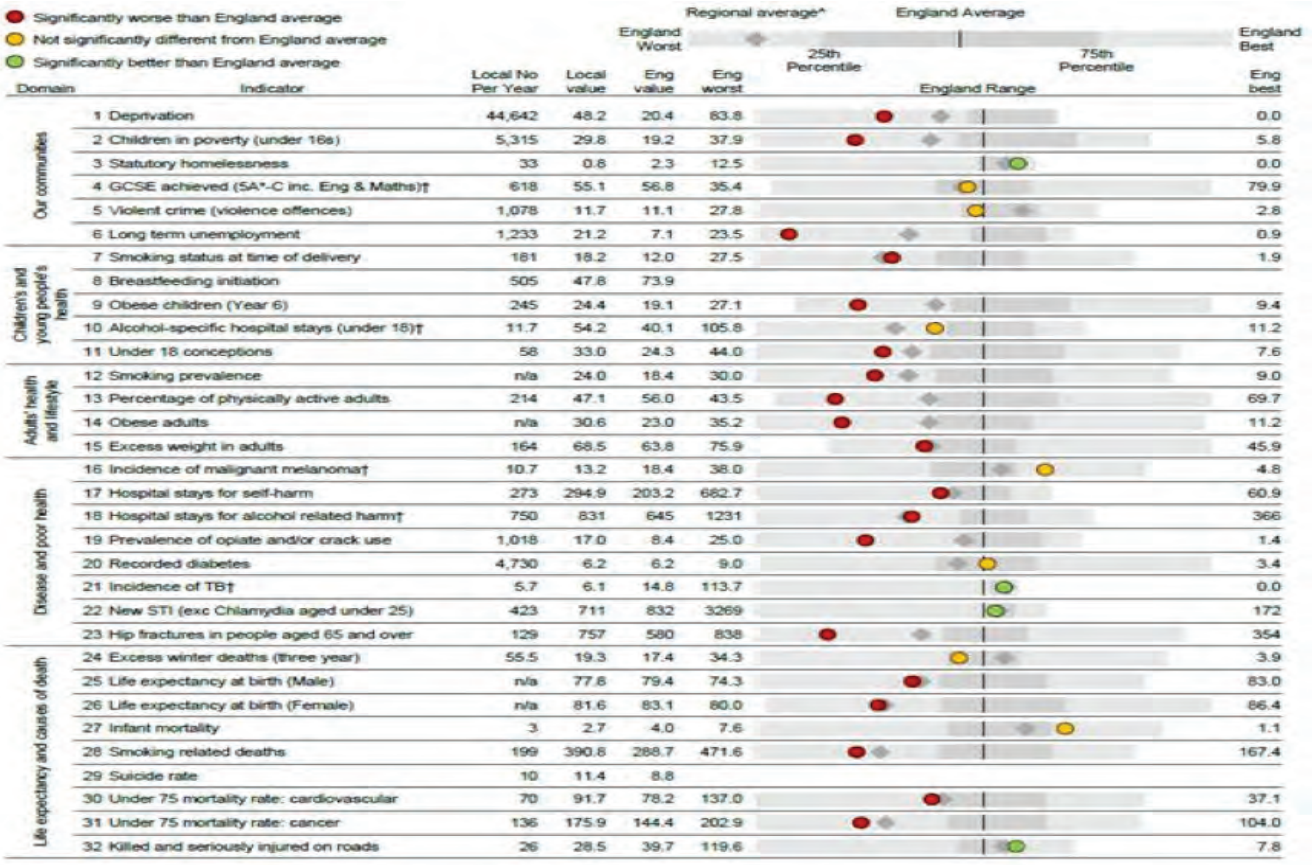
Vulnerable Groups				
Topic	**Indicator**	**Hpool %/rate**	**Hpool no.**	**England %/rate**
Learning disabilities	Proportion (%) of supported adults with a learning disability living in settled accommodation	83.6%	255	72.9%
	Proportion (%) of eligible adults with a learning disability having a GP health 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	63.8	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. 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. Integrated records and shared information, especially around out of hours services; 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. Information should be shared more effectively with improved communication.	Better communication around the services provided to ensure patients were able to make informed decisions. Communication around the services available in Hartlepool needs to be improved to raise awareness of what was available. 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. 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: **-INTEGRATION** **-DEVELOPMENT OF COMMUNITY ASSET** **-PROVISION OF SERVICES LOCALLY** **-TRANSPORT** **-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. Developing community assets such as a community hub to provide information and advice for carers as well as service users. Transport. Domiciliary care and the need to value the role, give respect and recognition to care staff. Introducing an education and training programme for individuals and carers in the management of long term conditions; 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. One contact providing the right service, at the right time, with the right expertise. Better co-ordination of a single point of delivery/expertise. Signposting to the right service at first point of contact, and improved communication between hospital/ community. Transport services within localities needed reviewing to develop community based/ primary care services in relation to spending review cuts in health and social care. 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. One service, one place, with one provider should be a key priority. 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. 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. 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. The above should be provided within the Hartlepool boundary, preferably at the University Hospital of Hartlepool. Transport was highlighted as a challenge for accessing services at the University Hospital of North Tees. 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. 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. 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. Improved workforce planning to ensure the number and skills of the workforce meet future needs of patients on both sites. 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. 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. 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. Shortness of community based beds. 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. Lack of 24/7 pharmacy at the One Life centre yet pharmacy in the hospital. Need a strong Hartlepool focus for services as currently no clear focus. Hartlepool hospital should host services such as elective care, chronic lung disease, pain services, birthing. A telephone care service is needed. 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'. 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: **-PREVENTION** **-TACKLING SOCIAL ISOLATION** **-CLEAR CARE PLANS**	Making sure every individual has a tailored assessment plan with a single named co-ordinator upon discharge from hospital. 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. Improvements in relation to carer and support around hospital discharge. Tackling isolation and loneliness. 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. 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. 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. 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. 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

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?

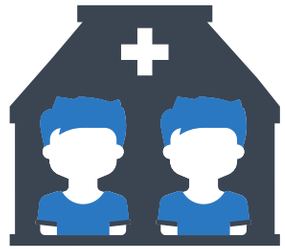
Physical infrastructure will be in place to provide services where they are required, in the most effective way.

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.

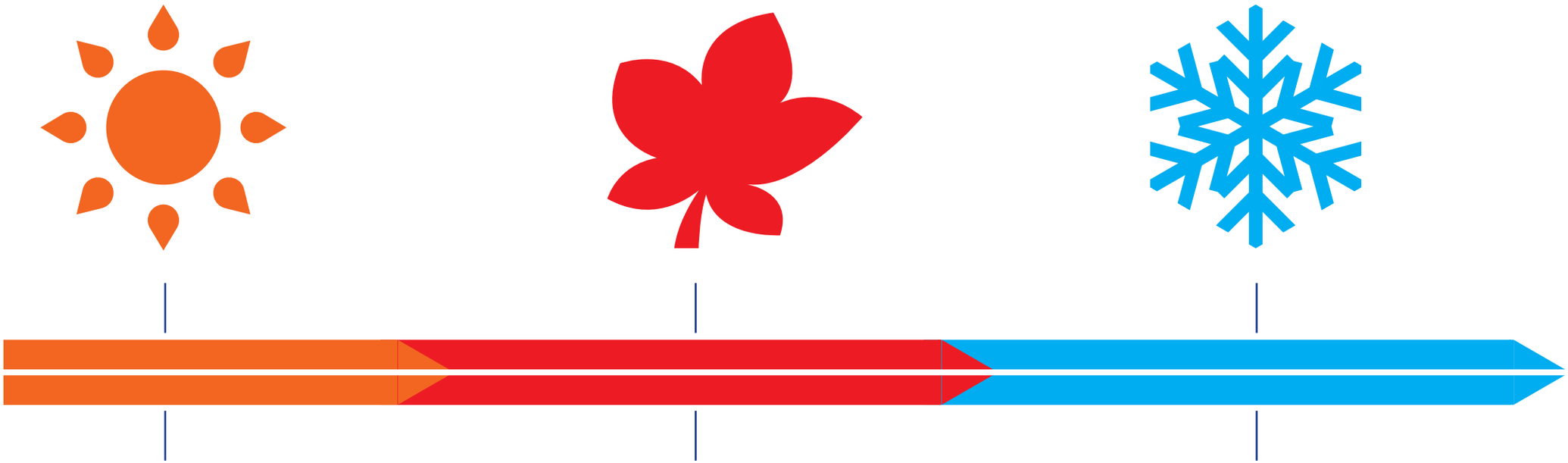
Located Care Co-ordinators in each GP surgery to prevent avoidable hospital admissions.

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.

HARTLEPOOL BOROUGH COUNCIL

NHS

Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Response by Professor David Colin-Thomé to *Hartlepool Matters* Draft Implementation Plan

Hartlepool Matters was published in October 2016, within which was a commitment for an annual review to assess progress on implementation. *Hartlepool Matters* described 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

The Draft Implementation Plan was presented to the public on 2nd October 2017, at a meeting I was privileged to chair. This Plan focuses on four overarching areas of work: Prevention; Primary, Community and Social Care; Local Hospital, Acute and Urgent Care; People and Places

I am pleased to report that impressive progress has been made on all fronts. The Implementation of all four overarching areas of work are helpfully categorised as: What have we achieved? What will we do next? How will we know than we have been successful? So much has already been achieved, that I am confident that future plans will equally be achieved which can only be for the benefit of the deserving people of Hartlepool.

One area of contention remains relating to the relative low numbers of births taking place at the Hartlepool Hospital Birthing Centre compared to the number of births of Hartlepool residents at the North Tees Hospital Maternity Unit. In *Hartlepool Matters* I foresaw this as a likely issue and to quote '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, 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'. That quote is still relevant today and the Hospital's current senior managerial and clinical leadership subscribe to better utilisation of the Hartlepool Birthing Centre. I would recommend that jointly all commissioners and relevant providers of care for Hartlepool residents should made public all the facts and issues. A relevant advisory statement from the Which organisation - 'If you're a healthy first time mum and having a straightforward pregnancy, planning to give birth in a birth centre is particularly suitable for you because it's as safe for your baby as planning to give birth in a labour ward, and you're less likely to have medical interventions. Similarly, if this is your second, third or fourth baby then birth in a birth centre is as safe as giving birth in a labour ward but with a reduced chance of medical interventions.'

Returning to the general Implementation Plan and acknowledging that comparisons can be invidious, certain of the overall excellent achievements stand out as they significantly enhance integration of individual staff and of organisations - the driving force behind *Hartlepool Matters* and incidentally, National policy.

1. Prevention- Falls Prevention Service, Care Co-ordinators/Navigators, Community Hubs, integrated Health and Social Care Teams and the Centre for Integrated Living.
2. Primary, Community and Social Care- Co-Location of teams in single point of access, Integrated Hospital patient's Discharge Team, Locality teams and Health Visitors, Hubs, working with Cleveland Fire Brigade.
3. Local Hospital, Acute and Urgent Care- NHS 111 for all urgent healthcare needs, combined Urgent Care Service now from the University Hospital of Hartlepool. (the Hospital Trust has also repatriated back to Hartlepool more elective care so 40% now delivered there), new 24/7 mental health crisis team throughout urgent/emergency services.
4. People and Places- Recruitment, education and training of staff

Conclusion

There are many very good examples of joint working to a common purpose throughout the NHS and care systems. They have mostly been instigated and developed by a forward looking local leadership, however widespread adoption and spread has been patchy. Current national policy strongly encourages and *de facto* mandates integrative new models of care. The question facing the Hartlepool NHS and Care System leadership is how far down this path do they wish to go? Whether it's for staff working across organisational boundaries or at the level of inter organisational working, sustainability of such approaches will require clear governance which can be either informal or formal. Whatever form is chosen, it must incorporate common purpose and desired outcomes. Governance must not major on compliance but on relationships, behaviours and joint sharing of the achievement of outcomes and concomitantly the sharing of any gain or loss. A tall order or the only way forward for sustainability and value? To sustain the current achievements and deliver the future plans, even if changes of personnel or even to organisational form, requires a commitment to such an approach to governance.

Of my Hartlepool Matters Report, one recommendation and one strong suggestion need at least an exploration.

Recommendation viii) on page 18 '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.'

Page 21. '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.

A Hartlepool organisation for Hartlepool people

Recommendations;

- That jointly all commissioners and relevant providers of care for Hartlepool residents should made public all the facts and issues relating to the suitability of giving birth at Hartlepool Birthing Centre.
- 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.'
- Consideration of a Hartlepool organisation for NHS and Care services for Hartlepool people

Health and Wellbeing Board

Hartlepool Matters Implementation Update

5 March 2018

Introduction

- In 2016, Professor David Colin-Thomé's 'Hartlepool Matters' report outlined a new model for integrated health and social care services in Hartlepool.
- Health and Wellbeing Board set up this group to monitor the implementation of the Hartlepool Matters report and report back.
- The report made recommendations in relation to Prevention, Primary / Community and Social Care and Local Hospital, Acute and Urgent Care Services.
- The report also outlined overarching principles for a new way of working.

Overarching Working Principles

- **Move services out of hospital to a community setting** (with funding);
- **Capacity in the right part of the system** with trained/competent staff;
- Integrate community / local authority / hospital services with general practice;
- **Sufficient paramedic led ambulances** when patients need transport to specialised centres;
- The right **care in the right place, at the right time**;
- All parts of the **local urgent care system to be** integrated;
- All health and care organisations to **work together to increase the effectiveness and coordination** of support to those who need care and support;
- Patients to be part of the process to **hold the whole system to account**; and
- **Public support** for the Plan, its delivery model and for local outcome measures (complimenting national measures).

Prevention

Prevention Issues (PHOF)

- Premature Deaths – too many, too early
- Healthy Life Expectancy – 2nd worst and 10th worst
- Smoking Prevalence – 18.7% but worst in north east
- Drugs Misuse and Alcohol Abuse – 2 x England average
- Adult Obesity highest in NE – Physical Activity lowest

Prevention Achievements

- 3 Community Hubs opened in areas of greatest need
- Joined Wave 3 of national Diabetes Prevention Programme
- Continue to work to 5% smoking prevalence by 2025 (known as 5 by 25) including smoke free NHS by 2019
- Work with GPs and Pharmacies to improve effectiveness and uptake of NHS Health Checks
- Reviewing Early Help Offer to improve effectiveness & impact

Acute and Urgent Care Services

NHS
North Tees and Hartlepool
NHS Foundation Trust

Anaesthetics

Integrated Urgent Care Service

RAPID RESPONSE 24

Endoscopy

Holdforth Unit

Hartlepool Matters
University Hospital of Hartlepool

Out-patients

OUTPATIENT

Psychology

Orthopaedic outpatients

Surgery

Maternity (Birthing Centre)

NHS

North Tees and Hartlepool

NHS Foundation Trust

Integrated Urgent Care Service

Anaesthetics

Integrated Urgent Care Service

Endoscopy

Out-patients

North Tees and Hartlepool
NHS Foundation Trust

Hospital at Home- Respiratory:

Amber care bundle:

Integrated Single Point of Contact

Community matrons:

Hartlepool Matters

Musculoskeletal Services:

Hospital of God

Multi Disciplinary Hub: McKenzie House

Integrated Discharge Team:

Trusted assessor;

North Tees and Hartlepool
NHS Foundation Trust

Hospital at Home

Hospital at Home-Respiratory:

Integrated Single Point of Contact

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North Tees and Hartlepool
NHS Foundation Trust

Hospital at Home

Hospital at Home- Respiratory:

Integrated Single Point of Contact

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Primary Care Services

NHS
Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Hartlepool Matters – Achievements to date

INTEGRATION OF HEALTH & CARE RECORDS:

E- CONSULTATION: Phase 1 undertaken with a number of GP Practices.

INTRODUCTION OF CARE CO-ORDINATORS

EXTENDED ACCESS 7 DAYS PER WEEK: provided from One Life centre for LTC management for all registered patients

RECRUITMENT OF GPs: work being undertaken to recruit GPs internationally to ensure sustainability of primary care

CARE NAVIGATION & TRAINING - Phase 1 undertaken by admin and clerical staff in practice, to better sign post patients to services

MULTI DISCIPLINARY HUB: McKenzie House – Piloting new model of care to then roll out across town

PATIENT ONLINE - launched in every practice- allowing more patients to manage their appointment needs, order repeat prescriptions and view summary care records online

Hartlepool Matters - Next Steps

Short term deliverables 0-6 months

NHS
Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Initiative	Where have we got to?
E consultations	Delivery plan submitted to NHSE to release funding- application accepted. Engagement sessions planned with practices to discuss next phase of roll out.
Increase uptake Patient Online registrations	Continuing to work with the transactional services team in NECs to offer additional support and resources to practices to increase uptake of registrations.
Phase two of care navigation training	Working group established, with support of the GP Federation (H&SH,) to review and implement care navigation templates. All practices now have care navigators trained.
Review care coordinator scheme patients	Feedback received from practices and the service provider is being used to review to service specification and focus of the care coordination scheme. Funding has been agreed for a further two years by the LADB.
Develop NMOC in hubs • **Develop SPA to include MH**	New models of Care is to be relaunched in April 2018, taking on board feedback from existing clusters of practice and in line with national direction of travel. A Clinical Advisor has been appointed to ensure the work continues to be clinically led. Within NMoC will be the development of a single point of access to include mental health. The CCG will work closely with Public Health to develop healthy profiles of practice hubs to ensure services meet the needs of the local population.
Develop Integrated Discharge team	All partners and stakeholders across Hartlepool have worked in collaboration to develop an Integrated Discharge Team (IDT) to improve unnecessary delays for people leaving hospital once their acute care is complete and to support them return and remain safely at home. The IDT now consists of the following representatives/ services:- NTHFT Discharge Liaison Service NTHFT Emergency Care Therapy Team, NTHFT Acute Therapies , LA Assessment/ Reablement Teams, Social Workers from the locality teams, CHC Nurse Assessor, Home from Hospital service to support people to return and remain safely at home. The Integrated Discharge Team won an award for Best Innovation Project at the North East, Cumbria, Yorkshire and Humber Commissioning Awards in 2017 and current data shows that across Hartlepool Delayed Transfers of Care have reduced by 27% (April – December 2017/18 compared to the same period in 2016/17).

Hartlepool Matters - Next Steps

Medium term deliverables 6-12 months

NHS
Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Initiative	Where have we got to?
Primary care hubs established	The work which is launching in regard to New Models Of Care will underpin the establishment of primary care hubs and the development of primary care at scale. A work plan will be developed following the launch to enable hubs to be established within the first half of 2018/19.
Develop a strategic workforce plan	All Hartlepool practices are now submitting their workforce data via the Health Education North East (HENE) primary care workforce tool which enables a greater understand of workforce risks and allows workforce planning to be developed across the locality. The Cleveland LMC has requested access to this data to further support bringing together workforce data to inform future staffing models.
Implement a fully integrated single point of access	An event took place in June 2017 which included a range of stakeholders to understand the vision and requirements for an Integrated Single Point of Access across Health and Social Care. The CCG, HBC and NTHFT are working closely to deliver the vision for integrated single point of access (iSPA) for Adult Social Care and Health referrals and it is hoped that the service will be mobilised in April 2018.
Explore opportunities to deliver further integration of health and social care services at One Life	1) Funding has been allocated to undertake a feasibility study to support the potential creation of a hub of primary care services on the Hartlepool hospital site. 2) The Local Estates Forum has identified void space at the One Life Centre. Connections have been made with the Local Authority to look to utilise the space e.g. drug and alcohol services.
Share electronic records utilisation of the Great North Care Record (GNCR)	100% of all secondary care referrals are now processed via the e-referrals system with 100% sign up to the MIG from Hartlepool practices, supporting the movement towards the development of a GNCR.

Children's Services

Children's Services Achievements

- Development of North of Tees Children's Hub – a multi agency partnership to help children and their families get the right support at the right time

- Development of four locality based integrated early help teams for children, young people and their families bringing together local authority family support workers and health visitors, school nurses around the Children's Centre offer

Children's Services
What next?

- Develop improved pathways for children and young people with Special Educational Needs and Disabilities and strengthen joint commissioning of services for children with education, health and social care needs
- Review the delivery model for children's community health visiting and school nursing services to make sure this is responsive to the emerging needs of children and young people.
- Develop locality based joint commissioning partnerships between the local authority, CCG and schools.

Adult Services

Adult Services Performance

- User & Carer Survey Results
- Complaints & Compliments Report
- Integrated Discharge Team Award
- CQC Local System Review
- Improvements in key performance measures

Adult Services Achievements

- New Centre for Independent Living
- Support for people living with dementia
- Tackling social isolation
- Care Quality Improvement
- Care home capacity

Adult Services Plans

- Integrated Single Point of Access.
- Closer working with GPs and community services.
- Joining up intermediate care services.
- Integrated discharge pathways & trusted assessors.
- Strengthening support available for carers.

People and Places

People and Places Achievements

- Local Estates Forum established.
- Shuttle bus (UHH and UHNT).
- International recruitment and retention of GPs.
- Plans for education and training of specialist teams (commissioned with the support of Education North East).
- Recruited paramedics to meet the shortfall.
- Plans to ensure we have the right leadership and management skills for future.
- Relevant medical information from GP records available to other healthcare professionals who provide direct care.

People and Places
What next?

- Plan the estate required to provide services - maximise the use of estate we hold.
- 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.

Questions

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NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group

Review of Mental Health & Wellbeing Services for Children & Young People

1.0 Introduction

1.1 This report is to provide the Health & Wellbeing Board with an overview of the rationale and intended outcomes for reviewing the Mental Health & Wellbeing provision for children & young people in Hartlepool.

2.0 Background

2.1 The improvement of the mental health & wellbeing of children and young people has been a focus of national policy in recent years. *Future in Mind – Promoting, protecting and improving our children and young people's mental health and wellbeing* responds to the national concerns around provision and supply of system wide services and support for children & young people. This approach is being supported by the current Green Paper which is out for consultation on '*Transforming Children & Young People's Mental Health Provision'.*

2.2 Both Future *in Mind* and the Green Paper emphasise the need for a whole system approach to ensure that the offer to children, young people and their families is comprehensive, clear and utilises all available resources.

2.3 As a CCG we are responsible for ensuring there is a comprehensive Local Transformation Plan in place which is compiled and annually reviewed in partnership with our Local Authority colleagues and wider stakeholders.

2.4 The refreshed plan, which was produced in October 2017, built on the success of previous years by setting actions for 2018 to review the CCG commissioned CAMHS service and to work with Hartlepool Borough Council to map their mental health and wellbeing offer for children & young people.

2.5 This would then enable us to understand the full provision and to determine where the gaps are which would allow us to work together to commission differently.

3.0 Review of Core CAMHS

3.1 Hartlepool & Stockton CCG have a contract in place with TEWV for a suite of services but the one which the review will focus on is the core CAMHS service; 'Community child and Adolescent Mental Health Service'.

3.2 To enable us to conduct an holistic review, there are a number of approaches we have started to take. The information below highlights work already completed, work in progress and work to be commenced imminently. The Board need to be advised that as the review is

happening across both Hartlepool and Stockton, some actions are being undertaken in one locality and others in both, however, the learning will be taken across both.

3.3 It is worthy to note that although we commenced the review in November 2017 and began gathering data etc. TEWV have changed the way in which they process referrals through core CAMHS. From January 2018 all referrals are receiving a 30 minute initial assessment appointment. Therefore all children & young people have one face to face contact, if they do not meet the threshold for the specialist service they are signposted to services which could give them support to meet their needs.

3.4 The outcomes which we want to achieve from this review are:

- An informed view of the cohort of young people accessing mental health services
- An understanding of the thresholds for accessing services, and therefore any gaps in the services will be identified with an evidence base to support the findings
- A thorough understanding of the processes young people and their families go through to access a service
- An agreed set of outcomes which TEWV will report on
- A streamlining of processes if this is identified as a finding
- Being able to demonstrate to stakeholders/partners what CAMHS are doing, what they can do and what isn't achievable to increase understanding and partnership working

4.0 Actions to date

4.1 We have a better understanding of the staffing structure and the skill mix within that structure – who, how and when children and young people are seen. Alongside the number of cases held, frequency and length of appointments.

4.2 We have more detailed data from TEWV relating to the cohort of children and young people who access the service. This piece of the project is sitting with Contract management colleagues to disseminate and analyse further for us.

4.3 We have a clinical lead who is working with us on this piece of work. They have pulled case studies together of referrals their practice has made and we are carrying out reflective practice of decisions made. They are also spending time shadowing CAMHS practitioners and sitting in on the assessment process.

4.4 We have attended a number of internal TEWV meetings to ascertain a better understanding of working practices and internal reporting mechanisms. There are more booked in to attend.

5.0 Work in progress

5.1 We have created a stakeholder questionnaire which we want to circulate to all schools and relevant local authority teams in Hartlepool. We are working with our Engagement Team to finalise this process, but would welcome the support of Hartlepool Borough Council in circulating this to all the relevant teams and individuals.

5.2 We are also creating a questionnaire for children & young people to complete. Initial discussions with Hartlepool Borough Council have indicated a number of avenues as to

how we can circulate this to as wide an audience as possible. We will also utilise the feedback from Healthwatch to support the finding from the questionnaire.

6.0 Work to commence

6.1 Additionally from TEWV we have requested:

- Further joint analysis of where children & young people are signposted to
- Analysis of repeat referrals
- Analysis of referrals which are not accepted

6.2 We need to commence work through the Future In Mind group to understand the mental health & wellbeing offer from the Local Authority

6.3 Work has started with schools to understand the Mental health & wellbeing provision which they purchase. This is being built on to enable us to have a full picture, we will then ask schools to participate in a task & finish workshop to look at the feasibility of joint commissioning.

7.0 Governance

7.1 Both Hartlepool and Stockton local authorities are aware of the review and the review outcomes and process were agreed at the FIM oversight group.

7.2 A report will also be brought to the Health & Wellbeing Board upon completion.