HEALTH AND WELLBEING BOARD

AGENDA

Monday 17th March 2025

at 10.00am

Committee Room B
Civic Centre,
Victoria Road, Hartlepool

MEMBERS: HEALTH AND WELLBEING BOARD

Prescribed Members:
Elected Members, Hartlepool Borough Council - Councillors Boddy, Darby, Harrison (C) and Roy.
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 – Craig Blundred
Executive Director of Children's and Joint Commissioning Services, Hartlepool Borough Council - Sally Robinson
Executive Director of Adult and Community Based Services, Hartlepool Borough Council - Jill Harrison
Representatives of Healthwatch - Margaret Wrenn and Christopher Akers-Belcher

Other Members:
Managing Director, Hartlepool Borough Council – Denise McGuckin
Executive Director of Development, Neighbourhoods and Regulatory Services, Hartlepool Borough Council – Tony Hanson
Assistant Director for Early Intervention, Performance and Commissioning, Rebecca Stephenson
Representative of Hartlepool Voluntary and Community Sector – Christine Fewster and Carl Jorgeson
Representative of Tees, Esk and Wear Valley NHS Trust – Jamie Todd
Representative of North Tees and Hartlepool NHS Trust – Dr Deepak Dwarakanath
Representative of Cleveland Police – Alan O'Donoghue
Representative of GP Federation - Fiona Adamson
Representative of Headteachers - Sonya Black
Observer – Statutory Scrutiny Representative, Hartlepool Borough Council – Councillor Jorgeson

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 2 December 2024.

3.2 To receive the minutes of the meeting of the Children's Strategic Partnership held on 17 July 2024.

4. ITEMS FOR CONSIDERATION

4.1 Better Care Fund Update – Executive Director and Adult and Community Based Services

4.2 Pharmaceutical Needs Assessment (PNA) 2022 - Maintenance and PNA 2025 Progress - *Director of Public Health*

4.3 Clinical Services Strategy Update - Group Model - Presentation - *Group Chief Medical Officer and Group Chief Strategy Officer, NHS University Hospitals Tees*

4.4 Year One Actions of the Joint Local Health and Wellbeing Strategy 2025-2030 - *Director of Public Health*

5. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT

FOR INFORMATION

Date of next meeting – To be confirmed

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

2 December 2024

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

Councillor Harrison , Leader of Council (In the Chair)

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors Boddy, Darby and Roy
Representative of North East and North Cumbria Integrated Care Board – Katie McLeod as substitute for Karen Hawkins
Director of Public Health, Hartlepool Borough Council – Craig Blundred
Executive Director of Children's and Joint Commissioning Services, Hartlepool Borough Council – Sally Robinson
Executive Director of Adults and Community Based Services, Hartlepool Borough Council - Jill Harrison
Representative of Healthwatch – Steve Thomas

Other Members:

Managing Director, Hartlepool Borough Council – Denise McGuckin
Representative of Tees, Esk and Wear Valley NHS Trust – Jamie Todd
Representatives of Hartlepool Voluntary and Community Sector – Carl Jorgeson
Representative of Headteachers – Sonia Black
Representative of North Tees and Hartlepool NHS Trust – Linda Hunter
Observer – Statutory Scrutiny Representative, Hartlepool Borough Council – Councillor Jorgeson

Also Present:-
Philippa Walters, Pharmacy Lead
Julie Simons, Hartlepower Community Trust
Louise George and Calvin George, Hartlepool Sport
Nicola Haggan and Amanda Britten, Alice House Hospice

Officers: Ashley Musgrave, Danielle O'Rourke, Public Health Team
Claire Robinson, Public Health Principal
Joan Stevens, Statutory Scrutiny Manager
Denise Wimpenny, Democratic Services Team

20. Apologies for Absence

Representative of Tees Esk and Wear Valley NHS Trust - Brent Kilmurray
Representative of North East and North Cumbria Integrated Care Board - – Karen Hawkins
Representatives of Healthwatch – Christopher Akers-Belcher and Margaret Wrenn
Representative of Hartlepool Voluntary and Community Sector – Christine Fewster
Representative of GP Federation – Fiona Adamson
Head Teacher Representative – Sonia Black

21. Declarations of interest by Members

None

22. Minutes of the Meeting held on 9 September 2024

Confirmed

23. Minutes of the Meeting of the Children's Strategic Partnership held on 27 September 2023

Received

24. Minutes of the Meeting of the Tees Valley Area ICP held on 9 August 2024

Received

25. Hartlepool and Stockton-On-Tees Safeguarding Children Partnership Annual Report 2023-24 (*Executive Director, Children's and Joint Commissioning Services)*

The Executive Director, Children's and Joint Commissioning Services updated the Board on the work undertaken by the Hartlepool and Stockton-On-Tees Safeguarding Children Partnership during the year 2023-24. The report summarised the key successes and achievements of the Safeguarding Children Partnership throughout 2023-24 including updates on qualitative and quantitative data, information for the reporting period and outlined the specific areas being taken forward in the coming year.

In the discussion that followed Board Members debated issues arising from the annual report. In response a query raised, clarification was provided in relation to child protection data across the two areas and the predominant reasons were also outlined. Details of consultation arrangements with young people were provided which included consultation and engagement events

and involvement activity with school councils across the secondary and primary sectors.

Decision

The contents of the HSSCP Annual Report were noted.

26. Teeswide Safeguarding Adults Board Annual Report 2023/24 (*Executive Director of Adults and Community Based Services and Independent Chair of Teeswide Safeguarding Adults Board)*

Members were referred to the Teeswide Safeguarding Adults Board (SAB) Annual Report for 2023-24 appended to the report. It was noted that it was required under the Care Act 2014 that each SAB published an annual report setting out what had been done during that year to achieve its objective and implement its strategy, the findings of any safeguarding adults reviews and what had been done to implement findings of any reviews.

Decision

The Board noted and endorsed the Teeswide Safeguarding Adults Board Annual Report 2023-24.

27. Tobacco Control Strategy (*Director of Public Health)*

Board Members were referred to the updated Tobacco Control Strategy Action Plan for Hartlepool, attached at Appendix 1, which provided an update on progress to date on actions against priorities and also updated the Board on the new Specialist Smoking Service for Hartlepool.

The Board was provided with a summary of key deliverables between April and November 2024 against the Tobacco Control Action Plan, appended to the report. The action plan set out under each theme the detail of how each priority area would be delivered, who would deliver, the timescales and outcome framework arrangements.

Board members expressed support of the strategy and debated issues arising from the report. Members welcomed the redevelopment of the stop smoking service in Hartlepool, the benefits of which were outlined. Clarification was provided in response to concerns raised regarding the increasing access and prevalence of vaping particularly in young people and the challenges around managing this issue. The Public Health Principal advised of the ongoing work and plans in place with schools in relation to changing behaviours around vaping. Representatives from the Hartlepool Community and Voluntary Sector and Hartlepool Sport commented on the benefits of sharing messages around the dangers of smoking and vaping in sports and community facilities and it was suggested that this be progressed following the meeting with a member of the public health team.

Concerns were also raised in relation to the illegal sale of tobacco products. The Managing Director referred to the successes of the Council's Environmental Health Team and ongoing work with the police in terms of tackling this issue.

Decision

The Board noted progress against the Tobacco Control Action Plan.

That messages around the dangers of smoking and vaping be shared in sports and community facilities.

28. Director of Public Health (DPH) Annual Report (*Director of Public Health*)

Elected Members were referred to the requirement for the Director of Public Health to write an Annual Report on the health status of the town, and the Local Authority duty to publish it, as specified in the Health and Social Care Act 2012. The 2024 Annual Report looked at how to address the key early years to give children the best start in life. There was strong evidence that the first 1001 days of a child's life from conception to age 2 were critical in providing the foundations needed to build a healthy life in the future. The report highlighted some of the key areas where this support was provided and provided an overview of a number of activities. Following the success of utilising an electronic format and videos in recent years, the report was again accessed via a link included in the report with a copy of the Director's report also appended to the report. The Director of Public Health presented a video to the meeting from the Annual Report.

Members welcomed the approach and debated issues arising from the Annual report including the benefits of utilising videos to present information, school readiness, the challenges for schools given the increasing numbers of children and families with complex and additional needs, concerns in relation to child poverty and the factors which had an impact on the health wellbeing and outcomes of children. In response to a query raised, the Chair was pleased to report that breastfeeding take- up in Hartlepool had increased in the last 12 months. Clarification was provided in relation to how the Board could access supporting health data including breast feeding information via the Joint Strategic Needs Assessment.

Emphasis was placed on the need for more collaborative working with the voluntary sector in terms of supporting families to ensure every child in Hartlepool was given the best start in life.

In response to a number of further queries raised, clarification was provided in relation to the budget position around the future of family hubs and the challenges around responding to the increasing number of safeguarding

referrals. A number of queries were raised in relation to interpretation of the school readiness data and a breakdown of school readiness data was requested by school following the meeting.

Decision

That the 2024 Director of Public Health annual report be approved.

That a breakdown of school readiness data by school be provided following the meeting.

29. Joint Local Health and Wellbeing Strategy 2025-2030

(*Director of Public Health)*

Type of decision

Non-key

Purpose of report

To present the Health and Wellbeing Board (HWBB) Strategy refresh for approval (Appendix 1).

Issue(s) for consideration

The Director of Public Health presented the Joint Health and Wellbeing Strategy refresh for Members' approval. The strategy, attached at Appendix 1, outlined the key priority areas for the next five years:-

- **Starting Well** – All Children and young people living in Hartlepool have the best start in life.
- **Live well** - People live and work in connected, prosperous and sustainable communities.
- **Age well** - People live healthier and more independent lives, for longer

The strategy would inform the development of a detailed action plan and outcome framework which would be monitored and reviewed through the Health and Wellbeing Board.

In the discussion that followed officers responded to issues raised arising from the report in relation to the positives around a GP early dementia diagnosis and monitoring arrangements in terms of reablement care.

Decision

That the Health and Wellbeing Board Strategy be agreed and be utilised to support the joint development of the 2025/26 action plan.

30. Pharmaceutical Needs Assessment (PNA) 2022 – Maintenance Report *(Director of Public Health)*

The report updated the Board on the process for statutory maintenance of the Pharmaceutical Needs Assessment 2022, to receive notification of applications, decisions or other notice of changes to pharmaceutical services in Hartlepool from the ICB NENC or Primary Care Support England (PCSE) since the date of the last Health and Wellbeing Board Maintenance Report (9 September 2024). In relation to the requirement to seek approval for publication of any Supplementary Statement to the PNA 2022 required as a consequence of those reported changes to pharmaceutical services, the Board was advised that no new Supplementary Statements had been issued under delegated authority since the last meeting of the Board in July 2024.

Members were advised of the process towards statutory publication of a new PNA by 30 September 2025.

In response to concerns raised regarding the high levels of poor literacy in the town, details of the proposed communication and engagement arrangements were provided which would include face to face communication co-ordinated by Healthwatch and it was noted that information would be made available in different formats in community hubs. The need for Board Members to advocate on behalf of individuals where necessary was highlighted.

Decision

The Board noted:-

1. That no supplementary statements to the Hartlepool PNA 2022 had been issued since the last report in July 2024 and no further changes to pharmaceutical services in Hartlepool had been notified.

2. Progress towards the publication of a new PNA by September 2025.

31. Voluntary and Community Sector Reports *(Director of Public Health)*

Voluntary and Community Sector representatives, who were in attendance at the meeting presented the following reports to Board Members as being of interest to the Board, copies of which had been circulated with the agenda documentation in advance of the meeting:-

- The Haven, Service and Information (Appendix A)
- Urban Sport and Urban Play Summer Activity Report (Appendix B)
- Pumpkins in the Park 2024 (Appendix C)

Following presentation of the reports, Members commended the work of the groups and welcomed the health and wellbeing benefits as a result.

Decision

That the contents of the reports be noted.

The meeting concluded at 11.35 am.

CHAIR

CHILDREN'S STRATEGIC PARTNERSHIP

MINUTES AND DECISION RECORD

17 July 2024

The meeting commenced at 1.00 pm in the Civic Centre, Hartlepool

Present:

Councillor Rachel Creevy, HBC
Sally Robinson, Executive Director of Children's and Joint Commissioning Services, HBC
Amanda Whitehead, Assistant Director, Education, HBC
Laura Gough, Assistant Director, Children's and Families, HBC
Craig Blundred, Director of Public Health
Martin Hopps, Cleveland Police

Also Present: Kaylee Anderson as substitute for Jo Heaney

Officers: Becky Stephenson, Head of Service Quality and Review, HBC
Penny Thompson, Head of Service, HBC
Kate Proctor, Family Hub Manager, HBC
Kelly Prescott, Project Manager
Denise Wimpenny, Principal Democratic Services Officer

1. Apologies for Absence

Apologies for absence was submitted on behalf of Danielle Swainston, HBC, Jo Heaney, Integrated Care Board Tees Valley, James Graham, Tees Esk and Wear Valleys NHS Trust, John Hardy, St John Vianney Primary School, Alison Darby, Kingsley Primary School, Martin Todd, Changing Futures North East.

2. Declarations of Interest

None.

3. Minutes of the meeting held on 27 September 2023

Confirmed.

4. Family Hubs – Presentation (*Transformation Manager – Family Hubs)*

The Family Hubs Manager referred to discussions at the last meeting of the Partnership and provided a detailed and comprehensive presentation which updated Members in relation to Family Hubs/Supporting Families Programme. The presentation focused on the following issues and included a video of the website:-

- Transformation – Rossmere, Hindpool Close and Miers Avenue Family hubs been open for one year and Middleton Grange for 15 months. Work underway at Windsor offices to make this a permanent town centre Family Hub

- Funded Elements of Family Hub Programme
  - Parent-Infant Relationship
  - Infant Feeding
  - Parenting Support
  - Early Language and Home Learning Environment
  - Digital Support including website work

In the discussion that followed Members debated issues arising from the presentation and the Family Hubs Manager responded to queried raised. The Director acknowledged the excellent work of the team in terms of progress to date. Concerns were raised in relation to the uncertainty around future funding and potential risks as a result. The Chair outlined the benefits of raising this issue with the relevant Central Government department and it was agreed that this be further explored separately following the meeting. Clarification was provided in relation to how the easy peasy app was shared with parents, publication and engagement arrangements, funding criteria and support available in relation to baby loss. The police representative commented on the difficulties around dealing with bereaved families following baby loss and emphasis was placed upon the importance of sharing procedures to enable parents to have a better understanding of support available in such circumstances.

Decision

That the contents of the presentation and comments of Members be noted and actioned as appropriate.

5. Supporting Families Presentation (Project Manager)

The Project Manager provided a detailed presentation which updated Members in relation to the Supporting Families Programme and included the following:-

- Aim of the Programme: to reduce the cost to the public purse and break the cycle of inter-generational issues and improve the quality of life of families and their communities

- Culture Change
  - One assessment
  - One family plan developed with the family
  - One lead worker
  - Responsibility for all organisations which prevents families having to share same story to different professionals

- Evolution of the Programme - Criteria
  - Phase 1 April 2012 to March 2015
  - Phase 2 April 2015 – March 2020
  - Phase 3 April 2022 – March 2025

- Outcomes for Families
  - Early help and supporting families
  - Data collected

- Funding

- Risks

Following the presentation, the Partnership debated issues arising from the update and the Project Manager responded to issues raised. Clarification was provided in relation to sources of information in terms of data sharing and the challenges in this regard. Members debated the data collection arrangements, how families were identified as well as the challenges around recruitment and accessing information and the impact as a result.

The police representative expressed a willingness to share information and work together to progress delays around recruitment. Concerns were raised regarding the uncertainty around funding to enable the programme to continue and the risks associated with capacity and resilience and data matching issues.

Decision

That the information given be noted and comments of Members be noted and actioned as appropriate.

6. Early Years and Childcare – A New Offer – Presentation *(Head of Housing, Hardship and Welfare Support Services)*

The Head of Service provided a detailed and comprehensive presentation which updated the Partnership in relation to the previous offer and new offer in terms of early years in child care provision, the timeline for introduction and what this meant for the Council in practice going forward.

The presentation focussed on the benefits of the proposals and the key challenges in relation to capacity of current childcare providers in terms of buildings and premises, the difficulties around recruitment and retention of qualified workers and the issues of meeting the needs of a varied workforce.

Partnership Members debated issues arising from the presentation and officers responded to queries raised. Clarification was provided in relation to the difficulties managing children and young people with special educational needs and the impact of insufficient funding to support providers to offer inclusive placements. Members raised concerns in relation to the lack of funding to support providers, the challenges for parents given the lack of provision in general as well as provision for post 11 year olds, the lack of provision during school holidays and acknowledged the challenges around staff recruitment and retention to childcare roles. Emphasis was also placed upon the importance of early help and prevention.

In concluding the debate it was agreed that an introductory letter be sent to all Partnership Members from the new Chair of the Partnership, Councillor Creevy.

Decision

(i) That the information given and comments of Members be noted and actioned as appropriate.

(ii) That an introductory letter be sent to all Partnership Members from the new Chair of the Partnership, Councillor Creevy.

7. Date and Time of Next Meeting

It was reported that the next meeting would be held on 25 September 2024 at 1.00 pm.

The meeting concluded at 2.25 pm.

CHAIR

HEALTH AND WELLBEING BOARD

17 March 2025

Report of: Executive Director of Adult and Community Based Services

Subject: BETTER CARE FUND UPDATE

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1. COUNCIL PLAN PRIORITY

Hartlepool will be a place:
- where people are enabled to live healthy, independent and prosperous lives.
- where those who are vulnerable will be safe and protected from harm.

2. PURPOSE OF REPORT

2.1 To update the Health and Wellbeing Board on 2024/25 performance against the Hartlepool Better Care Fund Plan and planning for 2025/26.

3. BACKGROUND

3.1 The Better Care Fund (BCF) has been in place since 2015/16 and provides a mechanism for joint health and social care planning and commissioning. The BCF brought together ring-fenced budgets into a single pooled budget that has been focused on integration of health and social care services for older people, delivering system wide improvements and better outcomes for local people.

3.2 The BCF Plan for 2023 - 2025 was developed collaboratively by Hartlepool Borough Council, North Tees & Hartlepool NHS Foundation Trust and the North East & North Cumbria Integrated Care Board and approved by the Health & Wellbeing Board in July 2023.

4. PROPOSALS

4.1 The Better Care Fund Policy Framework 2025 to 2026 was published on 30 January 2025.

4.2 For 2025 to 2026, the objectives of the BCF reflect the government's commitment to reform by shifting from sickness to prevention, supporting people to live independently and to shift from hospital to home.

The objectives are:

1. reform to support the shift from sickness to prevention
Local areas must agree plans that help people remain independent for longer and prevent escalation of health and care needs, including:

- timely, proactive and joined-up support for people with more complex health and care needs
- use of home adaptations and technology
- support for unpaid carers

2. reform to support people living independently and the shift from hospital to home
Local areas must agree plans that:

- help prevent avoidable hospital admissions
- achieve more timely and effective discharge from acute, community and mental health hospital settings, supporting people to recover in their own homes (or other usual place of residence)
- reduce the proportion of people who need long-term residential or nursing home care

4.3 The metrics have been amended with three headline metrics agreed for 2025/26 as follows:

- emergency admissions to hospital for people aged over 65 per 100,000 population;
- average length of discharge delay for all acute adult patients, derived from a combination of:
  - proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)
  - for those adult patients not discharged on their DRD, average number of days from the DRD to discharge
- long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population.

4.4 Health and Wellbeing Boards are required to submit for assessment:

- a narrative plan
- a completed planning template
- an intermediate care (including short-term care) capacity and demand plan

Plans must be accompanied by signed confirmation from local authority and ICB chief executives that they have agreed to their BCF plans, including the goals for performance against headline metrics.

4.6 The timescales associated with the plan are as follows:

- Draft headline plans to be submitted by 3 March.
- Final plans to be submitted by 31 March.
- Assurance letters will follow in May.
- S75 Agreements must be signed off by 30 September.

4.7 The draft Hartlepool BCF Plan for 2025 – 2026 is at **Appendix 1**.

5. RISK IMPLICATIONS

5.1 A risk register was completed as part of the original BCF plan with mitigating actions identified. This has routinely been reviewed and updated as the plan has been revised.

6. FINANCIAL CONSIDERATIONS

6.1 The BCF Pooled Budget is made up of a number of elements, some of which have mandatory funding requirements, and the Hartlepool plan demonstrates that these minimum contributions are being maintained.

6.2 The Pooled Budget is hosted by Hartlepool Borough Council and governed through the BCF Pooled Budget Partnership Board.

6.3 Allocations for Hartlepool for 2025/26 are shown below:

Funding	**2025/26**
BCF (Minimum NHS Contribution) #	£10,607,749
Disabled Facilities Grant	£1,516,148
Local Authority Better Care Grant *	£6,610,259
TOTAL	**£18,734,156**

- Now incorporates the ICB Discharge Grant
* - New grant consisting of former iBCF and ASC Discharge Grants

7. LEGAL CONSIDERATIONS

7.1 The legal framework for the pooled budget is a Section 75 Partnership Agreement.

8. EQUALITY AND DIVERSITY CONSIDERATIONS

8.1 None identified.

9. STAFF CONSIDERATIONS

9.1 No staff considerations have been identified.

10. ASSET MANAGEMENT CONSIDERATIONS

10.1 No asset management considerations have been identified.

11. ENVIRONMENT, SUSTAINABILITY AND CLIMATE CHANGE CONSIDERATIONS

11.1 There are no environment, sustainability and climate change considerations.

12. RECOMMENDATION

12.1 It is recommended that the Health and Wellbeing Board approves the Hartlepool Better Care Fund Plan for 2025/26 return, noting that this will be finalised for submission by 31 March with the final plan signed off by the Health & Wellbeing Board Chair, Managing Director of Hartlepool Borough Council and Chief Executive of the North east & North Cumbria Integrated Care Board.

13. REASON FOR RECOMMENDATION

13.1 It is a requirement that Health & Wellbeing Boards approve BCF plans.

14. CONTACT OFFICER

Jill Harrison
Executive Director of Adult & Community Based Services
Tel: (01429) 523911
E-mail: jill.harrison@hartlepool.gov.uk

Integration and Better Care Fund

BETTER CARE FUND 2025-26 HWB SUBMISSION

Hartlepool Joint BCF Narrative Plan

Hartlepool Health and Wellbeing Board

Hartlepool Council
North East and North Cumbria Integrated Care Board
North Tees System Partners

Department of Health & Social Care | Ministry of Housing, Communities & Local Government | NHS England

Section 1: Overview of BCF Plan

Priorities for 2025/26: Please describe your key priorities for the plan period and how these align to local need

The vision of the Hartlepool Better Care Fund (BCF) plan is to enable everyone to live at home for longer, be healthier and get the right support where and when required, whether this be provided by health and / or social care, as well as community and voluntary groups from across the town.

Our priorities for 2025/26 are in line with the national objectives of supporting people to live healthier independent lives in the community.

Hartlepool and the North East in general, have a high level of deprivation and health is generally worse that the England average for health outcomes. Through joint Health and Wellbeing Strategy we will address health inequalities to ensure everyone in Hartlepool has the opportunity to thrive and achieve their potential.

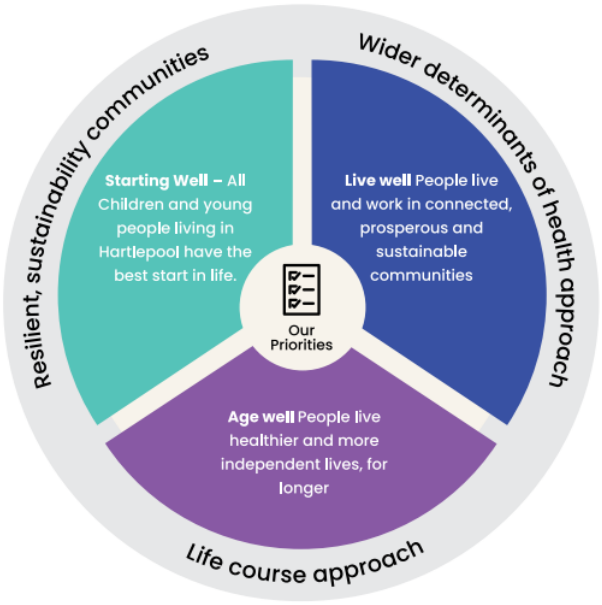
Hartlepool's BCF plans have been developed over a number of years through a committed approach to partnership working. Regular meetings between the ICB and Local Authority commissioners are overseen by Pooled Fund Managers and BCF leads. Many of the BCF schemes are embedded within service delivery models on a recurrent basis haven proven to be successful in achieving shared goals.

Colleagues across the system collaborate, share and develop ideas to meet pressures within the health and social care system, supporting system priorities including BCF plans and metrics. AS it stands currently, there is no uncommitted funding within the pooled budget which partners have agreed, but we are aware of the uncertainties of future societal issues, potential impact of flu and pressures within the system and the continuation of our drive to support interventions regarding specialist elective surgeries (and the impact on numbers being discharged). This needs to be agreed at the Pooled Budget Partnership board. It is the view of partners that a flexible approach is most beneficial for the system, enabling financial resources to be used to meet emerging challenges and threats.

Locally, the Better Care Fund plan has been jointly developed by partners, specifically:

- NHS NENC ICB
- Hartlepool Borough Council
- North Tees and Hartlepool NHS Foundation Trust
- Tees Esk and Wear Valleys NHS Foundation Trust

The principles of the strategy will see partners working together to:



Working collectively with our partner organisations, our priorities and plans support the improvements of flow through our acute hospitals, reduce pressures across urgent and emergency care and develop community services including intermediate care to support people to be cared for in the right place, right time by the right people.

The focus is on strategic and operational collaboration across health and social care, including primary prevention, early diagnosis and intervention and supported self-management. The aim is to promote independence and close the health and wellbeing gap and in doing so reduce health inequalities as well as drive transformational change

Strategic partners are working closely with the Voluntary Care and Social Enterprise Sector (VCES) as a preventative intervention and subsequently following an episode of ill health to ensure people and their family carers are supported to regain independence and improve their quality of life.

We will:

- Through effective collaboration drive our ambition to provide excellent health and adult social care services to the people we serve.

- Continue to focus on the development of our Integrated Single Point of Access (iSPA) to ensure a local and effective integrated health and social care response to support hospital discharges, prevent avoidable hospital admissions and keep people safe and independent at home for as long as possible.
- Strengthen the focus and use of assistive technology service to support people to remain in their communities through specialist digital technologies working in collaboration with system partners, including new Falls pathways.
- Maintain, review and expand urgent health and community care-based services to meet the national 2-hour national urgent community response (UCR) requirements and to ensure more timely system responses, supporting increasingly flexible approaches to managing people in their own homes and community.
- Work together across partner organisations (including GP's, Pharmacists, Therapists etc) to continue to support and develop an effective Hospital at Home Model, as well as setting up interfaces between systems, e.g. the newly developed 'Optimised Patient Tracking & Intelligent Choices Application' (OPTICA) IT system. This will help reduce unnecessary hospital admissions and facilitate timely discharge with better quality and quicker access to information by both health and social colleagues, which will assist with decision making.
- Ensure people living in long term residential receive effective and optimum care and support through a range system initiatives to maximise their health and wellbeing, to ensure they can remain in the preferred place of care where possible.
- Further develop the overnight home care support service with the two existing independent domiciliary providers, building on the work of the internal Direct Care & Support service. This development will see more people to be supported at home (as their first choice), as well as reduce the use of residential care.
- Work together to review existing reablement and rehabilitation intermediate care services to ensure we can support people to remain in the community and be discharged home from hospital with the optimum chance of recovery (Step down) but also to support people in the community (Step Up) reducing the need for short- and long-term bed-based care.
- Continue funding for a discharge to assess period to maximise recovery potential before decisions are made in relation to ongoing care needs.
- Support health, social care and system partners to continue to work closely together to develop initiatives to reduce length of stay and discharge people home as quickly and safely as possible. Partners have worked together to agree discharge arrangements, including the use of D2A funding and implementing a Trusted Assessor scheme.
- Create healthier communities through a neighborhood health approach across NHS, local government, social care and partners through more integrated ways of working.
- Continue to identify and support more people who are providing unpaid care working by working closely with 'Hartlepool Carers' organization

- Support the upskilling and scaling-up of social care staff and services across all of our places, enabling them to respond to the needs of local people and ensuring social care staff are valued as equals within the health and care system.
- Continue to develop our support around information, advice and guidance for those people from Black, Asian, and Minority Ethnic (BAME) groups by investing in a local support worker to more directly engage with the range of communities across the town.
- Provide enhanced support around people with sensory loss needs by developing a broader and more focused offer to this group of people.

The BCF plan supports local and regional objectives. Priorities for 2025/26 and 2026/27 are aligned to the ICB and Hartlepool Borough Council ASC objectives and more specifically to the BCF and HWBB Ageing Well principles. There is also a focus on managing the uncertainties of future societal issues, potential impact of flu and pressures within the system and the continuation of our drive to support appropriate interventions.

It is recognised that fundamentally we must maintain our focus on engaging with all our strategic partners to improve the quality of services across primary care, secondary health care, social care and the wider community.

The key changes to our plan this year will be the use of the BCF and additional Discharge Funding to continue initiatives that support discharges to the right place with the right care at the right time. Our aim is particularly to reduce the reliance on use of beds and to promote an enhanced reablement model to enable more people to be discharged on pathway 1 and 2 with rehabilitation and reablement to optimise the chance of recovery.

Key Changes Since Previous Plan: *Please describe the outcome of your review of impacts from your 2023-25 plan and the changes made as a result*

Avoidable Admissions

There is an increasing emphasis on responding to urgent care situations in the community, as well as a collaborative approach to providing a response. This requires robust assessment, decision making and navigation to more appropriate services and support when needed, including an enhanced assistive technology offer and urgent care offer. Communication continues to be key, and to this end the Hartlepool and Stockton Discharge Group and the Integrated Single Point of Access (ISPA) are critical to ongoing developments, including clinical triage.

We have invested in and strengthened the Urgent Community Response (UCR) and are developing the recommissioned assistive technology service with an innovative provider who is a specialist in this form of service delivery.

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To summarise, there are a range of health and social care services funded by the BCF which are inextricably linked to reduce avoidable admissions into hospital and / or residential and nursing care.

Length of Stay and Discharge to Normal Place of Residence

Health and social care have worked together to develop initiatives to reduce length of stay (in hospital) and discharge people home as quickly and safely as possible. Partners have

worked together to agree discharge arrangements, including the use of D2A funding and supporting the Trusted Assessor scheme.

Our Extra Care and Domiciliary arrangements have broadened the offer and have increased our community care capacity, having identified this as an area for improvement in our response to increase availability of support to people to continue to reside in the community.

Residential admissions - *older adults whose long-term care needs are met by admission to residential or nursing care*

The Discharge to Assess (D2A) initiative along with intermediate care and rapid response services offers the opportunity for people to receive the care and time needed to maximise recovery, maintain independence and avoid unnecessary admission to long term residential, nursing care and home care whenever possible.

Additionally, positive relationships with providers of residential care, nursing care and home care services continues to support this work and reduce the number of people accessing long term residential and nursing care. A range of community-based services support people to feel safe in their own home and give them confidence to return to the community following a period of rehabilitation and recuperation. This includes:

- Embedding our Reablement service into our early intervention offer.
- Supporting all existing providers offering residential and nursing care placements.
- Working with our two contracted domiciliary care providers to implement further overnight care services and maximising the use of assistive technology.
- Engaging people earlier through therapy and Reablement services to reduce length of stay in residential care following a hospital stay in order to support them to return home safely and earlier.
- Further developing the Virtual Ward (Hospital@Home) model alongside the use of 'Home First' to reduce the reliance on residential and nursing care.

Effectiveness of reablement *proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation)*

The services provided via the BCF have proven to be effective with 90% of people confirming that they have achieved the outcomes they wanted in terms of supporting people to return home safely and have a better quality of life.

Learning from our direction of travel to support people in the community, our Community Led Support model has been successfully introduced with the use of community hubs to ensure people can effectively engage with one another and have a purpose in their lives.

Having strengthened our approach with health, social care and community groups coming to together to implement a revised offer that maximises technological solutions. Also, work is continuing with colleagues from Mental Health Services and the voluntary sector to support people experiencing challenges with their Mental Health, for example, with the continued expansion of Togetherall, an online Mental Health support tool that can be accessed by anyone over 16 years old in Hartlepool (from 2023). The outcomes have been positive.

We have further invested in our Reablement service by focusing on providing support in the community hubs and working with our NHS colleagues in ISPA.

Enhanced Health in Care Homes (EHiCH):

EHiCH remains part of the current national Primary Care Network Directed Enhanced Service (DES), which supported and delivered through a whole system approach across all care homes in Hartlepool. In addition there are BCF funded care home schemes including Training and Education, digital support, meds optimisation

The EHiCH continues to work well and there are positive relationships with Primary Care Networks (PCNs) and Clinical Directors, and there is a positive link to providers of residential care, nursing care and domiciliary care.

As part of the current DES, community matrons undertake a proactive home round and have monthly multi-disciplinary teams with GP, pharmacy and nursing input as a minimum to support personalised care planning, alongside the care home nursing team.

The dedicated pharmacy support (Meds Optimisation) continues to be successful in the implementation of proxy medication ordering for all care homes, and will continue.

A digital programme (Care Homes Connected Servcie) of support has been commissioned to enhance and support the delivery of digital developments in care homes including:

- NHS Mail is now operating successfully with all care homes using NHS mail as primary form of communication with ASC.
- Proxy ordering of medication.
- Personalised care and support planning.
- Information sharing.

In partnership with the wider North East councils, the regional technology group is now well established to support technology based developments across the region.

We have introduced a 'link model' which includes ASC representatives from social work teams, safeguarding and commissioning to further strengthen the relationships and communications between providers and ASC. This has been well received and ensured that communication is more effective, by introducing an early problem resolution mechanism.

Approach to Joint Planning & Governance: ***Please describe how you have worked with partners and stakeholders to develop and agree this plan***

We have planned and managed our BCF plans collectively in Hartlepool since the first roll out BCF nationally in 2013. Each partner has their own internal governance arrangements in line with their own organisations requirements. These link to the broader governance arrangements of BCF. Together these arrangements ensure that a system wide perspective and approach is taken with appropriate oversight from the local Pooled Budget Partnership Board (PBPB), the Health & Wellbeing Board (H&WB), and the North East North Cumbria Integrated Care Board (NENC ICB).

Decisions on BCF funding allocations, metrics and priorities are agreed jointly between the ICB, Local Authority and partner organisations. This approach has meant we have been able to develop schemes covering both health and care areas including UEC (Flow) and intermediate care. This supports equity and consistency in services and helps promote integration.

BCF leads link in with colleagues across the system including both our acute and mental health Trusts, housing and VCS organisations to develop and consider new proposals which would help to support the BCF objectives and metrics and our system priorities.

If we have any queries or need some guidance, we contact our regional Better Care Manager, refer to the Better Care Exchange and we have a representative on the Local Systems Group.

Our current governance arrangements:

- Regular meetings of the **BCF Delivery Group,** which is formed of commissioning, finance and BCF leads from the Local Authority and the ICB. This group collectively plans, reviews new business cases, and monitors expenditure of the Better Care Fund.
- The **Pooled Budget Partnership Board (PBPB)** receives recommendations from the BCF Delivery Group. The Board has senior membership from the Local Authority and the ICB and its role is to provide strategic direction on schemes and receive and approve business cases for proposals against the Better Care Fund.
- The **Hartlepool Health & Wellbeing Board** is responsible for; signing off and ensuring delivery on the Hartlepool BCF Plan; ensuring that the BCF plan responds to local needs, is aligned with the Health & Wellbeing Strategy and supports system integration across health and social care; agreeing the use of funding under the Better Care Fund pooled budget arrangements; addressing any risks and issues arising that relate to the wider Hartlepool health and social care system; and progressing any joint commissioning implications and requirements arising from the Better Care Fund.

  The membership of the Board comprises of:

  - Hartlepool Borough Council (Elected Members and Officers).
  - NENC ICB

New planning and governance arrangements will be proposed as part of our 2025/26 plan to strengthen joint commissioning and delivery including some aspects of BCF and wider system planning to support alignment with national and local priorities.

The proposed new governance for our BCF Plans is illustrated in the embedded slide below:

Hartlepool%20BCF%20Planning%20and%

Section 2: National Condition 2: Implementing the objectives of the BCF

Sickness to Prevention: *Please describe how your plan will support the shift from sickness to prevention*

Enabling people to stay well, safe and independent at home for longer

A key system aim across Hartlepool and the Tees Valley is to continue to identify appropriate alternatives to a hospital admission through the use of more innovative service models and by better joining up the service offers available across primary, community and secondary care; including NHS 111 and our Ambulance Service provider.

We know from national and local evidence, and via the Fuller report, that people's care needs can often be best met outside of a hospital setting through integrated (neighbourhood) working , where admissions can be avoided with the right care and support in place. We are stepping up capacity for out-of-hospital care, including virtual wards, so that people can be better supported at home for their physical and mental health needs, and in some cases, replace the need for admission, and in others facilitate people being able to safely leave hospital sooner.

Across Hartlepool and the wider Tees Valley we have already commenced and made great progress in the development and implementation of our **Virtual Ward** (Hospital@Home) models. We are now supporting and extending the breadth of conditions and patients who can be supported, out of hospital, using this approach. Our Virtual Wards (Hospital@Home) aim to provide our patient population with hospital standardcare within their own home, helping us to:

- Prevent unplanned hospital admissions and delays in hospital discharges.
- Further reduce inequalities for people by ensuring all health and care needs are met through delivery of virtual frailty ward and virtual respiratory wards.
- Embed good commissioning practices in integrated health and social care.
- Improve outcomes and experiences for people admitted into the virtual wards.
- Make data and evidence the basis for policy development, good practice, and targeted improvement support.

Although not currently funded from the Better Care fund, our Urgent Community Response and Hospital@Home services play a vital role in supporting the BCF outcomes:

Collaborative working across both health and care systems has supported and strengthened our Urgent Community Response (UCR). Our UCR services provide an urgent response within 2 hours with a reablement care response within two-days. In North Tees we provide a person-centred approach to optimise independence and confidence, enable recovery and prevent a decline in functional ability. We have promoted and adopted through new ways of working through a 'no wrong door' ethos through an integrated Single Point of Access (ISPA) working flexibly based on need, not diagnosis/condition.

Our Urgent Community Response (2-hour UCR) provides urgent care to people in their own homes (including care homes) which helps to avoid hospital admissions and enable people to live independently for longer. The service offers a high-quality multi-professional

integrated response, providing both intensive short-term hospital-level care at home or in a care home which:

- reduces the risk of deconditioning, delirium and hospital-acquired infection
- improves hospital flow
- supports older people to regain independence
- reduces demand for readmission and long-term support.

Close working between hospital, primary care teams, ambulance providers, community rehabilitation, and intermediate care and reablement services will ensure an efficient and sustainable integrated network of UCR in our locality.

Hospital@Home Services support sub-optimised patients to be discharged home from hospital earlier or for patients in crisis at home in the community to be monitored virtually by a Senior Clinician led multi-disciplined team. This service is coordinated through the Integrated Single Point of Access, wrapping the necessary health and care services, equipment and digital monitoring technologies around the patient, to enable early discharge with a Home First approach and to deliver care closer to home in avoiding unnecessary conveyances to hospital. North Tees Hospital @ Home Services provide 70 Virtual Beds split 40/30 between Respiratory and Frail / elderly patients. North Tees continue to work collaboratively with South Tees to expand their Hospital@Home offer to include more conditions being cared for virtually in the community.

Pro-active (Anticipatory) Care

Many of our BCF schemes support the delivery of proactive care and support, particularly older people living with frailty to help them stay independent and healthy for as long as possible at home (or the place they call home).

Over the coming months our collective system including community health teams, Primary Care Networks, social care, mental health teams, community pharmacy, the housing and voluntary sector will be establishing or building on multi-disciplinary teams to strengthen relationships where required, delivering Proactive Care to an identified cohort of individuals. A key outcome will be that services will be transformed from being crisis driven to working in a proactive integrated, personalised, and co-ordinated way for patients.

Priorities are:

The development of clear ambitions for Proactive Care across the Tees Valley, working closely with providers and more specifically, PCNs to translate these ambitions into a comprehensive Anticipatory Care Plan.

- To identify key segments of PCN's registered practice populations using risk stratification tools, who have complex needs and are at high risk of unwarranted health outcomes. Once this baseline/cohort has been developed, we need to agree the number of individuals to be offered Proactive Care
- To clinically validate individuals as appropriate for Proactive Care , prioritising those with greatest clinical need first.
- To implement a holistic assessment process to understand the goals and ambitions of those identified as the Proactive Care cohort.

As part of service re-design, the ICB aims to ensure that the key principles of personalisation are considered and embedded into new pathways including personalised care support plans, shared decision making and Patient Activation Measures (PAM). Knowledge and opportunities will be shared across all relevant Tees Valley place portfolio teams.

Integrated Neighbourhood Working:

There are several integrated ways of working across Primary Care with PCNs collaborating with non-GP providers to provide better care, as part of an integrated neighbourhood team.

This is supported by PCNs making significant advances in recruiting to their multi-disciplinary teams [MDT] through the Additional Role Reimbursement Scheme [ARRS], which has 19 roles available to PCNs to employ/ engage. Often PCNs do so by working with health and care community services, VCSE, GP Federations and Acute Trusts to make best use of the resource available.

Having a range of roles working together as an MDT is a key as the teams often work together to provide holistic care to enable the best outcomes for their patients.

Examples of integrated working include:

- Enhanced Health in Care Homes working across care homes, primary, community and mental health services to provide proactive care to residents
- Mental health hubs and the mental health practitioners embedded in PCNs
- Community nursing identified to work with defined PCN populations
- PCNs have also identified priority areas using population health management data including poverty proofing [Darlington], women's health [Stockton, healthy weight [Eston], Hypertension [Billingham and Norton], CVD [PCNs across Hartlepool], Frailty and wound management [PCNs across Middlesbrough, Redcar and Cleveland]

Hospital to Home: *Please describe how your plan will support people to live independently and the shift from hospital to home*

Hartlepool Discharge Pathways

In Hartlepool, the overarching aim is to support people in the community and when a person is admitted and discharged from hospital, to get them back to their usual place of residence, reflecting the Hospital Discharge and Community Support Policy and our 'Home First' ethos.

In almost all cases the short-term intermediate care services/ staff who support people to remain in the community (step-up) and support people following discharge (step-down) are part of the same service/ staffing cohort. This is the case for domiciliary/ home-based care and bed-based care with the intermediate care beds also being used for both step-up and step-down. Generally, there isn't dedicated step-up or step-down staffing/ capacity (including beds) rather usage is based on demand. However, the vast majority of the short-term intermediate care demand (home and bed-based) is following a discharge from hospital.

People going home with little or no support needs (Pathway 0) make up the largest proportion of discharges. There are several services available to support people with low

level support needs, including the NTHFT Home but Not Alone services. As an integral part of our community offer, including the use of community hubs and the VCSE community, people are provided with information, advice & guidance about the benefit and accessibility of using these services.

Depending on the level of need, there are services available to people being discharged on Pathway 1, who need a little more help to recover at home. This includes Domiciliary Care Providers and the Trust Rehabilitation Team who provide up to 4 weeks of support at home. Alongside these we also have a Home First service, Assistive Technology, the Intensive Community Liaison Service and some condition specific healthcare services i.e. Community Respiratory Service. Once again, our community is invaluable in this area.

We have a range of community beds which can be used for both step-up and step-down. In terms of Pathway 2 and 3 discharges there's no distinction to the way the beds are commissioned and they can be used for either Pathway.

There are 20 beds available at West View Lodge, which is the core intermediate care facility commissioned on a recurring basis. There is an option to flex depending on the level of need.

In addition to this there is an option to use spot purchase beds when West View Lodge beds are not available. The availability of spot purchase beds is dependent on a number of factors, including the local care home market, the needs of the individual, the wraparound supporting workforce and funding restrictions, as well as other restrictions such as D&V outbreaks (which can have a significant short term effect). We have systems in place (including the regular discharge meeting with health colleagues, regular performance reports [as well as development of Power BI, OPTICA and the predictive Affinity Landscape tool used by 8 North East Councils to give a more dynamic, up to date and interactive view of both capacity and demand]). This enables us to monitor and review pressures as they emerge through the year and we can flex the focus on this area as required.

2024/25 Learning Points

Completing the capacity and demand requirements in 2024/25 formalised a process which has been taking place in Hartlepool over the last few years. Representatives from Adult Social Care and Health services work together and collaborate on a daily basis at ISPA, via a weekly meeting (Discharge group) and have regular meetings with the BCF Delivery group to explore pressures, agree resolutions and plan how best to cope with demand and capacity, this ensures the flow of patients continues despite any arising challenges. In times of high demand measures are put in place to alleviate these where possible, for example increase the core domiciliary care hours or step up weekend working to facilitate discharge to Care Homes. We also use analytical demand projections to inform discussions regarding future capacity, particularly in relation to homecare and beds.

We use a range of tools to support this, including:

- **CareFirst 7** – main care management systems (used by the full dept) upgrade system implemented in August 2022 to better store, collate and report on performance data. This is a trusted system that has been successfully used in Hartlepool for 25 years.

- **Controcc** – Service based system used for over 15 years in Hartlepool to record all services, payments and provider details.
- **OPTICA** – hospital system being developed with the Trust to share information using a dynamic link to both the Trust and LA systems.
- **Affinity Landscape tool** – demand model and predictive tool used for the last 4 years to automatically generate intelligence showing trends and future predictions of all services, e.g. number of people accessing residential care, domiciliary care etc.
- **Power BI** – implemented in 2022, this on-line interactive tool is used to produce dynamic information directly from source systems automatically, so that users immediately have access to intelligence on the most up to date information – which is automatically recalculated as data changes. This is used in all ASC teams as part of our core business model.
- **Capacity Tracker** – national on-line system that gives local intelligence on care providers in Hartlepool, including capacity and vacancy details by each provider, care home etc.
- **Activity reports** – All functions are now replaced with the Power Bi tool interactive equivalents.
- **Complaints and compliments management** – regular report goes to Adults Services Committee to show the range, nature and trends of both compliments and complaints received, so that we are transparent with members about service delivery.
- **Liaison with independent providers** – regular weekly contact with all providers, regular provider forums allow detailed, consistent and comprehensive exchange of information and intelligence on both current issues and future developments. Our link model has enhanced our relationship with care providers.
- **Surge management** – 'Tees Valley Incident Command and Coordination Centre' call occurs on a daily basis as necessary, including Heads of Service for Early Intervention service along with health colleagues.
- **Hospital Discharge group** – regular weekly meeting with Trust, ICB and Local Authorities to identify current issues and trends and related problem resolution and options planning.

This combination of meetings, tools and information sharing monitors performance and expenditure and identifies gaps and pressures to respond to any demand and capacity issues. These tools and information sharing mechanisms produce our statutory returns (including the new Client Level Data national return) and enable us to have a better understanding prior to making any operational and strategic decisions.

They have also informed us that in comparison to earlier years, we saw an increase in the numbers of referrals coming into the Health and Social Care system, but also allowed us to break this down by area, pathway, function etc. However, both the current and previous BCF Capacity and Demand data collections show a one-dimensional view of capacity and demand, and do not consider any waiting lists or trends in waiting lists, and activity projections do not show whether patients have been discharged on the most appropriate pathways. This is hidden demand that we are not currently capturing.

It was difficult to use this data alone to accurately identify any shortage in capacity or unmet demand. We did however use the data alongside the local intelligence detailed above to inform further discussion/understanding and action including:

- It appeared that there were far more people being discharged on pathway 3 than we would expect, and the Discharge to Assess Model suggests should be the case, although this model is based on aged 65+ and we tend to report on all ages. Further discussion identified that this was due to the way discharges are coded to each pathway, for example someone returning to a Care Home is currently coded as Pathway 3. The figures for the other pathways had similar anomalies, which we now regularly and more effectively monitor by the use of Power Bi.
- Services are not commissioned in such a way that it is straight forward to measure the capacity for a certain element of them. For example, the staff members who deliver rehabilitation services also deliver other services, and the services they provide are flexed depending on the demand. This may mean that it appears we have sufficient enough capacity to meet the demand, but that is because of this flexibility and overall there may not be enough capacity in the system.
- Power Bi allows us to proactively monitor the position in terms of activity for Community Beds which currently shows a slight reduction. Work is ongoing to try to identify trends and to consider how sustainable this is going forward.

This accurate ongoing analysis has enabled us to negotiate and agree to any priorities to respond to the pressures identified – this could include discussing and agreeing alternative arrangements where demand cannot be met by the originally intended service.

These processes and tools allow us to keep a dynamic and up to date check on the capacity available, as well as the demand variation and the response to deal with this variation on a weekly basis, within the framework of the BCF and wider funding options.

2025/26 Approach to Capacity and Demand

As with last year, we continue to take a joint approach to completing the Capacity and Demand information. This is necessary to ensure all Capacity and Demand is considered across the locality, however it also provides challenges, as to do this we require data from different information systems. This introduces the risk of missing some patients, double counting others and the systems are used to record information in very different ways.

To project the demand over the coming year, we have looked at the demand across all functional areas and estimated future demand based on trends within this data.

Much of the low-level social support, including VCS, is provided by charity organisations and volunteers who support people on an ad-hoc basis. This includes helping with shopping, sorting bills and paperwork, cleaning and liaising with other services. There is no set time a person will receive this support and the commissioning of the services vary. Data analysis shows that both capacity and demand can fluctuate quite significantly.

When calculating the capacity of Care Home beds for reablement/rehabilitation we had to consider other factors as well as the actual number of available beds, including the workforce available to support people in the beds, and financial constraints.

Using Capacity and Demand to Inform BCF Plans

Existing systems, processes and analysis which are set up to manage capacity in response to changes in demand will continue and will develop further as needed. BCF plans for 2025/26 currently include capacity for pathway 1 discharges and a higher numbers of community beds, both based on the projections we have developed.

We have extended the contract for West View Lodge by a year, while collectively working on a future model. We are aware that historically we have a higher than expected reliance on beds, but over the last year (2024-25) due to the success of our community offer, this has seen a slight reduction and we are getting more people back home with support.

In terms of out of hours care, we identified that our existing assistive technology equipment and approach was outdated and no longer fit for purpose. Therefore, along with our health colleagues, we have commissioned a technology specialist (Taking Care), rather than a housing specialist, to avoid and reduce the number of unplanned admissions to hospital. We have now a broader range of options and technological solutions that is fit for 2023 and beyond.

Following the introduction of a revised assistive technology offer, we have introduced a more targeted approach based on supporting the reduction of length of stay in hospital and sustaining people to reside in the community.

This has required robust assessment, decision making and diversion to more appropriate services and support when needed. ISPA has been integral to this improved urgent care offer as communication continues to be key, along with better technology and improved relationships between health and social care.

Our improved technological offer will target people in the most need.

The implementation of the Discharge to Assess (D2A) initiative along with intermediate care and rapid response services offers the opportunity for people to receive the care and time needed to maximise recovery, maintain independence and avoid admission to long term residential, nursing care and home care whenever possible.

Additionally, positive relationships with providers of residential care, nursing care and home care services continues to support this work, with the aim of reducing the reliance on long term residential and nursing care. A range of community based services support people to feel safe in their own home and give them confidence to return to the community following a period of rehabilitation and recuperation.

Work continues across the Tees Valley with our health colleagues (including GP's, Pharmacists, Therapists etc) to develop Virtual Wards (respiratory and frailty), as well as setting up interfaces between IT systems, e.g. the newly introduced '**O**ptimised **P**atient **T**racking & **I**ntelligent **C**hoices **A**pplication' (OPTICA) system that will help reduce unnecessary hospital admissions and facilitate timely discharge. This will provide better quality and quicker access to information for both health and social care colleagues, which will assist with decision making.

We currently have an extensive programme to support care homes and people in the community around falls, but we intend to expand this to work closer with domiciliary care providers and the wider VCES, and more specifically Hartlepool Carers.

Falls response services are required in all systems for people who have fallen at home including care homes. We are therefore incorporating and building on the work in Enhanced

Health In Care Homes (EHICH) and UCR in order that we can provide a preventative and reactive comprehensive and coordinated community-based falls response for Hartlepool and the Tees Valley. Additionally, we continue to focus on our preventative agenda via operating a 'Steady Feet' service in our community hubs – this provides advice and guidance to people who are experiencing problems with their mobility with the intention of reducing falls.

In response to Hospital Discharge Operational Guidance, we continue to focus on safe and timely discharge to ensure that the right care is provided in the right place at the right time.

We have strengthened our previous discharge arrangements and the monitoring of all hospital discharges, so that we can focus on continuous improvement.

We continue to seek advice from our Healthwatch colleagues to have a more independent and person centred focus on the arrangements and in doing so, learn from any issues raised.

We have a range of well-developed and innovative options to support hospital discharges, including:

- Trusted Assessors.
- Enhanced weekend working to support admissions to care homes.
- Hartlepool Carers role to help navigate the discharge process for patients and their families.
- Spot purchase of beds for D2A.
- West View Lodge intermediate care centre.
- Home First.
- Virtual Ward.
- Assistive Technology (Hartlepool Technology for Care).
- Revised domiciliary and extra care contracts.
- Overnight domiciliary care.
- Mental Health support within ISPA from TEWV.
- Enhanced Reablement offer.
- Rehabilitation apartment.

Collectively, these initiatives work together to ensure that we offer a more personalised hospital discharge, which promotes the independence and wellbeing of the person and importantly, supports family carers at a time of crisis.

In terms of demand management at times of unprecedented pressure, surge meetings are utilised across the Tees Valley and mutual aid is made available to ensure patients are discharged and placed on the next stage of their pathway of care. This maintains flow throughout the hospital and promotes rapid and supported discharge to the most appropriate place for recovery in a planned manner rather than experiencing an extended length of stay in an acute hospital bed.

All partners work together to focus on ensuring that the person is provided with the right care, in the right place at the right time. This promotes opportunities to ensure that people stay well and they are safe and independent at home for longer.

We have continued to focus on collaboration, including operational elements as well as strategic commissioning between health and social care, building on the strengths of each organisation.

Operationally, the regular Hartlepool and Stockton Discharge Group has collectively worked across the ICB, Trust and LAs to ensure delivery of the Hospital Discharge Guidance offering mutual support and solutions to community bed provision including workforce issues, pathways/ processes and continued development of the 'Home First' approach and associated initiatives.

Our initiatives ensure people who need care receive it in the right setting. The services support patients to remain or return to their own home through provision of a 24/7 nurse led services, allowing for an individual to be both care managed and have their needs assessed within their own home environment by an appropriate representative of health and social care.

Our initiatives, including Home First, provide a multidisciplinary team offer that can deliver effective nursing and rehabilitation interventions during this initial period of recovery to promote independence. Our services works in collaboration to support a health and social care approach to the delivery of care. Our ambition is to develop this to include a more robust link with the Assistive Technology function.

Patients accessing our initiatives are generally:

- Suitable for Pathway 1 (able to return home with support from health and/or social care);
- Patients at the point of community crisis who require additional support to avoid escalation to Pathway 2 (rehabilitation or short-term care in a 24-hour bed-based setting); or
- Patients who have resolvable 1:1 needs

Our approach sits within a framework of joint commissioning and collaborative working where current and emerging challenges are discussed between all partners and appropriate solutions identified and implemented whenever possible.

iSPA provides a multi professional triage and care planning service to improve pathway access and delivery for health, social care and VCSE services ensuring people get access to the right early help at the right time, including specialist support where needed.

We work closely with a wide range of experienced VCSE organisations, including Hartlepool Carers, Lets Connect, Lillyanne's Coffee Shop, PFC Trust, Hartlepower etc, both in terms of supporting initiatives in the community and helping drive developments such as Community Led Businesses, that helps encourage a more diverse and wider community offer.

By collaborative commissioning, and close working relationships, we continue to focus on safe and timely discharge to ensure that the right care is provided in the right place at the right time.

All partners are committed to ensuring that the person is provided with the right care, which promotes opportunities to ensure that people stay well and they are safe and independent at home for longer.

We have used additional hospital discharge funding:

- To support Tees Community Equipment Service (TCES) to provide additional resources to allow for more same day equipment deliveries to reduce length of stay in hospital.
- To implement a weekend discharge arrangement with care homes to support increased numbers of people being able to be admitted to care homes over weekends.
- To support a workforce retention programme for independent care homes and domiciliary providers.
- To enhance our Reablement offer, and in doing so, support NHS Trusted Assessors.
- To improve complex discharge coordination and reduce length of stay.
- To expand the Tees Valley Mental Health discharge service.
- To continue with the D2A programme (for up to 4 weeks).
- To provider overnight domiciliary care and support.

We have an agreed strategic priority to support people to be discharged to their usual place of residence. There are a range of initiatives that have been put in place and enhanced to support this, they include:

- Home First – a multidisciplinary team that can deliver effective nursing and rehabilitation interventions during this initial period of up to 7 days to promote independence.
- Virtual Ward – working closely with our health colleagues to provide a collaborative approach.
- Enhancing our Extra Care model to provide a more responsive and up to date service.
- Improving our assistive technology offer by targeting support to people with the most need.
- Strengthen our domiciliary care offer by ensuring that our block contract providers work in partnership, ensuring more timely discharge and a greater capacity for people to move directly to their home, rather than a care home setting.
- Trusted Assessors – support this function within the hospital setting to identify potential patients who will able to return to their usual place of residence, who, once clinically able, can be prioritised.
- Increased TCES resource has provided additional capacity around same day deliveries, where the client is in a hospital setting.

We continue to implement and reflect from the High Impact Change Model areas of good practice, for managing transfers of care and many examples of this are outlined in other sections of this template. In summary:

- **Early discharge planning –** the Integrated Coordination Centre, daily system calls and on-going internal work with Trust colleagues
- **Monitoring and responding to system demand and capacity –** the reporting mechanisms and daily and weekly multi-agency meetings
- **Multi-disciplinary working -** examples include our ISPA and Integrated Coordination Centre
- **Home first –** our system aim wherever possible and established D2A processes
- **Flexible working patterns –** increased weekend working by social care
- **Trusted assessment –** in place to support and expedite discharges
- **Engagement and choice –** examples include our carers in hospital support and staff engagement with patients and families to seek the best outcomes but manage expectations
- **Improved discharge to care homes –** well established EHICH processes and Trusted Assessors
- **Housing and related services –** services in place to support with needs patients may have on discharge

Disabled facilities Grant (DFG)

The DFG is a capital grant paid to Hartlepool Borough Council to facilitate the adaption of older and disabled people's homes and is incorporated into the wider iBCF grant.

The DFG aims to support disabled and older people to be independent, enabling carers to continue their role safely, preventing accidents and helping people to return home from hospital.

It requires effective co-ordination between housing providers and the health and social care system and supports the increasing national focus on the integration of housing with health and social care services.

The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place.

HBC has a published 'Housing Assistance Policy' in accordance with the Regulatory Reform (Housing Assistance) (England and Wales) Order which gives local authorities permission to broaden the scope of how DFGs are used to support housing renewal and assist with improving housing conditions.

Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate.

This increase in DFG funding in recent years has afforded HBC and its key partners the opportunity to review existing arrangements to ensure that adaptations continue to play a significant supporting role in enabling the Boroughs residents to remain independent in their homes for as long as possible.

Hartlepool continue to deliver the adaptation programme into 2025/26 and we have prioritised resources to facilitate hospital discharge or prevent hospital admission by using our stair-lift and ramp loan scheme and prioritising/fast tracking DFG's on a case-by-case basis.

Within the Council, the decision to integrate Special Needs Housing within adult social care has supported increased integration and broadened understanding. Communication has improved and the service is operating more efficiently within the OT service rather than being overseen by Housing Officers. By doing this, we are in a better position to respond to the requirements of the 2021 government white paper ('People at the Heart of Care'), as there is a greater emphasis on the integration of housing, health and social care.

For the year 2024/2025, Hartlepool provided the following:

157 Grants in total consisting of:

- 80 level access shower/over bath showers.
- 59 stair-lifts.
- 4 major adaptions (extensions / conversions).
- 14 ramped access only.
- 12 other – door widening, alterations to staircase/remodelling.

Key changes and priorities for 2025/26

- Use of a discretionary power which permits the Council to make additional grants / loans etc. to top up the maximum permissible grant of £30,000 per property.
- Hospital Discharge Grants payable where NHS continuing healthcare funding is not available but the person requires an urgent adaption to support a discharge home.
- Removal of the means test for DFG applications up to £5k in circumstances which would cause undue financial hardship or in circumstances of a rapidly progressing or highly debilitating condition.
- Exploring opportunities to consider means testing of families on a case by case basis, to alleviate financial inequalities.
- Relocation assistance of up to £10k for owner occupiers where an existing home is unsuitable for improvement, repair or adaptation and the person is eligible for a DFG.
- Consideration of using DFG to support and pay discrepancies where stamp duty may limit a move.
- Assistive Technology development to target people with most need.
- Exploring improvements to Digital Technology across a range of areas including 'personal emergency response services and equipment and activity monitoring service for assessment.

Examples include:

Wider prevention – Providing support to a Community Led Support to 'Make every contact count'. This would identify people struggling with their homes before they get to crisis point by offering information advice and support from the occupational health service based in community hubs.

Short-term Interventions – increase rapid response services to enable people to come out of hospital or to prevent someone in crisis having to go into residential care by fixing trip and fall hazards, installing minor adaptations, repairing heating systems and providing an immediate deep clean and declutter.

Medium-term Solutions – continue to fund the provision of stair-lifts and showers, but with a range of integrated services to maintain independence which might include: minor adaptations such as grab-rails, key safes; a personal alarm system; other improvements such as repairs or a new heating system; and links to an exercise class, falls prevention training and befriending service to improve health and wellbeing.

Long-term Interventions – Purchasing and installation of equipment to continue to the use of a rehabilitation flat to facilitate intensive assessment and longer term reablement supporting recovery from major surgery, life limiting injuries, Stroke etc, including extensions and adaptations to properties. We are experiencing a particular pressure regarding supporting families with a child who has life limiting conditions. However, we are committed to continuing to provide support in order to ensure the family continue to stay together.

A significant and successful development has been our work undertaken with the VCS and Hartlepool Carers to engage earlier with people and their families to provide them with equipment to meet low level support needs and avoid progression to further assessment and associated services. This has enabled us to successfully manage our waiting list for occupational therapy services.

Joint Approach to Best Value: *Please describe the joint approach to meeting the BCF objectives, which reflects local learning and national best practice to deliver value for money*

Overall BCF plan and approach to integration

The Hartlepool BCF budget funds a range of schemes that continue to prove their value and provide the foundations to meet current challenges and emerging threats to the health and social care system in Hartlepool.

The schemes cover a wide range of areas including strengthening our offer for the BAME and sensory loss communities, and broadening our approaches to housing, integration, technology, workforce, market development and sustainability and working with and supporting the Voluntary Community and Social Enterprise (VCES) sector.

Our overarching approach has been one of collaboration and, where appropriate, integration with a broad range of partners. Key partners include the Local Authority, care providers, the ICB, Primary Care Networks and the Foundation Trusts (in terms of delivery). Statutory partners are increasingly working more closely with the voluntary sector through Community Led Support initiatives.

We are particularly successful in supporting family carers by strengthening our contractual arrangements and links with Hartlepool Carers organisation, who have recently received national recognition for their work. We have also worked with the online Mobilise solution as part of a NE ADASS programme – this is particularly beneficial for those carers who are employed and need support outside usual office hours, and are often hard to reach.

This approach has enabled partners to strengthen community based services and provides a platform to better respond to the requirements of the preventative and urgent care agendas, and to utilise opportunities that will emerge from other initiatives.

Collaborative approach to supporting Hospital Discharge

We currently operate a collaborative and co-located approach to supporting people to be discharged from hospital. This includes:

- ASC Direct Care & Support Service
- 24 hour ASC Telecare response service
- ASC Overnight domiciliary service
- Social work roles as part of the early intervention team
- The Foundation Trusts Community integrated Assessment Team (therapy)
- Trusts Clinical Triage team
- The Virtual Ward (which incorporates previous Rapid Response & Home First teams, and also includes pharmacy)
- Urgent community Response service
- Community Matrons
- Out of hours Nursing service
- Safeguarding.
- This includes representation from TEWV services, the role of which is currently being reviewed.
- Harbour (domestic abuse support)
- START (drug & alcohol services)
- District Nursing service

By collaborating and working together, and improving communication and coordination of care, we are able to more readily respond to urgent requirements of the community and support more timely and safer discharge from hospital or 24 hour care. An example of this would be the development & implementation of Acute & Community OPTICA across both health and social care.

This has worked successfully for a number of years but has continued to develop, i.e. with the inclusion of additional services, such as Harbour, START etc. Staff are now more aware of the range of services that can be used to support people in the community.

As part of our development agenda, we will work with our assistive technology partner to develop more imaginative and bespoke solutions around technology to help people to remain in their own homes.

Integrated Single Point of Access (iSPA)

The iSPA is an integral part of our 'front door' arrangements alongside the use of our community hubs.

In terms of iSPA, this provides a multi professional triage and care planning service to improve pathway access and delivery for health, social care and VCSE (Voluntary Community and Social Enterprises) services ensuring people get access to the right early help and specialist support.

This strengthens information sharing, improves risk assessment and enhances joint decision making to ensure people and their families receive the right services, at the right time, in the right place.

As we respond to increasing pressure within the system our investment in ISAP continues to give health and social care the infrastructure to be able to respond more flexibly and quickly to a dramatically changing landscape. This is ongoing challenge as people continue to receive appropriate support in a timely and effective way.

Our ambition is to continue to invest in the iSPA to ensure that we have sufficient coordination, resources and flexibility across health and social care to address future needs and emerging threats.

While working with our colleagues, from Healthwatch (so we have an independent challenge), their analysis has found a very positive picture, as well as highlighting some actions to improve our offer further.

The iSPA model has been acknowledged as successful using the following criteria:

- Effective pathways for people requiring health and/or social care support.
- Improved rates of response to referrals with timely decision making and a reduction in delays associated with information gathering and duplicated effort.
- Reduction in the number of hospital admissions for people known to Out of Hospital services.
- Reduction in the number of people requiring admission to care homes.
- More holistic triage of people's needs.
- Increased referrals to non-statutory services for people with less complex needs.
- Reduction in the number of bed days in hospital, which frees up health resources to meet growing demand and focus on key areas, such as acute care.

The Care Act 2014 introduced a national framework to determine whether a person has eligible needs and for the first time, the Act, ensured that family carers had the same rights to assessment and support as the people that they care for.

The Care Act 2014 introduced a legal duty to prevent, reduce and delay people's needs from worsening and confirmed that people must be supported at an early stage to prevent and reduce the likelihood of people ending up in crisis.

There are six principles that underpin the work of professionals and other staff who work with adults. They apply to all sectors and settings that work to care for and safeguard adults, including care and support services, further education colleges, commissioning, regulation and provision of health and care services, social work, healthcare, welfare benefits, housing, wider local authority functions and the criminal justice system. These principles are as follows: -

- **Empowerment –** You know best about the care and support you need; your views, wishes, feelings and beliefs should always be considered. To ensure that this is implemented in the right way, professionals must discuss all the possible outcomes of the person's decision, without enforcing their opinions too much. If the person does not have capacity to give consent, then their decisions can be made for them. Whether the person has capacity depends on a few factors that are specified in the Mental Capacity Act 2005.
- **Protection –** Professionals should always work to protect you and other people from abuse and neglect. The Act clearly states how people can raise concerns about the safety or wellbeing of someone who has care needs. If a person is at risk of abuse or neglect, authorities must act immediately. An effective response must be in place to protect the person in need.
- **Prevention –** The main aim of professionals should be on the person's wellbeing, on reducing the need for care and support, and on reducing the likelihood that the person will need care and support in the future. Local authorities have a legal duty to prevent, reduce and delay people's needs from worsening. The aim is to have responsive local authorities that are able to support people at an early stage, to prevent and reduce the likelihood of people ending up in crisis situations.
- **Proportionality –** Appropriateness and proportionality are concepts that must apply to all assessments and are not themselves forms of carers' or needs assessments. A proportionate assessment will be as extensive as required to establish the extent of a person's needs and any decisions made will always be person-centred and based on their individual circumstances.
- **Partnership –** Any decisions should be made with the person's involvement, and their wellbeing should be balanced with that of any involved family and friends. It also applies to multi-agency collaboration working in partnership to provide the appropriate care and support for the individual.
- **Accountability –** Professionals should ensure that any actions taken to support a person receiving care affect their rights and freedom as little as possible. The accountability principle also states that safeguarding is everybody's duty, and everyone in contact with a vulnerable person should be responsible for noting any risks and taking action on any harm identified.

Although all of the six principles are important, the main principle of the Care Act 2014 is to help to improve people's independence and wellbeing and for care providers and givers to promote a person-centred approach to the care and support they provide. The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life. The Act requires local authorities to involve adults in their assessment, care and support planning and review. Considering the person's views and wishes is critical to a person-centred system. In terms of person-centred care, these are the four principles: -

- Affording people dignity, compassion and respect.
- Offering coordinated care, support or treatment.
- Offering personalised care, support or treatment.
- Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

The Act highlights wellbeing as one of the key responsibilities for local authorities, with an inextricable link to the main principles, which is of prevention and protection.

The Statutory Guidance of the Care Act 2014 says at paragraph 1.21: “Promoting wellbeing does not mean simply looking at a need that corresponds to a particular service. At the heart of the reformed system will be an assessment and planning process that is a genuine conversation about people’s needs for care and support and how meeting these can help them achieve the outcomes most important to them.”

The Care Act 2014 places a duty on local authorities to promote an individual’s “wellbeing”. This means that they should always have a person’s wellbeing in mind when making decisions about them or planning services.

Wellbeing can relate to:

- Personal dignity, including treating the individual with respect.
- Physical and mental health and emotional wellbeing.
- Protection from abuse and neglect.
- Control by the individual over day-to-day life including over care and support.
- Participation in work, education, training or recreation.
- Social and economic wellbeing.
- Domestic, family and personal relationships.
- Suitability of living accommodation.
- The individual’s contribution to society.

Wellbeing is a broad concept and there is no hierarchy in the areas of wellbeing listed above – all are equally important. There is also no single definition of wellbeing, as how this is interpreted will depend on the individual, their circumstances and their priorities. Wellbeing encompasses several areas of life. Therefore, using a holistic approach to ensure a clear understanding of the individual’s views is vital to identifying and defining wellbeing in each case.

In order to ensure duties under the Care Act are delivered there are a significant number of activities that are implemented to assure the quality of adult social care services including:-

- Survey Feedback Tees Safeguarding Adults Board Quality Assurance Framework
- Practice Month
- Annual Conversation
- Peer Review of Adult Safeguarding
- Continuous Professional Development
- Feedback from the Workforce
- Peer Discussions
- Review of Complaints and Compliments
- Celebrating Success

Metrics Ambitions Support Alignment to System Partner Plans/Capacity & Demand: *Please describe how your metrics ambitions align with NHS and Local Authority plan, including support to meeting Intermediate Care need/demand*

Emergency Admissions:

For this draft submission, we have adopted a 2% proxy for demographic growth and a do nothing approach for 2025/26 to arrive at the numbers included on Emergency Admissions on our planning templates. This is to allow more time for detailed planning, discussions with Acute Trust and other colleagues and quantifying the expected impact of UCR, Virtual Ward and other admission avoidance schemes. There will be revised figures, ambitions and rationale in our final submission.

Discharge Delays:

For this draft submission, we have just maintained the 2024/25 position and assumed no change in numerator or denominator in the figures entered on our planning templates. As above this is to allow more time for detailed planning, discussions with colleagues and assessment of the impact of our schemes which support effective discharges. There will be revised figures, ambitions and rationale in our final submission.

Residential Care Home Admissions:

For the 2025/26 year, we have examined our activity data over the last year (from an ongoing monthly basis) and have determined that we can set a reducing target from the figure in 2024/25. We have used our Power Bi modelling tool to check this activity and therefore, have set a more challenging target than 2024-25, with the number of planned admissions reducing from 121 to 118 across the year – in line with expected/improved performance in 2024/25.

Home First Approach: *Please describe your Home First approach, including any evidence of reduced length of stay in hospital, reduced admissions to long term care and/or increase in people remaining independent for longer*

See above section, will be amended for final version.

Consolidated Discharge Funding: *Please describe any changes made to planned expenditure on discharge and step-down care, including how you have reviewed learning from previous spend and how revised spend will have a greater impact on UEC flow/outcomes for your residents*

See above section, will be amended for final version.

Please describe how figures for intermediate care (and other short-term care) capacity and demand for 2025-26 have been derived, including:

- how 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)

how capacity plans take into account therapy capacity for rehabilitation and reablement interventions

Intermediate Care Capacity & Demand: *Please describe how figures for intermediate care (and other short-term care) capacity and demand for 2025-26 have been derived, including:*

- *how 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)*
- *how capacity plans take into account therapy capacity for rehabilitation and reablement interventions*

Capacity & Demand

During 2022-23, HBC introduced a new approach to managing performance – this was to use a dynamic and interactive reporting tool called Power Bi. This links directly to adult social care source systems, e.g. CareFirst & Controcc

We also have a predictive tool ('Landscape') in place that links to live data sets in CareFirst & Controcc, and predicts future performance based current and past data. This tool is used to understand how data will vary over the next 1-3 years based on information over the last 1-4 years. This tool has been in place for 4 years and is based on machine learning to understand future levels.

These tools together, have been used to monitor current and recent performance in order to look at trends in the short and medium term ahead. This is in place for all activity and service data, including referrals into the dept, service usage such as short term placements, use of domiciliary care, D2A beds etc.

This shows data over shorter or longer periods (months or years) and can be sub divided into any component parts, e.g. Long Stay residential beds, Short stat rehab places etc.

The Power Bi tools used by HBC are now widely used in most other NE councils, and the NE Performance group have a sub-group (chaired by Hartlepool) that shares information on system planning to improve the knowledge, skills and understanding of performance data, including the shared ideas for development, lessons learned and top tips.

Recently, HBC has developed its own version of a predictive tool that will be used from May 2025 onwards.

Data quality reports are also in place that highlight all areas of data for checking within teams, e.g. where a particular data item may be outside an expected range etc.

We are also developing an interface form HBC adult social care systems into the Tees OPTICA system, that will auto upload activity/service information from HBC systems for the joint discharge team to view/access from OPTICA.

Section 3: Local priorities and duties

Local public bodies will also need to ensure that in developing and delivering their plans they comply with their wider legal duties. These include duties:

- to have due regard to promoting equality and reducing inequalities, in accordance with the Equality Act 2010 public sector equality duty.
- to engage or consult with people affected by the proposals. For ICBs, trusts and foundation trusts this includes their involvement duties under the NHS Act 2006.
- for ICBs, to have regard to the need to reduce inequalities in access to NHS services and the outcomes achieved by NHS services.
- for ICBs, to have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022

Please provide a short narrative commentary on how you have fulfilled these duties

Promoting Equality & Reducing Inequalities: *Please describe how these duties have been met as part of developing this plan*

Working in partnership, the ICB, local authority partners and other members of the Integrated Care Partnership (ICP), including Healthwatch and the voluntary, community and social enterprise sector, have developed our collective ICP strategy, 'Better Health and Wellbeing for All' which details our integrated care strategy for our region. All partners are developing local BCF and other plans, giving due regard to the commitment made within this strategy.

To support this and working with public health colleagues across the region, we created a Healthier and Fairer Group which is a forum with a purpose to tackle the health inequalities across our region. This enables joint planning and focus on some of the biggest health issues for the region

The Healthier and Fairer Programme leads the work on prevention and reducing health and healthcare inequalities across the ICB. Within our local system, we are committed to delivering on our major prevention programmes which include tobacco control, alcohol use and healthy weight and managing obesity and we work with partners to ensure a joined-up approach to tackling key risk factors through primary and secondary prevention.

The health inequalities workstream encompasses delivery against the ICB's statutory duty and the fulfilment of Core20Plus5 requirements and ambitions as set out in the integrated care strategy.

https://northeastnorthcumbria.nhs.uk/icp/better-health-and-wellbeing-for-all/#:~:text=The%20ICP%20includes%2014%20local,improves%20services%2C%20and%20reduces%20inequality

It is recognised that there are significant health inequalities across society and high levels of deprivation make this very stark in Hartlepool.

The local authority and ICB are committed to making sure equality and diversity is a priority and to rebalance any differential in relation to marginalised groups. We are endeavouring to achieve this by working more closely with our communities and their representatives to understand their needs and how best to commission the most appropriate services to meet

those needs, specifically around developing our community Led Support (CLS) solution and family carer initiatives.

We do this by understanding, identifying and then minimising or removing disadvantages suffered by people due to their protected characteristics; taking steps to meet the needs of people from protected groups where these are different and encouraging people from protected groups to participate in public life and other activities where their participation is disproportionately low.

We have undertaken the following in relation to Equality, Diversity and Inclusion (EDI):

- Corporate EDI Policy agreed March 2023
- Staff Equality Network established December 2022
- Promotion of Inclusion Week, Black History Month and World Mental Health Day
- Representatives on the EDI Officer Group
- Established departmental Equality in Experience and Outcomes Working Group
- Learning for Inclusion / ESOL
- Link Project in Community Hub
- Celebrating Diversity Week in September 2024
- Response to riots / community resilience work
- Signed up for Workforce Race Equality Standards
- NRASS Deaf Advocacy Service
- Specialist Sensory Loss Services
- Developing BAME Information Advice & Guidance Service

We will continue to work with the 'Living & Ageing Well' programme to ensure personalised care approaches are fully embedded, supporting healthy ageing across the life course, as well as within the programme specific workstreams, which are Anticipatory Care, Urgent Community Response, Enhanced Health in Care Homes and Virtual Wards.

One of the key issues in Hartlepool is the high level of Poverty. In order to improve this situation, we have been involved in the following:

- Undertaking a Scrutiny Investigation into Family Poverty
- Implementing a Poverty Truth Commission
- Developing and implementing a Poverty Strategy – Housing; Accessing Services; Community Spaces
- Undertaking work on Benefits and Income Maximisation
- Training staff across all functions in relation to a Beginner's Guide to Welfare, Benefits and Entitlements
- Commissioned the online tool "Entitled To" for people to identify where they may be entitled to benefits.
- We have a strategic partnership with VCS to undertake benefit calculations and support completion of applications.

- Resulted in outcomes of over £1m of identified benefits for the population of Hartlepool.

In terms of BCF, our prevention and Home First schemes support the most vulnerable, often those with long term conditions.

The four goals for the North East and North Cumbria Health and Care Partnership strategy are:

- Longer and Healthier Lives
- Fairer Outcomes for All
- Better Health and Care Services
- Giving Children and Young People the Best Start in Life

The summary of our NENC Health and Care strategy on the link below outlines the local challenges, goals and approach to prevention, fairer outcomes, Core20Plus5 and improving services across health and care for all.

Engaging or Consulting: *Please describe how these duties have been met as part of developing this plan*

The ICB published its People and Communities Strategy in July 2022, outlining how patients and key stakeholders are involved in key decisions. To underpin this further, a strategic relationship has been formed with Healthwatch across the region. The ICB currently funds the coordination of all 14 Healthwatch organisations across the region who, in turn, support local public engagement and involvement.

The ICB triangulates all feedback and seeks to understand consistent issues arising to inform local or regional action. This is coordinated through the ICB's Patient Voice Group which is also supported by Healthwatch.

Our BCF plans have been developed collectively over the past years through regular operational and strategic meetings between ICB and Local Authority commissioners, Pooled Fund managers and BCF leads. Linking with the members of these groups, colleagues across the system, including Housing and VCS organisations, who have the opportunity to present business cases around potential new schemes to address a need or gap identified and which would support the BCF and system priorities and metrics. These are duly considered against what uncommitted funding is available and decisions on whether to approve them are made jointly between the Integrated Care Board (ICB) and Local Authority.

In Hartlepool many of our recent schemes (2023-2025) have been developed to support the Home First/Discharge including Intermediate care agenda's. This has involved extensive discussions and planning with colleagues in North Tees & Hartlepool NHS Foundation Trust Hospitals, Tees Esk and Wear Valley Mental Health Trust and NENC ICB.

Hartlepool local authority hold regular care home forums and domiciliary provider meetings where feedback is used to identify needs and pressures. This has led to a number of schemes being developed to support the sector.

We work closely with our VCSE groups across the town and take an active part in working with these groups to collaborate on solutions. The recent Head of Transformation within

HBC has been a pivotal appointment in working more closely with these community groups, including an extensive range of organisations across all areas.

We have continued to build on our approach of co-production & design across a range of reviewed and new areas of work. A recent example was the re-tendering of an Extra Care Scheme's support that has included a range of people who use the service on the selection panel for the new provider – this followed a meeting were the full range of residents of the Extra Care scheme were invited to be consulted on the approach for a replacement care provider.

Reducing Inequality in Access to NHS Services: *Please describe how these duties have been met as part of developing this plan*

The ICB has funded a programme of work, facilitated through our local authorities, targeting inclusion health groups. This work identifies interventions to increase access to general health care for people with multiple and complex needs (associated with drug, alcohol, homelessness, and mental ill health), in line with place-based approaches already available or prioritised.

Another area of work is 'Waiting Well' which is a regionwide programme that uses a population health management approach to provide targeted support to patients who are waiting for planned surgical procedures.

The NHS Constitution sets out the right for patients to choose the organisation that provides their treatment when they are referred for a first outpatient appointment for a service led by a consultant, subject to certain exceptions. The ICB has arrangements in place to ensure that patients are offered choices.

Supporting and Involving Unpaid Carers: *Please describe how these duties have been met as part of developing this plan*

Supporting unpaid carers.

Health and social care partners have long recognised the value of unpaid carers and the significant contribution they make to the support of vulnerable people across both health and social care in Hartlepool.

HBC commission Hartlepool Carers to offer information, advice and guidance to carers in and round Hartlepool – the service they provide is confidential, non-judgemental and impartial.

We have a close working relationship between Hartlepool Carers and partners which allows us to have open discussions as to how best to support unpaid carers across Hartlepool.

Hartlepool Carers have recently received national recognition and are deemed to be an excellent provider, who receive positive support from HBC and statutory partners.

Additionally, during 2024, we have begun to utilise the Mobilise tool to help identify and support hard to reach carers, e.g. those that work and may be more easily supported with an on-line offer.

On behalf of HBC, Hartlepool Carers ensure we discharge our statutory responsibilities, but also do a lot more than this.

We have listened to their views through reviews and carer survey feedback and this has driven improvement in quality and empowered family carers to enhance the quality of their lives and those of their loved ones.

To do this, we have:

- Revised and improved our contractual relationship.
- Provided access to social care IT systems and information, allowing joint recording in systems.
- Created a dedicated social worker liaison role.
- Jointly implemented a carers assessment and review tool.
- Regular meetings to address concerns and develop solutions.
- Work closely around Community Led Support and the support hubs in Hartlepool, including Hartlepool carers have a base at the central hub.
- Supported the implementation of a Hospital based role to support clients and their carers.
- Implemented Carers Emergency respite scheme.
- Implemented the 'Respite caravan' facility.
- Introduced the 'Carers moving on from the carers role' service.
- Provided training and education for carers around specific conditions
- Provided a 'Young Carers service'.
- Provided a range of 'Social opportunities' including coffee mornings, friendship group, male carers group etc.
- Support Health and Wellbeing, by initiatives to access GP's, Mental Health support, access to health living resources (such as eat well, weight management)
- Advice and guidance.
- Regular newsletters.
- Carers Life Blogs.

To enhance our offer to unpaid carers and in response to identifying a 'gap' in service provision, we have collaborated with Hartlepool Carers and commissioned a model of community provision using resources that are ordinarily available to all who live and work in Hartlepool. Hartlepool Carers work with cohorts of unpaid carers who find it more difficult to get 'respite' from their caring role to overcome barriers such as access to transport and meeting additional support needs to enable unpaid carers to continue in their role they do this by providing information, advice, guidance and access to practical support.

Hartlepool Carers complete the majority of carer's assessments, giving them access to the relevant information/IT systems within the councils ASC function.

This builds on the 'Expert by Experience' approach of Hartlepool Carers to enable them to build informal and well based networks and share experiences, leading to a more person-centred approach without the necessity to go through a formal assessment with council staff. This avoids unnecessary delays.

As a result of this work family carers now benefit from a more tailored and bespoke service, which is closely linked to the development of community hubs and Community Led Support.

As a mark of the success of Hartlepool Carers across the town, in July 2022 they were awarded the Queens Award for Voluntary Service – the highest recognition a voluntary group can receive in the UK.

Hartlepool Health and Wellbeing Strategy Missions:

Our Health and Wellbeing Strategy and Vision for the population of Hartlepool sets out our approach supports all the above areas. Details are in the embedded document.

WB Board members are assured that our BCF plans contribute to our objectives.

Joint_Local_Health_and_Wellbeing_Strateg

HEALTH AND WELLBEING BOARD

17th March 2025

Report of: Director of Public Health

Subject: PHARMACEUTICAL NEEDS ASSESSMENT (PNA) 2022 – MAINTENANCE AND PNA 2025 PROGRESS

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1. COUNCIL PLAN PRIORITY

Hartlepool will be a place:
- where people are enabled to live healthy, independent and prosperous lives.
- where people will be safe and protected from harm.

2. PURPOSE OF REPORT

2.1 To update the Board in accordance with the process for statutory maintenance of the Pharmaceutical Needs Assessment 2022 (link to PNA - https://www.hartlepool.gov.uk/info/20015/social_care_and_health/768/pharmaceutical_needs_assessment_2022/1).

2.2 To receive notification of applications, decisions or other notice of changes to pharmaceutical services in Hartlepool from the NENC ICB or Primary Care Support England (PCSE) since the date of the last Health and Wellbeing Board Maintenance Report (4th December 2024).

2.3 To determine approval for publication of any Supplementary Statement to the PNA 2022 required as a consequence of those reported changes to pharmaceutical services.

2.4 To report progress towards statutory publication of a new PNA by 30th September 2025.

3. BACKGROUND

3.1 The Health and Wellbeing Board (HWB) published its Pharmaceutical Needs Assessment on 30th September 2022. A link to the PNA is provided in Section 12.1.

3.2 The HWB are reminded of their statutory duties and responsibilities[1] for maintenance following publication of the PNA 2022 which are, in summary, they must:

[1] To comply with NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended

a) Publish a revised statement of need (i.e. subsequent pharmaceutical needs assessments) on a three-yearly basis, which complies with the regulatory requirements;
b) Publish a subsequent pharmaceutical needs assessment sooner, when it identifies changes to the need for pharmaceutical services which are of a significant extent, unless to do so would be a disproportionate response to those changes; and
c) Produce supplementary statements as required, which on publication become part of the PNA 2022. Supplementary Statements explain changes to the availability of pharmaceutical services since publication of the PNA, in certain conditions.

3.3 The HWB also has duties related to other regulatory processes managed previously by NHS England, now by the NENC ICB, e.g., applications (from service providers) to provide new or amended pharmaceutical services or to consolidate two pharmacies. The current process maintains a scheme of delegation of authority to the Director of Public Health, in consultation with the Chair of the Health and Wellbeing Board and with specialist pharmaceutical advice, for use in the event that it is not possible for any reason to obtain HWB approval in advance of the required response to meet statutory timelines.

3.4 A PNA Maintenance Report will be submitted to every Health and Wellbeing Board meeting to:

a) report any action taken under delegated authority and seek ratification where necessary;
b) seek approval for Supplementary Statements prior to publication, including any required update to PNA maps;
c) report on notification or decision-making for changes to pharmaceutical services which fall outside of the requirement to publish a Supplementary statement e.g., Changes of Ownership which do not impact on service provision, including any required update to PNA maps;
d) report for information, or for decision where necessary, on actions towards meeting the duty identified in 3.2 part a (publishing a revised statement by 1st October 2025) or 3.2 part b (identifying changes to the need for pharmaceutical services that might require earlier publication of a revised PNA).

4. NOTIFICATION OF ACTION, APPLICATIONS OR DECISIONS MADE SINCE THE LAST MEETING OF THE HEALTH AND WELLBEING BOARD

4.1 In accordance with the agreed process for the approval of actions in respect of section 3.2 c, the Board is advised that no new Supplementary Statements have been issued under delegated authority since the last meeting of the Board in December 2024.

Notification of change to Supplementary opening hours.

4.2 Regarding actions in respect of section 3.4 c, on 16th January 2025, NENC ICB Contracting & Performance Directorate for Pharmacy & Optometry notified changes to the opening hours of the pharmacy trading as Healthways Chemist located at 38a Middleton Grange, Shopping Centre, Hartlepool, TS24 7RY. These were changes to Supplementary Hours; the pharmacy is permitted to apply to make these changes, by notification of the date of change only i.e., the change does not need to be approved by the ICB. The effective date of the change was given as the date of notification.

4.3 A summary of the change is shown in Table 1 below. The change is a reduction of three hours on a Saturday afternoon. Taken by itself, this change is unlikely to be relevant to the granting of an application for a new pharmacy or dispensing appliance contractor premises, or changes to pharmaceutical services as there are other pharmacies in Hartlepool open at these times. The combined impact of changes to opening hours since the last PNA will now be incorporated into the revised PNA to be published by 30th September 2025.

Table 1. Change to supplementary opening hours for Healthways Chemist effective from 16th January 2025.

Previous opening hours			
Days	Core contracted hours	Supplementary hours	Total hours
Monday Tuesday Wednesday Thursday Friday Saturday Sunday	09:00-17:00 09:00-17:00 09:00-17:00 09:00-17:00 09:00-17:00 None None	None None None None None 09:00-16:00 None	09:00-17:00 09:00-17:00 09:00-17:00 09:00-17:00 09:00-17:00 09:00-16:00 Closed
Total Hours per week	40 Hours	7 Hours	47 Hours
Revised hours with effect from 16/01/2025			
Days	Core contracted hours	Supplementary hours	Total hours
Monday Tuesday Wednesday Thursday Friday Saturday Sunday	09:00-17:00 09:00-17:00 09:00-17:00 09:00-17:00 09:00-17:00 None None	None None None None None 09:00-12:00 None	09:00-17:00 09:00-17:00 09:00-17:00 09:00-17:00 09:00-17:00 09:00-12:00 Closed
Total Hours per week	40 Hours	3 Hours	43 Hours

Application to open a new pharmacy (Stockton-on-Tees HWB area).

4.4 Regarding actions under section 3.4 a, on 27th November 2024, PCSE notified the Hartlepool HWB of an application to open a new NHS pharmacy in the Stockton-on-Tees HWB area i.e. land east of Hanzard Drive, south of Bloomfield Drive/ Applecross and north of Glenarm Drive, Wynyard, TS22 5FA. This was a re-started application as it had been identified that this 'best estimate' of location would be in what is described in legislation as a 'controlled location'. This changes elements of the process of decision-making adding specific tests and procedures, hence the reason for the restart by the ICB.

4.5 The proximity of this location to the boundary between the two HWB areas meant that Hartlepool HWB were invited to comment as part of the 45-day consultation which takes place in advance of the process of decision-making by the ICB. The response was made under the delegated authority described in section 3.3 as a consequence of the time frame of the closing date of this consultation process and is reported here in accordance with section 3.4.

4.6 The application was made under the category of the applicant's assertion of 'unforeseen benefits'. In making their decision, the ICB must be satisfied that the applicant has offered to provide services which will secure substantial improvement or better access to pharmaceutical services, which were not identified in the relevant Pharmaceutical Needs Assessment (PNA).

4.7 The applicant did not refer to the 2022 PNA of either Hartlepool or Stockton-on Tees in their application. However, the need for, and provision of, pharmaceutical services in the vicinity of this location was described in the relevant PNA under which this application would be considered by the ICB (i.e., PNA Stockton-on-Tees 2022). Similarly, the Hartlepool PNA 2022 also referred to the need and likely near future need for pharmaceutical services in the vicinity, making clear and substantive reference to the potential for future development in the Wynyard area and the pharmacy already located at The Stables, Wynyard, TS22 5QQ. The response on behalf of the HWB highlighted this and noted other points of relevance to the consideration of the status of 'reserved locality', the eligibility of the current pharmacy for the national Pharmacy Access Payment and the absence of specific proposals in the application for improvement or better access to pharmaceutical services, such as core hours extending substantially beyond those offered by the existing pharmacy.

4.8 On 13th February the HWB were notified by the HWB that NENC ICB had considered the above application, which had been refused, with reasons given for their decision. The applicant has the right to appeal. Should there be an Appeal, the decision will be made anew by NHS Resolution. The Hartlepool HWB should again be invited to make representations in response.

5. PROCESS LEADING TO PUBLICATION OF A NEW PHARMACEUTIAL NEEDS ASSESSMENT FOR 2025

5.1 In accordance with section 3.4d, in July 2024 the Board confirmed that the process of preparing a new PNA has commenced, towards publication before 29th September 2025. The Steering Group continues taking forward the plans outlined.

5.2 Public and professional engagement has been completed with the support of Healthwatch Hartlepool, the communication and engagement teams within the local authority and other officers. This generated valuable insight into the current and future provision of pharmaceutical services including 376 visitors and 266 responses to the survey of the views of anyone who 'lives, works, shops or visits Hartlepool' as defined in the survey. This includes 8 responses submitted on paper via access at the Hartlepool hubs or supported by Healthwatch Hartlepool.

5.3 The purpose of this activity is to provide opportunity for people to contribute their views on pharmaceutical services, not necessarily to identify a representative sample of the population.

5.4 The draft PNA is being finalised prior to approval under delegated authority for release to consultation for the statutory minimum 60-day consultation period. This is slightly behind the initially drafted schedule but on a similar timeframe to the previous PNA for which the consultation period commenced in March 2022.

5.5 The latest ONS estimates (mid-year 2022) show that Hartlepool has a resident population of 93,861 and virtually unchanged from the mid-2020 estimate of 93,836 used in the PNA 2022.

5.6 Regulations require that the PNA explains how the localities for the HWB area have been determined. The process used in this assessment is underpinned by those used in the three previous PNAs. The Steering group re-considered the localities for the 2022 PNA and determined that thy remain suitable for use in 2025. PNA localities and are shown on the new map in Figure 1 which also shows the location of all the pharmacies in Hartlepool.

5.7 Pharmaceutical services are currently provided by **21 pharmacies** located in the Hartlepool HWB area. Two of these pharmacies opened on 1st June 2022[2] and April 2024 are categorized as 'distance selling' (DSP) therefore cannot provide face-to-face essential services from the premises, but must do so remotely via phone, email or a website. Two of the remaining pharmacies are known as '100-hour' pharmacies which opened under an exemption which required them to open for 100 hours each week. Recent legislation change has permitted these pharmacies to open not less than 72 hours per week. There are no dispensing doctors and no appliance contractors. Six of these pharmacies have changed ownership since 2022 but there have been no changes in location and no other new pharmacies.

[2] NB. This was after the conclusion of both engagement and consultation processes for the PNA

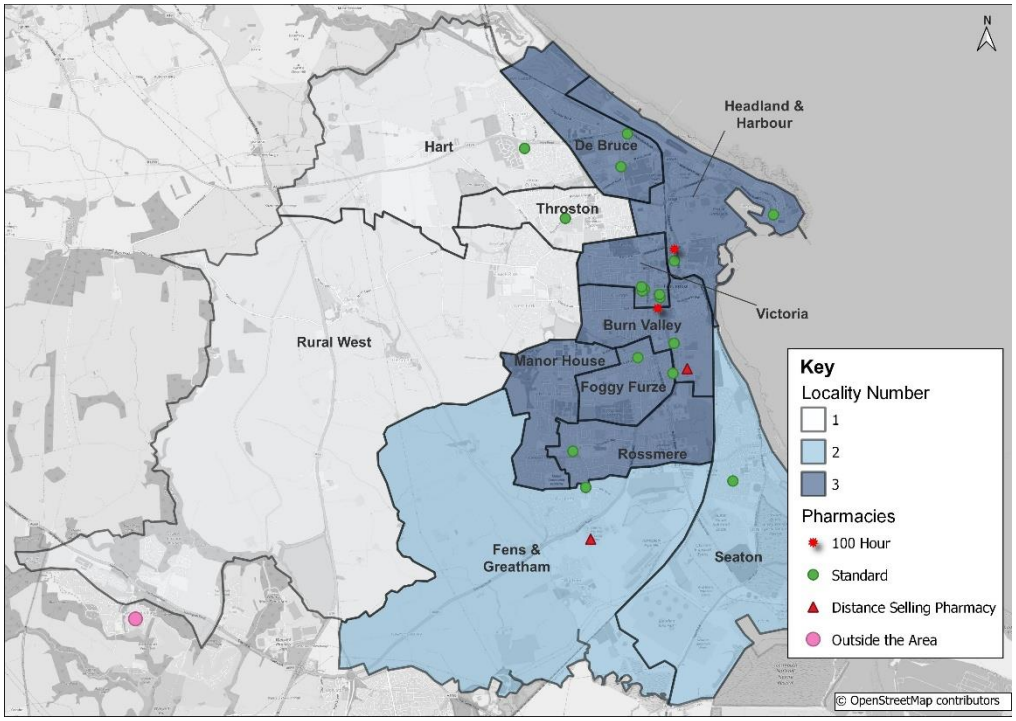

Figure 1. Map of Hartlepool showing location of 21 community pharmacies at 1st January 2025.
Two are '100-hr' pharmacies[3] (denoted by a red circle). Two are 'distance-selling' pharmacies[7] (denoted by a triangle). The pharmacy at Wynyard in Stockton Tees HWB area is also shown. Data Source: NENC ICB. Mapped in HBC.

5.8 The projected population changes and housing developments identified may impact on the type of services required and the number of people accessing pharmaceutical services within the Borough. However, notwithstanding the final deliberations of the Steering group prior to conclusion of the draft, given the current population demographics, housing projections, the distribution of pharmacies across Hartlepool, and mapped reasonable travel times, it is anticipated that the current pharmaceutical services providers will be continue to be able meet local needs for a time up to and including the statutory lifetime of this PNA.

5.9 The draft PNA will be updated in response to the consultation before seeking outline approval of the HWB in July ahead of final publication before the statutory deadline of 29th September 2024. The assessment will be maintained by Supplementary Statements, including new maps if required, issued in accordance with the Regulations, as services change.

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6. OTHER CONSIDERATIONS

FINANCIAL CONSIDERATIONS	
LEGAL CONSIDERATIONS	To fulfil the requirements of Section 128A of the National Health Service Act 2006 (NHS Act 2006) for each Health and Wellbeing Board to publish a Pharmaceutical Needs Assessment (PNA)

[3] See explanation of these terms in the text

EQUALITY AND DIVERSITY CONSIDERATIONS	**None**
STAFF CONSIDERATIONS	**None**
ASSET MANAGEMENT CONSIDERATIONS	**None**
ENVIRONMENT, SUSTAINABILITY AND CLIMATE CHANGE CONSIDERATIONS	**None**

7. RECOMMENDATIONS

7.1 Health and Wellbeing Board to note:

i) No supplementary statements to the Hartlepool PNA 2022 have been issued since the last report in December 2024.
ii) Changes to pharmaceutical services in Hartlepool have been notified.
iii) The response provided under delegated authority in respect of the application to open a new pharmacy in an area covered by Stockton-on-Tees HWB.
iv) Progress towards the publication of a new PNA by September 2025 which will now include reference to this recently refused application.

8. REASONS FOR RECOMMENDATIONS

8.1 Included in the body of the report.

9. BACKGROUND PAPERS

9.1 Pharmaceutical Needs Assessment 2022 (link to PNA - https://www.hartlepool.gov.uk/info/20015/social_care_and_health/768/pharmaceutical_needs_assessment_2022/1)

9.2 National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 SI 2013/349 as amended (the 2013 Regulations).

9.3 The NHS (Pharmaceutical and Local Pharmaceutical Services) (Amendment) Regulations 2023 (the 2023 regulations).

10. CONTACT OFFICERS

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NHS
University Hospitals Tees

James Bromiley

University Hospitals Tees Group Strategy Update – Hartlepool HWB

Caring
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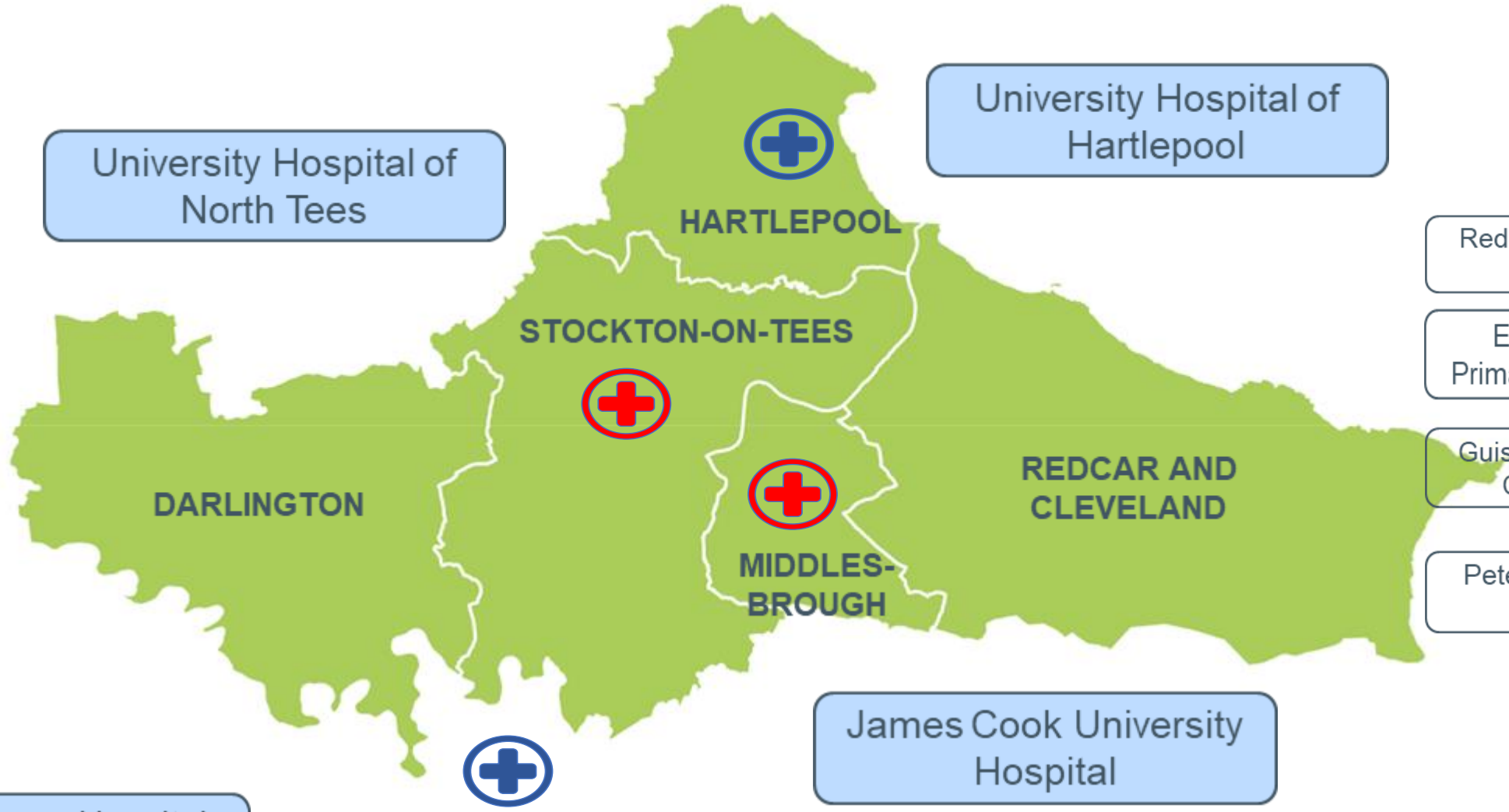
Case for change

Key points

- We came together as a Group in 2024 building on years of collaborative working.
- Joint working as a Group enables us to operate more effectively to meet the population health challenges and to deliver high quality care.
- Fundamental ambition is to drive better outcomes for patients and population by implementing optimal clinical strategy.
- Need to balance opportunities and ambition with external drivers and key context of finance, performance and health outcomes and national / system priorities
- The financial context is critical. While it is not the primary driver for our strategy, we need to be confident that the strategy will deliver a financially sustainable model for services in the medium to long term
- The strategy should be grounded in the experiences of our patients, their families and carers and the communities that we serve

Caring Better Together

University Hospitals Tees: Our main locations



University Hospital of North Tees

University Hospital of Hartlepool

Redcar Primary Care Hospital

East Cleveland Primary Care Hospital

Guisborough Primary Care Hospital

Peterlee Community Hospital

James Cook University Hospital

The Friarage Hospital, Northallerton

Caring Better Together

Vision and values

Key points

- Our vision was agreed in 2024 and is being reinforced consistently through our communications
- Our draft values build on the core of the vision: Caring Better Together
- The values are being developed with extensive involvement from staff teams. They are an important touchstone as we bring together the two organisations and start to forge a new culture that draws on the best of our two trusts.

Our vision

“Caring better together to continuously improve the lives and wellbeing of the communities we serve”

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Proposed final strategic objectives

Putting patients first with **high-quality, safe care** and consistent outcomes across the group

Working with partners to tackle shared population health challenges and to reduce health inequalities for our population

Developing **excellence as a learning organisation** through our work in research, education, improvement and innovation

Creating an **outstanding experience for our people** by leading well and being an employer of choice

Using our resources well by driving productivity in services to achieve financial sustainability

Caring Better Together

UHT strategy: action plan and timescales

	12-18 months Early strategic imperatives		2-5 years Core service transformation	Beyond 5 years Transform into new estate
Clinical	Pathology Radiology	Single point of access Urology Cardiology Stroke Urgent care Reproductive medicine	Clinical Including: • Consistent single services • Expand hospital@home • Maximise elective hubs • 2 emergency departments …. and more	**Future care model and outcomes for our patients and communities**
Quality	Safety, effectiveness and experience		Quality strategy	
Health inequalities	Health inequalities: waiting times		Health inequalities strategy	Developed in a way that is::
Place and ICS plans	Place: demand management in Stockton		Place plans and Joint Forward Plan with the ICB and Las	Owned by our patients and communities
Academic / research	Academia/research (tbc)		Academic strategy	Developed by our clinical teams
People	Recruitment		People strategy	Enabled by our corporate teams
Finance	Delivering CIP and financial targets for 25/26		Delivering financial sustainability: MTFP	Built with our system partners to deliver on shared ambition for our population across NENC
Digital	Aligning and integrating systems		Developing a single EPR	Delivering national ambitions in line with future reform agenda and emerging 10-Year Health Plan
Estates	Community estate		Estates strategy	Strategic Outline Case for future estate

All underpinned by: (1) communications, (2) patient, staff and partner engagement, (3) programme management

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Clinical strategy: implementation

Key points

- The Clinical Boards have now all agreed on a broad ambition for our clinical proposals based on their work and the external referencing they have carried out
- We have organised the clinical ambitions into three time horizons
- The final strategy will articulate the **specifics** for early changes and areas that have universal support
- It will set out the **general principles and themes** for later changes where further work is required to finalise specific service proposals

Timescales and clinical ambition

1. **Horizontal integration of six pilot areas across group (1 year: up to 2026)**
   - Clear outcomes; some co-location to drive operational efficiency and address service vulnerabilities
2. **Full horizontal integration (2-3 years) and transformation (2-5 years: up to 2030)**
   - Based on developed proposals from the clinical boards; reconfiguration of services to improve clinical outcomes
   - Drive towards phase 3 within existing estate
3. **(subject to further work) Proposal for a broad model of an acute general hospital site and an acute specialist hospital site (5 years plus: beyond 2030)**
   - Linked to the Strategic Outline Case (SOC) being progressed to set out our future estate model in five years' time. We will need to flex depending on success of our SOC/OBC

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Clinical strategy: horizontal integration

All services will become single teams across the two trusts so that there is greater resilience in the service and equity of access for patients. We are wanting to test this model of horizontal integration and spread learning as we develop integrated services across the Group.

Horizontally integrated services will:

- **Develop standard clinical pathways across UHT**
- **Enable seamless staff movement between the Trusts**
- **Standardise waiting times as initial step towards single service waiting lists**
- **Create joint recruitment strategy and processes**
- **Create single point of access for patients requiring any of our services**
- **Embed single leadership and management structure**

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What does this mean for Hartlepool?

- UHH is an integral and valuable part of our estate infrastructure and staff base which we want to make best use of
- As part of the need to move services off our acute sites, potential for more UHT group services to come to Hartlepool
- Fair access to specialist services
- Expansion of care closer to home – virtual wards
- Concentrated powerful voice to address health inequalities and press for fairer funding
- Commitment to engage fully on specifics as well as on the model as a whole

- Principles are clear; and detail being developed –but some is still in discussion and will continue to evolve

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Discussion and feedback

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Areas for discussion

- General feedback on the proposals
- What are the gaps / areas that you would like to hear more about?
- What needs to be changed or removed?
- What are the greatest opportunities and challenges for our services? How can we get the right focus on these?
- What are your strategic priorities where we can join up our action or think about working differently?

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Thank you

HEALTH AND WELLBEING BOARD

17th March 2025

HARTLEPOOL BOROUGH COUNCIL

Report of: Director of Public Health

Subject: YEAR ONE ACTIONS OF THE JOINT LOCAL HEALTH AND WELLBEING STRATEGY 2025-2030

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1. COUNCIL PLAN PRIORITY

Hartlepool will be a place:
- where people are enabled to live healthy, independent and prosperous lives.
- where those who are vulnerable will be safe and protected from harm.
- of resilient and resourceful communities with opportunities for all.
- that is connected, sustainable, clean and green.
- that has an inclusive and growing economy.
- with a Council that is ambitious, fit for purpose and reflects the diversity of its community.

2. PURPOSE OF REPORT

2.1 To summarise the outcomes from the Health and Wellbeing Strategy Action Planning Session and propose year one actions for consideration by the Board

3. BACKGROUND

3.1 On 2nd December 2025 the Joint Local Health and Wellbeing Strategy 2025-2030 was presented to the Health and Wellbeing Board. This strategy laid out proposed principles, cross-cutting priorities and specific priorities for Starting Well (children and young people's health), Living Well and Ageing Well. On 12th February, Health and Wellbeing Board members took part in a session to begin development of a Year One Action Plan to address these priorities. Board members were asked to consider what the Health and

Wellbeing Board could do, over and above business as usual, to make an impact on the health and wellbeing of residents. Notes from these discussions were then collated and examined for themes.

4. COMMON THEMES

4.1 Common themes across all three Starting, Living and Ageing Well priorities included:

New places/roving access to health-building activities e.g.

- Health Checks (also linking to Cardiovascular Disease (CVD), obesity, physical activity work)
- Childhood vaccines
- Community Navigators

Very early identification/support, utilising the wider workforce/volunteers

- Prenatal, antenatal and early years support to reduce later issues (e.g. obesity & mental ill heath). This includes midwife, health visitor and breastfeeding support.
- Early targeted Multi-disciplinary team (MDT) help (e.g. mental health, substance use and domestic violence)
- Training staff, the wider workforce and volunteers using Adult Education Qualifications or experts by experience, regarding mental health, healthy weight and dementia (including training available outside of office hours).
- Specific staff (0-11 social prescriber, dietitian) within services
- Multi-agency/MDT support wrapped around schools or workplaces, co-located, conducting joint home visits and providing community care (with continuity of care, carer support and supporting people to stay in their own home)

Communication/promotion

- Sharing information on existing community physical activity opportunities, healthy weight services, smoking education
- Considering trusted local voices, literacy, social media and offline communication as well as using voluntary, community, public & employers/private sector networks.

Maximising opportunities for physical activity and healthy weight e.g.

- Physical activity on Play/School Streets, chairs, public places
- With intergenerational/peer support
- By stealth (Big Town Tidy)
- Look at opportunities in the school curriculum, for pilot expansion, use of data to identify and support less active people, use Sport England/GRIP funding

Linking this work to other strategies (Family Hubs, Early Years, Early Intervention, IThrive, , Curve, Community Hubs, Carers Strategy) or existing work (Work around Making Every Contact Count, Flippin' Pain, Community Led Support, Better Health at Work, Falls, Domestic Abuse Protection Orders, Partnership Integrated Triage)

4.2 In discussion on Starting Well, child mental health, obesity and analysing A&E attendance data were mentioned by more than one group. On the topic of Living Well, roving smoking support/education and Health Checks were common suggestions. When discussing Ageing Well, long-term condition support and avoiding social isolation were recurring topics. Other topics included Antisocial Behaviour/crime prevention (through the youth offer, diversion and education) and carer support. Board Members also noted key issues to consider when implementing any changes e.g. stigma, literacy, poverty and ensuring services are accessible for all.

4.3 It was noted that some ideas may be best progressed within other existing partnerships or strategies, or by individual partners. These need to be investigated for feasibility.

5. PROPOSALS

5.1 It is proposed that the Health and Wellbeing Board agree actions to progress in year one of the Health and Wellbeing Strategy selected from ideas generated at the Action Planning Session. Suggested year one actions are outlined below, accompanied by a rationale.

5.2 Proposed year one actions:

- Develop an accessible and integrated approach to Health Checks. Ensure these are linked up with work on cardiovascular disease (CVD), obesity, physical activity and smoking.
- Prevent/reduce obesity through prenatal, antenatal and early years support, upskilling staff/volunteers and maximising/promoting physical activity opportunities across the life course
- Support childhood immunisations (e.g. access/information through trusted voices in the community)

5.3 These three specific actions are proposed because they:

Address current challenges within Hartlepool

- For example, obesity in reception year children suggests that intervention below this age is key in preventing and reducing obesity

Have proven successful

- For example, many areas offer Health checks in multiple/roving locations and link up with other services

Involving multiple HWB partners, would enhance rather than duplicate existing work and appeared to have broad support at the HWB action planning day

- For example, obesity or physical activity was mentioned across all discussions sessions/groups, actions would involve multiple partners and synergies with strategies regarding healthy weight, food and physical activity are possible

Could lead on to other opportunities

- For example, success with Health Checks in new locations/roving access could allow consideration of other activities in similar locations. Also, experience of upskilling staff/volunteers around healthy weight and seeing the positive impact of this could make it easier to upskill on a variety of health topics. Considering physical activity across the life course means it may be possible to benefit several generations within the same family

Agreement of these initial actions would not preclude other actions being taken by partners, assessment of the feasibility of other larger projects or analysis of data to inform future Health and Wellbeing Board action.

5.4 It is also proposed that the Health and Wellbeing Board review, and amend as necessary, the draft timeline for year one actions below. Actions within the proposed timeline incorporate the strategy principles of building health, reducing health inequalities, community voice/empowerment, working together on an integrated approach and shared responsibility for health/ inequalities outcomes.

Proposed timeline:

March-June actions	July-November	December-March
Plan implementation of agreed options (including monitoring/ evaluation methods) with partners and community members. Ensure proposed changes to services reduce inequalities and access is inclusive, stigma-free and poverty-proof. Ensure synergies of this work with other existing/planned work. **Begin implementation of agreed options** Detailed action plan with updates on implementation as applicable presented at next (June/July) HWB meeting	**Adapt implementation** as needed based on initial experience or monitoring Progress update at September & November HWB meeting	**Collate initial feedback and reflections** from partners, staff, patients, community to inform future action **Analyse** data, feedback, KPIs & action plan progress. Evaluate success & incorporate learning, ongoing activities and emerging opportunities into the year 2 action plan. **Discuss Year 2 actions at Jan 2026 HWB action planning session.** Agree year 2 plans at March 2026 HWB meeting

6. RISK IMPLICATIONS

None

7. FINANCIAL CONSIDERATIONS

Financial implications will be identified in each specific project once agreed. The intention is that the projects will be achieved within existing budgets, through improved / changed ways of working and developing a synergistic approach across the local system.

8. LEGAL CONSIDERATION

None

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

Proposed actions are designed to reduce inequalities and ensure inclusion

10. STAFF CONSIDERATIONS

Staff across HWB partner organisations may contribute time to planning/ implementing actions and benefit from the actions

11. ASSET MANAGEMENT CONSIDERATIONS

None

12. ENVIRONMENT, SUSTAINABILITY AND CLIMATE CHANGE CONSIDERATIONS

Some proposed actions around physical activity may have co-benefits for the environment and sustainability (e.g. Active travel and use of green space)

13. RECOMMENDATIONS

That the board agree the proposed key activity areas and agree actions to progress in year one of the Health and Wellbeing Strategy

14. REASONS FOR RECOMMENDATIONS

To facilitate timely planning and implementation of agreed year one actions

15. BACKGROUND PAPERS

None

16. CONTACT OFFICERS

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