

Health and Wellbeing Board

Agenda

8 October 2026

Time: 10.00am

Location: Council Chamber

Members: Health and Wellbeing Board

Prescribed Members:

Elected Members, Hartlepool Borough Council - Councillors Darby, B Harrison, Jorgeson, Roy (C)
Representatives of NHS North East and North Cumbria Integrated Care Board (NENC ICB) - Karen Hawkins (VC) and Levi Buckley
Director of Public Health, Hartlepool Borough Council - Chris Woodcock
Executive Director of Children's Services, Hartlepool Borough Council - Alison Sutherland
Executive Director of Adult and Community Based Services, Hartlepool Borough Council - Jill Harrison
Representatives of Healthwatch - Margaret Wrenn and Christopher Akers-Belcher

Other Members:

Chief Executive, Hartlepool Borough Council – Matt Wilton
Director of Development, Neighbourhoods and Regulatory Services, Hartlepool Borough Council - Kieran Bostock
Assistant Director, Inclusive Growth, Hartlepool Borough Council - Javed Khan
Assistant Director, Housing and Community, Hartlepool Borough Council - Suzanne Halliwell
Assistant Director for Early Intervention, Performance and Commissioning - Rebecca Stephenson
Representative of Hartlepool Voluntary and Community Sector – Nicky Haggan and Tracie Bestford
Representative of Tees, Esk and Wear Valley NHS Trust - Jamie Todd
Representative of University Hospitals Tees - Neil Atkinson
Representative of Cleveland Police - Helen Wilson
Representative of GP Federation - Fiona Adamson
Representative of Headteachers - Sarah Nevison

CIVIC CENTRE EVACUATION AND ASSEMBLY PROCEDURE

In the event of a fire alarm or a bomb alarm, please leave by the nearest emergency exit as directed by Council Officers. A Fire Alarm is a continuous ringing. A Bomb Alarm is a continuous tone. The Assembly Point for everyone is Victory Square by the Cenotaph. If the meeting has to be evacuated, please proceed to the Assembly Point so that you can be safely accounted for.



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 16th July 2026.

4. Items for Consideration

4.1 Changing Futures Programme Update – *Director of Public Health*

5. Items to note

5.1 Neighbourhood Health Update – Deputy Director Neighbourhood Health South, *NENC ICB*

5.2 Integrated Neighbourhood Team – Deputy Director Neighbourhood Health South, *NENC ICB*

6. Items for information

6.1 Hartlepool Mental Health Strategic Partnership – *Mental Health Strategic Lead*

7. Any other business which the chair considers urgent

For Information

Date of next meeting – 3 December 2026.



Health and Wellbeing Board

Minutes and Decision Record

16 July 2026

Meeting commenced

Time: 10:00 am

Location: Council Chamber, Civic Centre, Hartlepool

Present:

Karen Hawkins (VC) (In the Chair)

Prescribed Members:

Elected Members, Hartlepool Borough Council – Councillors Darby, B Harrison and Jorgeson.

Representative of North-East and North Cumbria Integrated Care Board (NENC ICB) – Karen Hawkins

Director of Public Health, Hartlepool Borough Council – Chris Woodcock

Interim Assistant Director of Education - Fiona Stobbs

Representatives of Healthwatch – Christopher Akers-Belcher and Margaret Wrenn

Other Members:

Representatives of Hartlepool Voluntary and Community Sector – Sandra Britten (Alice House Hospice) and Nicola Haggan (Alice House Hospice)

Representative of Tees, Esk and Wear Valleys NHS Trust - Jamie Todd

Also in Attendance:

Councillor Sue Little

Councillor Rob Stevenson

Natalie Frankland – Health Transformation Lead, Lets Connect

Katie McLeod - Deputy Director of Delivery, NENC ICB

Officers:

Joan Stevens – Democratic Services and Statutory Scrutiny Manager

Gemma Jones – Scrutiny and Legal Support Officer

1. Apologies for Absence

Apologies were received from Councillor Dunbar, Councillor Roy, Christine Fewster, Neil Atkinson, Sarah Nevison and Lisa Adams.

2. Declarations of Interest

None.

3. Minutes

Minutes from 16 February 2026 – confirmed.

4. Health and Wellbeing Board Peer Review - Review of Health Protection Board Terms of Reference – *Director of Public Health*

The Director of Public Health provided an update on the Local Government Association (LGA) peer review of the Health and Wellbeing Board (HWB). The responsibilities and functions of the HWB were summarised in the report. Members were advised that a time of significant and complex change had recently taken place, with the Health and Care Act 2022 introducing major reforms to the NHS landscape, and a greater focus on 'place' level activity.

The Peer review outcomes were listed within the report and highlighted key opportunities for the HWB, they were -

- Support from members for reviewing and resetting how the board works to maximise impact.
- The HWB has the potential to play a stronger strategic leadership role in the system and to be at the forefront of reducing inequalities, neighbourhood health and integration and pride in place.
- Hartlepool benefits from strong partnership relationships and goodwill across organisations and the VCSE.
- Community and partnership voices shape the Joint Local Health and Wellbeing Strategy (JHWS) and reducing inequalities is at the heart of the strategy.

Common areas of challenge were outlined including the potential of the statutory requirements of the HWB to inadvertently direct the capacity of the board.

The review findings enabled HWB partners to develop some initial concepts for future HWB operations via an informal workshop. Concepts included far fewer strategic priorities and the endeavour to minimise duplication and maximise participation. Members were advised that there was a consensus for the HWB to move from a transactional to a transformational way of working.

A proposed governance structure for the HWB was also presented to Members. This set out plans for two development groups reporting to the Board, each aligned to a key local priority requiring a strategic partnership approach to achieve desired outcomes. The proposed focus areas for these groups were Changing Futures and Neighbourhood Health.

In the discussion that followed Members of the HWB raised the following points –

- The importance of partner attendance at HWB meetings was emphasised to ensure strong engagement and effective representation from all partner organisations.
- The importance of the continued involvement from partners from the voluntary and community sector.
- The potential to strengthen links with other HWBs on issues affecting the Tees Valley and the wider region.
- Greater emphasis being placed on patient voice and lived experience, with opportunities for the public to contribute to and inform the process.

The Chair highlighted the value of undertaking a peer review. The Chair commented that an independent assessment of how effective and constructive the HWB is would support the Board in identifying areas for improvement and help inform its future development.

Decision

- i) The progress towards the improved governance approach and partnership commitment to the Health and Wellbeing Board was noted.
- ii) The strategic priorities of Changing Futures and Neighbourhood Health were agreed.

5. Embedding Neighbourhood Health: Integration, Collaboration and Transformation – Presentation - *Deputy Director of Delivery – Tees Valley Local Delivery Team*

Members of the Board received a presentation on Embedding Neighbourhood Health, a new initiative focused on creating integrated care services that deliver personalised care closer to where people live. The six core components of Neighbourhood Health were outlined and included within this were; population health management, modern general practice, integrated intermediate care and urgent neighbourhood services.

The presentation also outlined actions for 2026/27 and as well as plans for a longer-term reform. The key outcomes and benefits were discussed such as more care closer to home, cutting hospital admissions and faster discharge and follow-up. The neighbourhood health framework was provided and included how this would be delivered and what this would mean operationally. Challenges and opportunities were also outlined.

In the discussion that followed Members raised concerns about the availability of GP appointments, hospital discharge delays for those needing care packages and the availability of emergency and health services in Hartlepool.

The Chair acknowledged the importance of the points raised. The Chair noted that this initiative would focus on how changes could be implemented to improve services through greater integration and collaboration between health services, the voluntary and community sector, and wider social care partners. It was also noted that the GP

Federation was represented on the HWB, and that patient representatives and other key stakeholders would play an important role in co-designing new ways of working.

A Member welcomed the new initiative and commented on the need to change the perception that hospitals are the sole providers of care. The Chair echoed this point and advised that this was an opportunity to reframe how care is provided. Engagement would continue to build this narrative.

A Healthwatch representative discussed the importance of public engagement in relation to neighbourhood health, particularly ensuring that people with accessibility needs and those experiencing challenges such as drug and alcohol dependency were able to participate in and contribute to the process.

The Chair commented that this was about all partners linking into programmes of work and described the initiative as a whole system focus approach. The Healthwatch Representative commented that this was a great opportunity for partners to challenge each other and bring about solution focussed change.

Decision

- i) Members noted the content of the presentation.

6. Changing Futures Presentation - *Assistant Director of Early Intervention, Performance and Commissioning*

The Director of Public Health outlined the UK government initiative aimed at improving outcomes for adults experiencing multiple disadvantage. The programme aims to work with people with multiple and complex needs who have two or more overlapping issues including –

- homelessness
- substance use
- poor mental health
- domestic abuse
- involvement with the criminal justice system

The Director of Public Health advised that people with complex needs often face underlying challenges such as trauma, communication difficulties, poverty and stigma. It was noted that these factors contributed to poorer health outcomes, including a lower life expectancy and a greater reliance on healthcare services.

It was reported to Members that many services, teams and partnerships were working with this cohort. Each were trying to resolve the individual challenges, whilst recognising the many other competing challenges which they may not have the capacity or remit to resolve. Outcome challenges were highlighted within the presentation and what was working well.

In the discussion that followed Members asked how many people in Hartlepool would be in this cohort. It was estimated to be around 300 people. A Member noted

that there were some fantastic agencies working with people in the town and highlighted the benefits of peer support and those services that employed people with lived experience.

A member asked whether the initiative involved working with young people. It was clarified that the programme was aimed at adults; however, it was noted that learning from the initiative could help inform future support and preventative work for younger people.

Decision

- i) Members noted the content of the presentation.

7. Better Care Fund Update - *Executive Director of Adult Services & Public Health*

The Deputy Director of Delivery (NENC ICB) presented the 2025/26 Better Care Fund (BCF) Plan and provided an update on performance for 2025/26. It was noted the Hartlepool BCF plan was appended to the report. The plan outlined key performance indicators, and it was noted that all performance targets for 2025/26 were achieved. A summary of performance against targets was noted in the report.

Decision

- i) The Health and Wellbeing Board noted the submission of the Hartlepool Better Care Fund Plan for 2026 – 2027 and the achievement of all 2025/26 performance targets for the national metrics.

8. Healthwatch Hartlepool Annual Report - *Chief Executive - Healthwatch Hartlepool*

The Chief Executive of Healthwatch Hartlepool presented the Healthwatch Hartlepool published annual report for 2025/26. The report provided an overview of the diverse work that Healthwatch Hartlepool had been involved in throughout the year. Staffing and funding for Healthwatch Hartlepool was also discussed.

The report highlighted key projects and work carried out with partners, areas of work included –

- Primary Care Access
- Winter care
- WorkWell
- Palliative Care
- NHS Digital
- Mental Health and Rehabilitation
- University Hospital of Tees

Future priorities were outlined, with the top three being cardiovascular disease, supporting the NENC ICB work on Modern General Practice and the Cancer Patient Experience Project.

Members highlighted the importance of the work of Healthwatch Hartlepool in giving a voice to the residents of Hartlepool, particularly regarding the issue of Dementia.

The Chair echoed this and thanked Healthwatch Hartlepool for their significant engagement with the public and to recognise the staff and volunteers for their dedicated professionalism in ensuring the voices of residents are heard.

Decision

- i) Members of the Health & Wellbeing Board commented on and noted the Healthwatch Hartlepool Annual Report 2025/2026.

9. Hartlepool Community Mental Health Transformation – Let's Connect Hartlepool

This item was noted for information.

10. Any other business which the chair considers urgent

None.

The meeting concluded at:

Time: 12pm

CHAIR



Health and Wellbeing Board

8 October 2026

Report of: Director of Public Health

Subject: CHANGING FUTURES PROGRAMME UPDATE

1. Council Plan Priority

Hartlepool will be a place:
- where people live healthier, safe and independent lives. (People)

2. Purpose of Report

2.1 To provide an update on the development of the changing futures programme.

3. Background

3.1 Hartlepool was selected as one of 18 local authorities in England to participate in the latest phase of the national Changing Futures programme. The programme aims to improve outcomes for adults experiencing a combination of homelessness, substance misuse, poor mental health, domestic abuse and criminal justice involvement through a whole-system, person-centred approach.

- 3.2 Underlying complicating factors often include trauma, communications challenges, poverty and stigma. The co-existence of several overlapping and intersecting issues faced by an individual significantly impact their overall wellbeing and ability to function effectively in society. From a service provision perspective, this cohort can be identified by two key components: breadth and depth. Breadth refers to the presence of multiple needs across different domains that are interrelated and interconnected, rather than existing in isolation. Depth indicates that the individual needs are profound, severe, serious or intense in nature.
- 3.3 National learning has demonstrated that people with multiple disadvantage often experience fragmented services, repeated crises and poor outcomes because organisations work in isolation. The programme therefore seeks to improve collaboration, data sharing, trauma-informed practice and coordinated support across the local system.
- 3.4 The programme will run for three years with the national goal of learning and practice being embedded locally beyond that.

4. Multiple and complex needs in Hartlepool

- 4.1 Local data demonstrates the scale of need and the importance of developing a more coordinated response. Key indicators include:

Mental health

- Local estimates suggest approximately 15,000 residents experience poor mental health.
- Hartlepool has seen increasing rates of secondary mental health referrals and inpatient admissions.
- The suicide rate for 2022-2024 was 17.6 per 100,000 population, among the highest rates in England.

Substance misuse

- An estimated 6,000 residents have a drug or alcohol treatment need, with approximately 1,200 known to services.
- Hartlepool experiences significantly higher than average rates of alcohol-related mortality and alcohol-related hospital admissions.
- Rates of drug-related mental and behavioural disorder admissions are among the highest in England.

Safeguarding

- Adult safeguarding concerns involving mental health support needs have increased from 2020/21 to 2024/25.
- Safeguarding concerns have risen year-on-year since 2019/20.

Domestic abuse

- Local estimates suggest approximately 1,400 residents have a domestic abuse support need.
- The wider Cleveland area continues to have the highest domestic abuse rate in England.

Housing and homelessness

- An estimated 650 residents have a homelessness need.
- Significant overlap exists between homelessness, offending and substance misuse.
- Homelessness rates have more than doubled since 2018/19.

These indicators reinforce the need for agencies to work differently and collectively to support people who experience repeated crisis and poor outcomes.

5. Steering group

5.1 A multi-agency Changing Futures Steering Group is now in place with representation from:

- Hartlepool Borough Council
- NHS Integrated Care Board
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Cleveland Police
- Probation Services
- VCSE sector representatives
- Relevant commissioned providers

Systems change consultants have facilitated the initial steering group workshops, with follow-up discussions taking place across partner organisations.

5.2 There was a national requirement for the establishment of the steering group and for that group to complete a system maturity assessment. This highlighted strong partner engagement and commitment but that the system

was ‘emerging’ in relation to a partnership approach to those with multiple and complex needs. Partners importantly demonstrated extensive knowledge of local communities and individuals who experience multiple disadvantage and are high users of services.

6. Emerging findings

6.1 Several key themes emerged through initial workshops and partner discussions:

- Hartlepool has a strong history of multi-agency working.
- Established governance and partnership structures.
- Excellent practitioner knowledge of local communities and the most vulnerable residents.
- There is existing outreach activity supporting people who are not actively engaged with some services. Yet these remain attached to those individual service areas.
- A strong commitment across organisations to improve outcomes for people experiencing multiple disadvantage

6.2 Common areas of challenge were also identified:

- There are known difficult transitions between services, particularly when individuals complete treatment programmes and require ongoing support regarding other aspects of their lives.
- Challenging data and intelligence systems across partner agencies. Frequently using organisational systems which are not compatible with partners. There may be restricted information sharing across those agencies due to appropriate information governance requirements.
- There may be a lack of a shared definition and collective understanding of the multiple disadvantage cohort.
- There is a risk of individuals falling through service gaps during key life transitions. Whilst this is a recognised challenge, it is complex to address given the changing statutory responsibilities.

7. Steering group developments

7.1 A second multi-agency Changing Futures steering group has begun to move the programme from reflection into agreement, action and delivery. The workshop built on the initial maturity assessment and a series of one-to-one conversations with partners across the system.

Partners agreed that the cohort definition may not need to be perfectly aligned, but that through service interactions, the complexities of the current system may begin to emerge.

7.2 Thematic focus

Feedback from partner interviews, the steering group and consideration of the developments to date, four consistent themes have been identified which will shape the initial developments of the service and system change programmes:

1. People do not fit neatly into service categories

Partners recognised that individuals experiencing multiple disadvantage often have interconnected needs across housing, mental health, substance misuse, domestic abuse and criminal justice services. The programme must therefore focus on the complexity of people's lives rather than individual service labels.

2. Opportunities exist at crisis and transition points

Partners consistently highlighted repeated presentations, multiple hand-offs between services and critical transition points where people become visible to services but do not receive a coordinated response. There was strong agreement that earlier intervention and stronger collaboration could improve outcomes.

3. The key change required is how services work together

How organisations coordinate support, share responsibility and work collectively around individuals will be critical. Frontline practitioners need greater freedom and support to work differently.

4. Pace must be accompanied by learning

Partners want to move quickly but recognised the need to continually learn and adapt. Data, lived experience, professional insight and frontline learning should all shape programme development and decision-making. It is likely that an academic institution will support the learning and evaluation of this programme.

Partners want to move quickly but recognised the need to continually learn and adapt. Data, lived experience, professional insight and frontline learning should all shape programme development and decision-making.

8. Initial workstreams

8.1 To translate ambition into action, the steering group has agreed three early core workstreams.

1. Multidisciplinary Support and Pathways

This workstream will focus on improving transitions and pathways, strengthening trauma-informed and person-centred practice, exploring how to reduce 'hand offs' and support individuals

A community gathering event is planned for September 2026 which will include those with lived experience, key frontline practitioners and the changing futures steering group. The session will be developed to further develop understanding of the complexity of vulnerable residents' life and the system challenges that prohibit the support. Ideally this should help to inform the gradual shift in local service provision.

2. Data and Intelligence

This workstream will focus on improving the understanding and definition of need. Currently this will be defined in relation to support or prevention of the particular service they are involved. The challenge is to ensure that prevention and need are understood across the individual's life, not solely that service area.

3. Strategic Alignment, Ownership and Permission

This workstream will focus on creating senior leadership commitment required. As and when the opportunities to better serve our residents emerge and greater clarity on where the system barriers exist, this partnership commitment will be critical to developing person centred approaches. The Hartlepool Health and Wellbeing Board will need to continue to champion this approach and support innovative practice across the system.

9. Recruitment and workforce

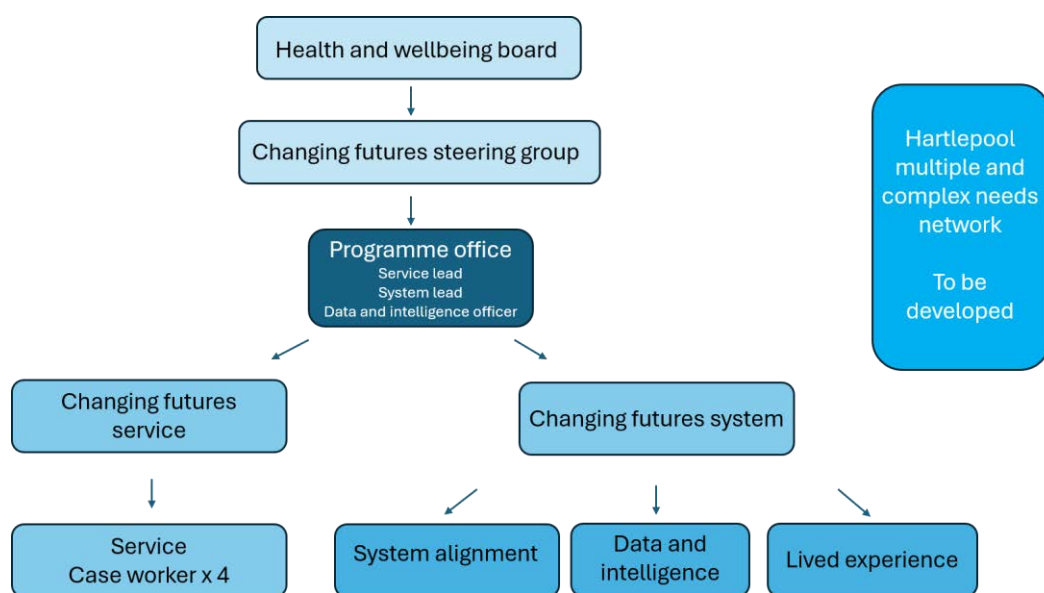
9.1 National guidance highlights good practice in relation to service delivery. This learning has informed the initial development of the Changing Futures service.

9.2 Recruitment has been completed for an operational lead to develop the changing futures service, a systems lead to work across the local system to help create the change that partners aspire to, and a data and intelligence lead to work across the steering group to explore current requirements and

opportunities to better work across Hartlepool. Plans remain in place to recruit a team of case workers, depending on need, to deliver the frontline service.

9.3 National guidance suggests recruiting to posts to ensure lived experience is embedded throughout the programme. The local authority has lived experience provision through existing services and will explore the local offer before further recruitment.

10. Changing futures organisational structure



11. Changing futures organisational structure

11.1 A delivery plan based on the activity to date and current aspirations has been submitted to the programme leads. A review session with the national leads will occur on a quarterly basis and the initial session, delivery plan and quarterly report have all been positively received by national colleagues.

12. Other Considerations/Implications

RISK IMPLICATIONS	None
FINANCIAL CONSIDERATIONS	None

SUBSIDY CONTROL	None
LEGAL CONSIDERATIONS	None
SINGLE IMPACT ASSESSMENT	None
STAFF CONSIDERATIONS	None
ASSET MANAGEMENT CONSIDERATIONS	None
ENVIRONMENT, SUSTAINABILITY AND CLIMATE CHANGE CONSIDERATIONS	None
CONSULTATION	None

13. Recommendations

13.1 To progress towards the improved governance approach and partnership commitment to the health and wellbeing board.

14. Reasons for Recommendations

14.1 To obtain formal approval from the Health and Wellbeing Board to continue to progress the approach and governance arrangements.

15. Background Papers

15.1 None

16. Contact Officers

Chris Woodcock

Director of Public Health

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Health and Wellbeing Board

8 October 2026

Report of: Deputy Director Neighbourhood Health South, North East and North Cumbria Integrated Care Board

Subject: NEIGHBOURHOOD HEALTH UPDATE

1. Council Plan Priority

Hartlepool will be a place:
- where people live healthier, safe and independent lives. (People)

2. Purpose of Report

2.1 To provide the Health and Wellbeing Board with an update on progress in developing and embedding the Neighbourhood Health approach in Hartlepool, including governance arrangements, priority cohorts, the Integrated Neighbourhood Team (INT) pilot, and development of the Hartlepool Neighbourhood Health Plan. A presentation on this matter is attached at **appendix A**.

3. Background

3.1 Neighbourhood Health is a nationally driven reform programme that seeks to improve population health and reduce inequalities through place-based, integrated working across health, social care, local government and the voluntary, community and social enterprise (VCSE) sector. The approach shifts services from reactive care towards prevention, proactive support and community-centered delivery.

4. Progress to date

4.1 The presentation outlines progress made during 2026/27, including:

- Establishment of governance arrangements through the Hartlepool Neighbourhood Partnership.
- Agreement of Hartlepool's neighbourhood footprint and priority cohorts for future transformation work.
- Delivery of a pilot Integrated Neighbourhood Team programme to test new ways of integrated working.
- Development of a Hartlepool Neighbourhood Health Plan, bringing together programmes of work across the three national reform priorities and establishing a framework for delivery during 2027/28.

5. Other Considerations/Implications

RISK IMPLICATIONS	None
FINANCIAL CONSIDERATIONS	None
SUBSIDY CONTROL	None
LEGAL CONSIDERATIONS	None
SINGLE IMPACT ASSESSMENT	None
STAFF CONSIDERATIONS	None
ASSET MANAGEMENT CONSIDERATIONS	None
ENVIRONMENT, SUSTAINABILITY AND CLIMATE CHANGE CONSIDERATIONS	None

CONSULTATION	None
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6. Recommendations

- 6.1 The Health and Wellbeing Board is asked to note the progress made in establishing neighbourhood health arrangements in Hartlepool and support the continued development of the Hartlepool Neighbourhood Health Plan and associated partnership arrangements.

7. Reasons for Recommendations

- 7.1 To obtain formal approval from the Health and Wellbeing Board to continue to progress the approach.

8. Background Papers

- 8.1 None

Embedding Neighbourhood Health: Integration, Collaboration and Transformation

**Health and Well Being Board
October 2026**

Neighbourhood Health: A reminder of what it is...

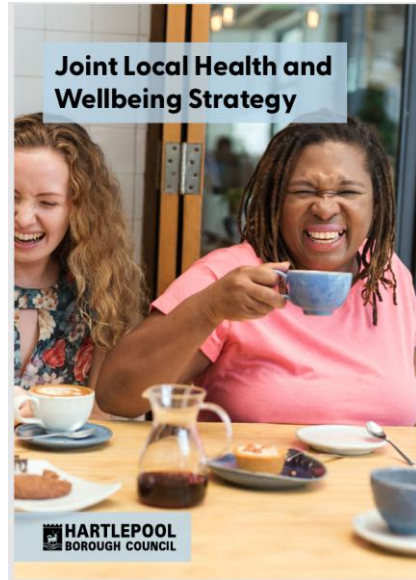
- A shift from organisational care delivery to place-based care for a defined population.
- Focuses on improving population health and reducing inequalities, not just treating illness.
- Delivers joined-up support across NHS, local government, social care and the VCSE sector.
- Moves from:
 - Reactive → Proactive and preventative care
 - Fragmented services → Integrated neighbourhood teams
 - Organisation-led care → Community-centred approaches

- Goes beyond healthcare to include wider determinants such as:
 - Housing, employment, education and social connection
- Built on key principles:
 - Co-design with communities
 - Shared accountability across partners
 - Person-centred, holistic care
 - Strong local partnerships

Strategic alignment for place based care...

- National guidance – neighbourhood health framework, neighbourhood health centre guidance.
- Council Plan; Health and Wellbeing Strategy.
- NHS 10 Year Plan.
- BCF Framework 2026/27.
- TEWV – Community services transformation.
- Pride in Place – PoF.
- Children's front door (family help point), family help pilot, SEND clusters.
- Adults' front door.
- Complex Lives Programme

How we deliver: community conversations, joint ways of working, cross-cutting intelligence analysis, etc.



H&WB Strategy:
System-wide strategic commitments & outcomes

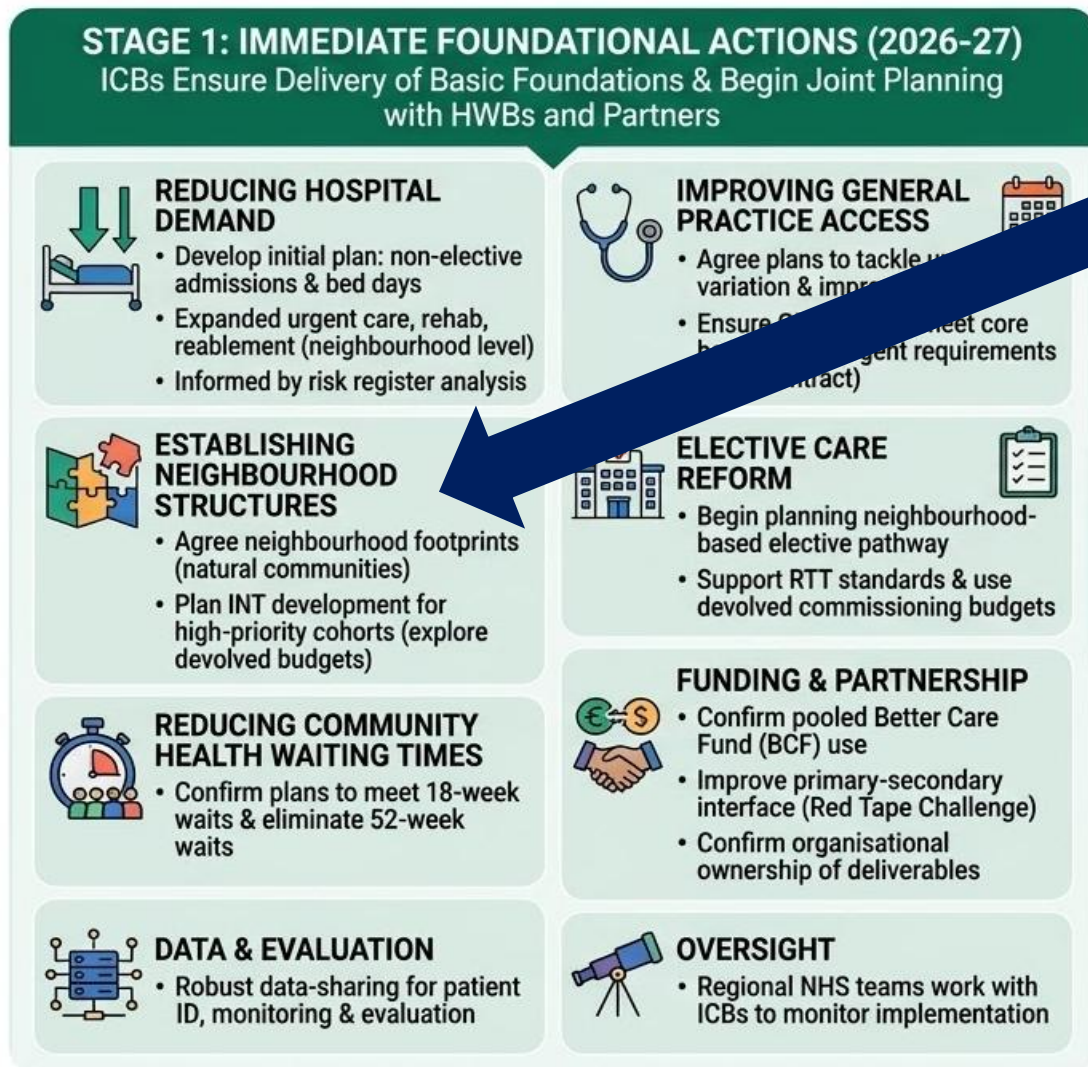
Neighbourhood plan:
Tactical ways of working to deliver: neighbourhoods, integrated teams, cohorts / communities of focus



Core role of HWBBs in Neighbourhood Health...

Set	Lead	Bring	Align	Ensure	Maintain
Set the shared vision for neighbourhood health locally	Lead development of locally owned outcomes and metrics	Bring partners together around shared priorities and accountability	Align strategies and plans, including: <ul style="list-style-type: none">➤ Better Care Fund (BCF)➤ Public health priorities➤ ICB commissioning plans	Ensure community voice and co-production are embedded	Maintain focus on reducing inequalities and improving wellbeing outcomes

Neighbourhood Health Framework – A focus on stage one...



- The Partnership is focussed on a number of key priorities during 2026/27
- To date they have:
 - Agreed the neighbourhood footprint for Hartlepool
 - Agree 2 priority cohort focus areas for 2027/28
 - Started development of an overarching neighbourhood health plan that draws together programmes of work across the three key reform agendas

Hartlepool as a neighbourhood...

- Hartlepool is one neighbourhood
- This aligns with its borough-wide footprint as the organising framework for strategic planning, governance and resource alignment
- This also reflects Hartlepool's size, civic identity and coterminous local authority
- All GP Practices accept patients from across the whole town, there are no boundary arrangements, which supports the town being treated as one neighbourhood
- The development of programmes of work however will take into consideration micro-neighbourhood delivery around the identified mission critical areas in Hartlepool, based on areas with greatest need

Priority cohorts...



Cohorts are set nationally and places are expected to focus on how they can work together across the whole condition pathway/life course to improve outcomes



Initial cohorts selected are: people with frailty, multiple long term conditions or rising risk and people experiencing multiple disadvantage and complex needs



Opportunity to test and embed proactive care pathways; systematically embed early prevention & identify opportunities for transformation & joined up provision



A focus on priority cohorts will support expansion of associated wellbeing initiatives, preventative approaches, and increased access to community-based alternatives to hospital care



A focus on these cohorts allows partners to align around shared outcomes and metrics



The work will support a resource shift from acute → community services. It will utilise the concept of Integrated Neighbourhood Teams (INTs) and Neighbourhood Health Centres as enablers to support change



The work of the partnership focussing on cohorts will happen alongside a range of programmes/areas of work that partners are delivering to support delivery of outcomes across the three reform agendas

Neighbourhood Health:

A Multi-Agency Approach

Responding to Population Health Needs

Working
Together...



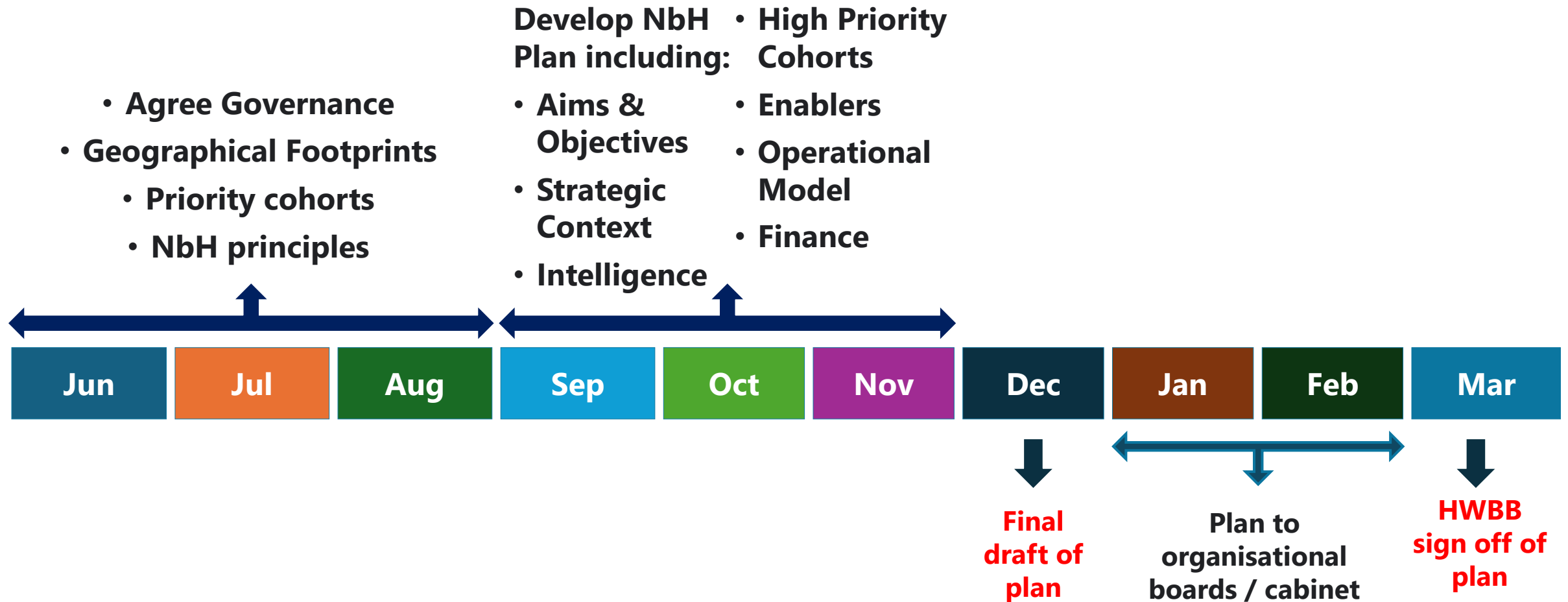
- Opportunity to develop a shared, collaborative programme of work to make a difference for the people of Hartlepool with key priorities agreed each year that will develop, progress and evolve
- Relies on collective ownership by partners, rather than seen as a single organisation's programme.
- The focus of work driven forward under this agenda should not only focus on how healthcare is delivered, otherwise it will not be delivering true neighbourhood health.
- Any model should shift the focus from treating illness to enabling people to live well, with shared outcomes across organisations and communities.
- It should not be viewed as an NHS-led service redesign, but as a collective approach to improving health, care, independence, and equity at neighbourhood level

What should a neighbourhood health plan set out...

- Set out the strategic framework and drivers within which the plan is placed
- Outline the current case for change and a summary of available intelligence that describes current health and social outcomes for people living in Hartlepool
- Set out the governance framework within which the plan is being driven and accountability arrangements across partners
- Outline key partnership principles and ways of working
- Set out what work is ongoing across Hartlepool to deliver change against the three key neighbourhood health reform agendas:
 1. *Improve services for people who need routine health and care, so neighbourhood health benefits everyone*
 2. *Improve proactive care for people*
 3. *Deliver better alternatives to hospital care*

- Set out key delivery actions for 2027/28
- Clarify the process of ongoing monitoring and evaluation by the partnership
- The plan is iterative, and will evolve and build on learning and progress each year
- It is important for the plan to reflect the broad agenda – but be stretching yet achievable for partners

Neighbourhood Health Plan Timeline...





Health and Wellbeing Board

8 October 2026

Report of: Deputy Director Neighbourhood Health South, North East and North Cumbria Integrated Care Board

Subject: INTEGRATED NEIGHBOURHOOD TEAM

1. Council Plan Priority

Hartlepool will be a place:
- where people live healthier, safe and independent lives. (People)

2. Purpose of Report

2.1 To update the Health and Wellbeing Board on progress of the Hartlepool National Neighbourhood Health Implementation Programme pilot, including achievements to date, emerging outcomes, key learning, challenges, and considerations for future development. A presentation on this matter is attached at **appendix A**.

3. Background

3.1 Since its original submission to the National Neighbourhood Health Implementation Programme (NNHIP), the Hartlepool proposal has evolved into a practical pilot operating across two local GP practices.

The original NNHIP proposal aimed to identify people with multiple long-term conditions who were at increasing risk of poorer health outcomes and intervene earlier to prevent escalating demand on health and care services.

In response, a pilot has been established in two Hartlepool GP practices:

- Havelock Medical Centre
- McKenzie Group Practice

The pilot focuses on residents aged 40 to 80 who:

- Have six or more long-term conditions;
- Have a recorded frailty diagnosis; and
- Have either attended their GP ten or more times in the previous year or experienced a hospital discharge within the previous 12 months.

4. The Pilot Model

4.1 The pilot uses a person-centred, multidisciplinary approach centred around a "What Matters to Me" conversation undertaken by a Social Prescribing Link Worker (SPLW). These discussions enable residents to identify priorities affecting their health and wellbeing, including clinical, practical, social and wider determinants of health.

Information gathered is reviewed through a Multi-Disciplinary Team (MDT) comprising representatives from:

- General practice
- Social care
- Community services
- Mental health services

The MDT identifies opportunities for coordinated intervention, allocates actions across organisations, and supports individuals until identified needs have been addressed. The Social Prescribing Link Worker acts as the single point of contact throughout the process and ensures continuity of support

5. Progress to date

5.1 The pilot has been delivered without national programme funding and has relied on local commitment, partnership working and GP Federation investment to provide GP backfill capacity.

- 45 patients discussed by the MDT

- 14 patients successfully discharged following completion of interventions
- 15 patients declined participation
- Average SWEMWBS wellbeing score increase of 4 points per participant
- Average wellbeing score of 22 recorded across participants

Wider progress

The programme has reported strengthened relationships between partner organisations and improved collaboration across health, care and community services. The establishment of a structured MDT model with shared ownership of patient outcomes is proving effective. The opportunity for wider involvement of social workers to undertake "What Matters to Me" conversations and increase capacity is being explored.

The pilot will continue until March 2027, with new referrals ceasing in December 2026 to allow all participants to complete the full MDT process.

Impact on residents

Feedback from participants indicates that the pilot is improving people's confidence, wellbeing, sense of hope and ability to access support.

Common themes from resident feedback include:

- Feeling listened to and valued.
- Improved access to practical support.
- Greater confidence in self-management.
- Reduced isolation.
- Benefits extending to carers and family members.
- Appreciation of having a single trusted contact within services.

While it remains too early to demonstrate reductions in emergency department attendance, hospital admissions or GP consultations, improvements in wellbeing measures and patient experience provide positive early indications of impact.

6. Factors supporting success

6.1 Strong Local Leadership

Leadership commitment across organisations has helped maintain momentum and overcome barriers.

Effective Partnership Working

The pilot has brought together services that traditionally operate separately around a shared population health objective.

Existing Infrastructure

The use of established GP systems, social prescribing infrastructure and MDT processes has provided a foundation for implementation.

6.2 Challenges and risks

The pilot relies heavily on already stretched services and requires significant professional time to support assessment, preparation and MDT discussions. Estimates indicate each patient requires four to five hours of GP preparation time before MDT discussion.

Current delivery has relied on local resources supported by the local GP federation, Hartlepool and Stockton Health. Sustainable funding will be required if the approach is expanded across Hartlepool. GP backfill and increased front-end capacity are particularly important considerations.

The programme currently depends on manual data collection and consent processes. Greater automation and data-sharing efficiencies could improve efficiency.

The pilot currently operates alongside existing services rather than replacing them. Further evidence is required to understand how this model could be embedded as business as usual and expanded sustainably.

7. Key learning

7.1 Several key themes have been identified to inform future programmes.

Define the target population before designing the service model.

- Focus on prevention and intervene earlier.
- Build on existing strengths rather than creating additional programmes.
- Measure outcomes rather than activity alone.
- Invest time in building relationships and trust between organisations.
- Ensure lived experience and co-production are embedded from the outset.
- Clearly define MDT operating arrangements and success measures.

8. Next steps

During the remainder of the pilot period, partners will continue to:

1. Collect patient, professional and MDT feedback.
2. Monitor changes in wellbeing using SWEMWBS scores.
3. Assess impacts on service utilisation, including GP attendance, hospital admission and A&E attendance.
4. Strengthen social work involvement within the pathway.
5. Evaluate resource requirements and scalability.
6. Develop evidence to support future commissioning decisions.

9. Other Considerations/Implications

RISK IMPLICATIONS	None
FINANCIAL CONSIDERATIONS	None
SUBSIDY CONTROL	None
LEGAL CONSIDERATIONS	None
SINGLE IMPACT ASSESSMENT	None
STAFF CONSIDERATIONS	None
ASSET MANAGEMENT CONSIDERATIONS	None
ENVIRONMENT, SUSTAINABILITY AND CLIMATE CHANGE CONSIDERATIONS	None
CONSULTATION	None

10. Recommendations

- 10.1 Note the progress and achievements of the Hartlepool NNHIP pilot.
- 10.2 Recognise the positive early evidence relating to patient wellbeing, person-centered care and system collaboration.

11. Background Papers

- 11.1 None

Integrated Neighbourhood Health (INT) Pilot Overview

**Health and Well Being Board
October 2026**

Integrated Neighbourhood Health Team pilot programme...

- National Integrated Neighbourhood Health Team (INT) pilot programme launched early in 2026/27
- Designed to test a different way of organising care around people and communities
- Although Hartlepool not successful as part of the national pilot, there was local agreement to still run a local pilot programme, to gather learning before broader development and roll of neighbourhood health plans
- It has acted as a proof of concept and a way to bring partners together and learn together to support future new ways of working

Pilot Integrated Neighbourhood Team (INT) programme in 26/27...



The Hartlepool Integrated Neighbourhood Team (INT) pilot has been used as the local test bed for neighbourhood health and integrated working across health, social care and VCSE partners



The pilot has been aligned to Hartlepool's eight "mission critical neighbourhoods" identified through the Pride in Place programme and is focused on a clearly defined high-need population cohort



The intention has been to identify people at high risk of deterioration and bring partners together around a proactive "what matters to me" approach to care



The wider ambition is to:

- Improve proactive care
- Reduce health inequalities
- Prevent deterioration
- Provide care closer to home
- Better coordinate health, social care and community support
- Move resources upstream towards prevention rather than crisis response

It was agreed that the pilot afforded an opportunity to create buy in and confidence across system partners to test new ways of neighbourhood working, which should be radically different to current ways of working and will help form the basis for future learning

The pilot was locally designed, to avoid partners feeling 'done to', with a view to aligning the pilot with wider work streams in future as these emerge

Pilot Integrated Neighbourhood Team (INT) cohort...

- Partnership discussions agreed that the focus of the pilot would be:
 - Age group 50-80
 - Focused on patients in mission critical postcodes initially
 - >10 GP practice contacts within 12 months and or a discharge from hospital
 - >6 co-morbidities
 - Records with a frailty code applied

- The pilot would identify patients from Havelock Grange Practice and McKenzie Group Practice [the practices of the Clinical Lead GPs], but the wider PCNs and remaining Hartlepool practices would be kept updated and invited to join as the project progresses
- The initial cohort of patients was those accessing services [phase 1] with the pilot extending to those who are not known to be accessing services [phase 2] once a review and evaluation of the pilot's success has been undertaken
- Based on the above cohort inclusion criteria this identified 44 patients from Havelock Grange Practice and 41 patients from McKenzie Group Practice

The INT pilot process...



Once the cohort of patients was agreed, they were contacted to consent to take part in the pilot



Once consent was provided, General Practice utilised Social Prescribing Link Workers [SPLW] to undertake an initial 'what matters to me' conversation with patients [either in their own home or their GP surgery] using a standardised patient 'what matters to me' engagement template



Following this the SPLW tasked the GP to undertake a review, and, if clinically appropriate patients were added to the Integrated Neighbourhood Team [INT] case load, who met weekly to identify support mechanisms and a case load template care plan was created.



Following discharge from INT caseload a discharge summary was created to include key actions and contacts, which will be shared with the patient and stored in the GP records.



Following this the SPLW tasked the GP to undertake a review, and, if clinically appropriate patients were added to the Integrated Neighbourhood Team [INT] case load, who met weekly to identify support mechanisms and a case load template care plan was created.



Following discharge from INT caseload a discharge summary was created to include key actions and contacts, which will be shared with the patient and stored in the GP records.

INT patient contact and engagement...

- Total patients eligible: 37
 - Havelock: 17
 - McKenzie: 20
- Total patients declined: 15
 - Havelock: 7
 - McKenzie: 8
- Total patients awaiting contact: 6
- Other circumstances for not contacting: 8 patients
- Patients discharged: 14

INT overview of patient information...

- Patient Information:
 - Female: 21
 - Male: 16
 - Average age: 71
- Average number of GP appointments in last 12 months per patient: 28.4
- Average number of admissions in last 12 months per patient: 1.1
- Average wellness score: 22
- Average wellness score increase (week 1 to 12): 4 - **which is statistically significant and likely demonstrates a reduction in resource use**

INT qualitative feedback...



“He said the support through the project has been invaluable. He said being supported means so much, he said to be introduced to the animal bereavement group by me has changed his life as he could not look at other dogs after losing his dog, and now he has a connection with Olive the dog that goes there. He said he knows he struggles with his bipolar but we have given him hope that he can deal with it better. He said it means so much to his wife too as we put some support in place for Hartlepool Carers and that has really helped both of them.”



“You have all given me a reason to look to the future and a reason to keep going, I could not have done it has helped without all of your support and it my son *** too. I will miss you all when you are gone ”

INT next steps...

Continue with existing cohort criteria but re-run reports for those 40+ with a view to expanding the cohort in that way rather than changing inclusion criteria

Further discussions with LA to firm up Social Worker offer for the 'what matters to me process' to create more capacity at the front end of the pilot

H&SH to develop proposal to offer some support to Hartlepool Network for 1 practice to join the pilot [agreed to not expand beyond 3 at this point to keep the pilot contained and the evaluation meaningful]

Re-review patients who declined involvement in pilot to understand reasons and potentially bring some of these patients back into the pilot

Agreed pilot will run until March 2027-
new patients will stop being accepted on
to pilot in December to ensure patients
can go through the full MDT cycle and
be discharged

Research and evaluation team to
continue to support working group as
more data becomes available to develop
evaluation approach

Questions...

Health and Wellbeing Board

8 October 2026

Report of: Mental Health Strategic Lead

Subject: HARTLEPOOL MENTAL HEALTH STRATEGIC PARTNERSHIP

1. Purpose of Report

1.1 Continuing to Develop a Relational, Place-Based Mental Health System in Hartlepool

This report provides the Health and Wellbeing Board with an update on the continued development of the Hartlepool Mental Health Strategic Partnership and the wider programme of work being progressed through the Mental Health Provider Forum.

It provides an update on recent partnership discussions regarding the proposed Mental Health Centre for Hartlepool and considers how this work connects with the wider development of Neighbourhood Health.

The report also outlines how the existing mental health transformation work, community insight and partnership infrastructure can complement the emerging Changing Futures programme, alongside the continued Connecting the Dots work which seeks to improve alignment across the growing number of place-based programmes and developments within Hartlepool.

2. Background

2.1 Executive Summary

Since the previous report to the Health and Wellbeing Board, work has continued to move from individual programme activity towards greater alignment across the wider Hartlepool system.

This is becoming increasingly important as a number of significant developments progress simultaneously across mental health, neighbourhood health, multiple disadvantage, prevention and community-based support.

There is considerable opportunity within these developments. There is also a risk that, without deliberate coordination, separate programmes with similar ambitions could create additional structures, engagement activity and pathways rather than simplifying the experience for residents.

The Mental Health Strategic Partnership and Provider Forum are therefore continuing to focus on how the relationships, community intelligence and learning developed through Community Mental Health Transformation can contribute to this wider landscape.

- Three areas are particularly relevant:
- development of the proposed Mental Health Centre and its relationship with Neighbourhood Health;
- opportunities for existing mental health insight, community relationships and relational approaches to complement the Changing Futures programme as it develops; and
- Connecting the Dots, which is providing an opportunity to identify commonality across programmes and strengthen collaboration rather than allowing individual developments to progress in isolation.

The intention is not to bring these programmes under a single structure or suggest that they are interchangeable. Each has its own purpose, leadership and governance. The opportunity is to recognise where their ambitions intersect and ensure that learning, insight and existing community infrastructure are used collectively wherever this adds value.

3. Mental Health Centre – Developing the Hartlepool Model

3.1 A partnership session took place on 7 September to progress discussions regarding the proposed Mental Health Centre for Hartlepool.

The discussion deliberately moved beyond consideration of a physical building and focused first on what Hartlepool needs the Centre to achieve and how this can be delivered sustainably.

A significant consideration is that the investment available is capital funding, with no additional ongoing revenue attached. This means that the development of the model must consider sustainability from the outset.

Partners therefore began by considering the potential revenue model, including how existing resources and services may be used differently, opportunities for redesign or relocation of existing provision and whether other sustainable income opportunities could contribute to the future model.

Discussion then considered where the Centre should be located, what should be delivered from it and who needs to be involved in delivery. There was strong recognition that the Centre should not become an isolated building or another destination into which people simply need to be referred.

Instead, its development provides an opportunity to consider how specialist mental health provision connects with primary care, neighbourhood provision, local authority services, the VCSE sector and trusted community organisations.

Further work will be undertaken through the Mental Health Provider Forum to ensure that organisations delivering support across Hartlepool, alongside community and lived experience insight, contribute to the development of the model.

This provides an important opportunity to connect the development of the Mental Health Centre with the wider direction of Neighbourhood Health and the existing ambition to provide support closer to where people live, through stronger connections between clinical, statutory, VCSE and community provision.

4. Complementing Changing Futures

4.1 Changing Futures represents an important emerging development for Hartlepool. The work being undertaken through the Mental Health Strategic Partnership and Provider Forum is separate from Changing Futures. However, there are clear opportunities for the existing mental health transformation work to complement the programme as it develops.

Over recent years, Community Mental Health Transformation has generated significant learning and community insight around how people experience

mental health support, the barriers they encounter, where people seek help and the importance of relational and community-based approaches.

The Mental Health Strategic Partnership and Provider Forum have also established relationships across NHS, local authority, VCSE and community organisations which provide an existing infrastructure through which wider system conversations can take place.

As Changing Futures begins to develop its own evidence, learning and insight around multiple disadvantage, there is an opportunity for learning to flow in both directions.

Existing community insight can help provide context and understanding around some of the challenges experienced by people accessing support, while emerging learning from Changing Futures can add to the wider understanding of how people experiencing multiple and interconnected needs navigate services and systems.

The intention is not to duplicate the work of Changing Futures or predetermine the learning that will emerge from it.

Rather, it is to ensure that the programme is able to benefit from existing relationships, insight and transformation learning where relevant, while creating mechanisms through which future learning from Changing Futures can inform wider developments across mental health, Neighbourhood Health and community-based support.

This creates an opportunity to maximise the value of Changing Futures by ensuring that its learning can contribute to wider system development, while maintaining the programme's distinct leadership, purpose and governance.

5. Connecting the Dots – Strategic Collaborations

5.1 The need to connect these developments reinforces the importance of the Connecting the Dots work already underway across Hartlepool.

Connecting the Dots is not intended to create another programme or additional governance structure. Its purpose is to create greater visibility across the significant amount of transformation and place-based activity currently taking place and identify where stronger alignment would add value. This is increasingly important.

Hartlepool currently has several developments progressing across mental health, Neighbourhood Health, Changing Futures, Helping Hubs, prevention, community development and wider place-based activity. Many are approaching similar issues from different starting points.

Common themes include:

- prevention and earlier intervention;
- reducing inequalities;
- working at neighbourhood and place level;
- building upon existing community assets;
- strengthening relationships between statutory and VCSE partners;
- understanding people's wider circumstances rather than individual presenting needs;
- improving community intelligence and insight;
- reducing duplication; and
- making support easier for residents to navigate.

Connecting the Dots provides an opportunity to identify these commonalities without removing the individual identity, leadership or governance of the programmes involved.

It allows partners to ask where existing work can be strengthened rather than replicated, where community engagement and insight can be shared, where learning from one programme may benefit another and where collective action may achieve more than individual organisational responses.

6. From Individual Programmes to Collective Learning

6.1 An important next step is therefore to strengthen how learning and insight move between programmes.

A considerable amount of intelligence is already being generated across Hartlepool through community engagement, VCSE organisations, mental health transformation, neighbourhood activity and direct work with residents. New programmes will generate further insight.

The opportunity is to avoid repeatedly asking communities the same questions and instead develop mechanisms through which existing evidence

can be shared, tested and added to over time. This is particularly relevant to Changing Futures.

Rather than attempting to define in advance what Changing Futures will tell us, the wider partnership can provide an existing evidence base and community context against which its emerging learning can be considered.

Equally, as insight emerges through Changing Futures, this can deepen the wider system's understanding of multiple disadvantage and potentially inform the development of mental health, neighbourhood and community approaches. This creates a continuous learning relationship between programmes rather than a series of separate evidence-gathering exercises.

7. Wider Strategic Opportunity

- 7.1 Taken collectively, these developments provide Hartlepool with an opportunity to move beyond individual transformation programmes towards a more connected approach to place.

The Mental Health Centre, Neighbourhood Health, Changing Futures and Connecting the Dots are not the same pieces of work and should not be presented as such.

However, they operate within the same place, often involve many of the same partners and communities, and share a wider ambition to improve how people experience support.

The benefit of the Mental Health Strategic Partnership's involvement is therefore not ownership of these wider programmes.

Its value lies in bringing established relationships, community insight, VCSE engagement and learning from mental health transformation into wider system conversations, while ensuring that learning generated elsewhere is able to influence the continued development of Hartlepool's mental health system.

This is particularly important if Hartlepool is to avoid creating multiple new initiatives around residents while retaining the same organisational boundaries between them.

Connecting these developments provides an opportunity to build a more coherent system around people and place while retaining clear accountability for the individual programmes responsible for delivering each element.

8. Overall Assessment

- 8.1 The Board can take assurance that the Mental Health Strategic Partnership continues to develop its role as part of the wider Hartlepool system.

Recent work demonstrates an increasing focus on collaboration beyond traditional mental health structures, particularly through the development of the Mental Health Centre, alignment with Neighbourhood Health, engagement with emerging programmes such as Changing Futures and the wider Connecting the Dots work.

The value of this approach is not in absorbing or directing other programmes.

It is in ensuring that the relationships, insight and learning developed through mental health transformation are available to the wider system and that new learning and investment across Hartlepool can, in turn, strengthen the development of mental health and community-based support.

This provides an opportunity to maximise collective impact while reducing duplication, fragmented engagement and the development of further organisational silos.

9. Contact Officers

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