HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL
BOROUGH COUNCIL

Tuesday 10 February 2009

at 3.00 pm

in Council Chamber
Civic Centre, Hartlepool

MEMBERS: HEALTH SCRUTINY FORUM:

Councillors: Barker, Brash, R W Cook, S Cook, A Lilley, Plant, Simmons, Sutheran and Young

Resident Representatives: Jean Kennedy, Linda Shields and Mike Ward

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

   3.1 Minutes of the meeting of the Health Scrutiny Forum held on 20 January 2009 (*to follow*)

4. **RESPONSES FROM LOCAL NHS BODIES, THE COUNCIL, EXECUTIVE OR COMMITTEES OF THE COUNCIL TO FINAL REPORTS OF THIS FORUM**

   None

5. **CONSIDERATION OF REQUEST FOR SCRUTINY REVIEWS REFERRED VIA SCRUTINY CO-ORDINATING COMMITTEE**

   None

6. **CONSIDERATION OF PROGRESS REPORTS / BUDGET AND POLICY FRAMEWORK DOCUMENTS**

None

7. **ITEMS FOR DISCUSSION**

Reaching Families in Need Investigation

7.1 Presentations on the Common Assessment Framework and the Activities of the Connected Care Service and New Deal for Communities:

(a) Covering Report – *Scrutiny Support Officer;* and

(b) Common Assessment Framework Presentation - *Head of Commissioning and Children's Partnership*

(b) Connected Care Presentation – *Officers from Connected Care*; and

(c) New Deal for Communities Presentation – *Subject to Confirmation of Availability*

7.2 Discussion with stakeholders:

(a) Covering report – *Scrutiny Support Officer; and*

(b) Discussion with representatives from a variety of stakeholders in Hartlepool who have a role in reaching families in need.

7.3 Six Monthly Monitoring of Agreed Health Scrutiny Forum's Recommendations – *Scrutiny Support Officer*

8. **ISSUES IDENTIFIED FROM FORWARD PLAN**

9. **FEEDBACK FROM RECENT MEETING OF TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE**

9.1 Tees Valley Health Scrutiny Joint Committee – *Scrutiny Support Officer*

10. **ANY OTHER ITEMS WHICH THE CHAIRMAN CONSIDERS ARE URGENT**

ITEMS FOR INFORMATION

Date of Next Meeting

Tuesday, 24 February 2009 at 3.00 pm in the Council Chamber, Civic Centre, Hartlepool

HEALTH SCRUTINY FORUM

MINUTES

20 January 2009

The meeting commenced at 3.00 pm in the Civic Centre, Hartlepool

Present:

Councillor: Jonathan Brash (In the Chair)

Councillors: Caroline Barker, Rob Cook, Alison Lilley, Michelle Plant, Chris Simmons and David Young

Resident representatives:
Jean Kennedy, Linda Shields and Michael Ward

Officers: Joan Wilkins, Scrutiny Support Officer
Denise Wimpenny, Principal Democratic Services Officer

Also Present: Councillor Geoff Lilley
Richard Harrety, Commissioning Manager, Hartlepool PCT
Michaela Robinson, Hartlepool PCT
Tom Butler, Westminster City Council

105. Apologies for Absence

Apologies for absence were submitted on behalf of Councillors Shaun Cook and Lilian Sutheran.

106. Declarations of Interest by Members

Councillor Jonathan Brash declared a non-prejudicial interest in minute 109.

107. Minutes of the meeting held on 8 January 2009

Confirmed with the addition of Councillor Simmons' apologies.

108. Reaching Families in Need Investigation – Evidence from Westminster Council (*Scrutiny Support Officer*)

The Scrutiny Support Officer introduced the representative from Westminster Council who was in attendance at the meeting to provide evidence in relation to the Forum's ongoing investigation into 'Reaching Families in Need'.

The representative gave a detailed and comprehensive presentation which provided an outline of the approach Westminster City Council, as a pathfinder authority, were taking to improve outcomes for families caught in a cycle of low achievement, particularly those who were not being effectively engaged and supported by existing services.

The presentation focused on the following:-

- Aims of Westminster
  - to improve outcomes for children
  - to reduce disorder and crime in communities
  - to strengthen families and improve outcomes for adults
  - to reduce the longer term costs to public services
  -
- Scope of the Project
- Findings of Think Family reports
- Key characteristics of the Think Family approach
  - No wrong door
  - Whole family approach
  - Build on family strengths
  - Provide support tailored to need
  - Family involvement
- Westminster City Council Family Pathfinder Bid - Aims
- Outcomes – parenting, health, employment, debt and housing issues, offending and anti-social behaviour, education, family/individual issues
- Progess to date
- Timelines for development of model team and working with families
- How families are identified including numbers
- Screening Criteria – how to test/refine the referral/screening criteria to ensure targeting right families
- Purpose of establishment of multi-agency information desk
- Learning and evaluation
- Next steps

Following completion of the presentation, discussion ensued which included the following issues:

(i) The Chair commented on the importance of the information desk and

queried how this operated in practice. The representative indicated that the police and Social Services worked hand in hand to bring together information into mainstream services.

(ii) A query was raised as to whether other partners were open to this type of joint working. The representative stated that the police and community protection team welcomed the arrangements and other agencies were slowly participating.

(iii) A Member stated that funding was a major factor for Hartlepool and sought clarification on the estimated level of funding required to establish such a scheme and who was responsible for managing the project once developed. Members were advised that details of costs were not available. It was envisaged that staff would be redeployed or existing services reorganised to manage the service once developed.

(iv) The Forum commented on the advantages of a multi-agency approach to the provision of services for hard to reach families, the potential savings that could be achieved in the long term as a result of this approach and the issue of health deprivation in the town.

(v) In response to a request for the representatives views on how to target families who did not wish to be part of the system, Members were advised that families with a history of criminality may be reluctant to take up the service and there was no legal grounding to address such hard to reach families.

(vi) A Member questioned whether budgets were pooled as a result of joined up working. The representative advised that resources were pooled, however, it was not anticipated that budgets would be pooled.

(vii) The Chair queried to what extent the programme centred around Westminster. It was reported that the programme was tailored towards crime and anti-social behaviour, however, the model could be adapted to meet the needs and priorities of Hartlepool.

(viii) In terms of the likelihood of savings being achieved as a result of this type of programme, a query was raised regarding the likely timescale for achieving such savings. The representative stated that costs were currently being tracked using the Department for Children Schools and Families evaluation tool, the results of which would take some time to analyse.

(ix) During discussions regarding the approach adopted by Westminster to assist families with multiple problems, it was reported that a case conference was carried out with all practitioners to discuss the issues as a whole with a view to recommendations and priorities being made collectively.

(x) In relation to comments regarding the low take up of benefits, a Member queried what arrangements were in place to ensure sufficient information was provided to families in need. The representative advised that the programme included a benefits assessment.

The Chair thanked the representative from Westminster for the informative presentation and answering Members' questions.

Recommendation

That the evidence provided and the comments of the Forum be used to assist with the scrutiny investigation.

109. Community Pharmacy Minor Ailments Scheme – Consultation (*Scrutiny Support Officer*)

The Commissioning Manager was in attendance at the meeting to seek the Forum's views and comments on the proposal to decommission the Community Pharmacy Minor Ailments Scheme. A Briefing Paper and Communication and Engagement Plan were attached at Apepndiix A and B respectively.

The PCT's Minor Ailments Scheme was launched in December 2003 with the intention of providing greater access and choice to patients for advice and/or treatment for conditions that were potentially self-treatable. The Scheme enabled patients who were exempt from the NHS prescription charges to access medicines at a Community Pharmacy. The briefing paper included details of the process to decommission the scheme, aims of the scheme, evaluation details, impact on access to services, types of treatment provided under the scheme, number of consultations by pharmacy and by ward together with details of proposed engagement with local people.

Discussion ensued in which the following issues were raised:-

(i) It was pointed out that the evaluation did not clarify whether the people accessing the service was in addition to those accessing GP services and it would assist the Forum if this information was available. The Commissioning Manager agreed to explore this suggestion.

(ii) Feedback from a recent Links meeting was provided which highlighted a lack of information from chemists that did take part in the scheme, not all chemists were involved, there was no decrease in prescriptions, it was not publicised that the facility was available and out of hour GP appointments were only available if booked in advance. The Forum was advised that 18 out of 19 pharmacies providing the service took part in the scheme . Details of the types of publicity rolled out when the scheme was launched was outlined which included a publicity campaign in libraries and supermarkets and information issued to pharmacies and GP surgeries.

(iii) A Member referred to the benefits of the minor ailments scheme, however, commented that the type of medicine available to patients who were exempt from NHS prescription charges was limited. Some concern was expressed regarding the impact this placed on low income families.

(iv) During discussions in relation to the location of pharmacies in the

town, Members suggested a need for pharmacies in the Dyke House and Hart Wards.

Recommendation

(i) That the content of the Briefing Paper and the views of the Forum, be noted.
(ii) That an update report be provided to the Forum prior to any decisions being taken on the proposal.

110. Issues Identified from Forward Plan

None.

111. Feedback from Recent Meeting of Tees Valley Health Scrutiny Joint Committee

None.

112. Date and Time of Next Meeting

It was reported that the next meeting would be held on Tuesday 10 February 2009.

The meeting concluded at 5.00 pm.

CHAIRMAN

HEALTH SCRUTINY FORUM

10 February 2009

Report of: Scrutiny Support Officer

Subject: REACHING FAMILIES IN NEED INVESTIGATION – PRESENTATIONS ON THE COMMON ASSESSMENT FRAMEWORK AND THE ACTIVITIES OF THE CONNECTED CARE SERVICE AND NEW DEAL FOR COMMUNITIES – COVERING REPORT

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1. PURPOSE OF THE REPORT

1.1 To inform Members that presentations on the Common Assessment Framework and the Activities of the Connected Care Service and New Deal for Communities will be given at today's meeting to provide evidence in relation to the Forum's ongoing investigation into 'Reaching Families in Need'.

2. BACKGROUND INFORMATION

2.1 Members will recall that at the meeting of this Forum on 9 September 2008, the Terms of Reference and Potential Areas of Inquiry / Sources of Evidence were approved by the Forum for this scrutiny investigation.

2.2 Consequently, representatives from the Children's Services Department (in relation to the Common Assessment Framework), Connected Care and New Deal for Communities (subject to confirmation of availability) have been invited to provide evidence, to further enhance the Forum's understanding of their activities and issues in relation to reaching families in need.

2.3 During this evidence gathering session it is suggested that it could be useful for Members to also seek responses to the following key questions, should they not become apparent during the course of the presentation:-

(a) What are your roles and responsibilities in relation to the provision of targeted intervention for hard to reach families in need?

(b) Evidence considered had so far shown that crime and anti-social behaviour were often used as trigger mechanisms for the identification of hard to reach families in need. What other trigger mechanisms are there and which one(s) do you use in your service area?

(c) When hard to reach families in need are identified, with additional issues outside your service area, where and how do you refer them? Is there a co-ordinated approach to facilitating dealing with them?

(d) What are your views on the current multi agency approach to the provision of targeted wellbeing and prevention health services for hard to reach families in need in Hartlepool?

(e) What areas of improvement if any, would you suggest reducing health inequalities and encouraging hard reaching families to take up local health services?

3. RECOMMENDATION

3.1 That Members note the content of the presentation, seeking clarification on any relevant issues from the representatives in attendance, where felt appropriate.

Contact Officer:- Joan Wilkins – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
Tel: 01429 284142
Email: joan.wilkins@hartlepool.gov.uk

BACKGROUND PAPERS

The following background paper was used in the preparation of this report:-

(a) Report of the Scrutiny Support Officer entitled 'Reaching Families in Need – Scoping Report' Presented to the Health Scrutiny Forum on 9 September 2008.

Steering Group Meeting 21st January, 2009

Connected Care Progress Report

October - December, 2008

Introduction

This report provides information to Steering Group members on the implementation of Connected Care Service from October to December, 2008.

Contract with Hartlepool Council and North Tees and Hartlepool Primary Care Trust- Monitoring Report, December, 2008

As reported at the last steering Group meeting the signed contract has now been received from HBC/PCT. Following receipt of the contract the six month review took place and the officer from the Procurement Section has now completed her report. The report provided an objective and in-depth analysis of the implementation phase of the Connected Care Service from April, 2008 and highlights the successes achieved in this reporting period. The final report is included for discussion as a separate item on the agenda.

Information Needs For Connected Care Relevant To Care Navigator Records: A Discussion Paper
Report Gill Callaghan and John Quinn (Durham University):

Following the discussion at the last Steering Group meeting on the details of the case work and the requests made for additional information a report has been produced by Gill Callaghan and John Quinn in conjunction with the Connected Care Navigators. The report outlines the work undertaken to develop the rationale and methods for collecting information to support Connected Care implementation. The purpose of the paper is to provide some preliminary information to the Steering Group, to highlight the implications of decisions about

data collection and to engage in reflection on the data needs of the service and of the evaluation
The report is included as a separate item on the agenda

Case Work

The following table below shows the breakdown of casework in the 9 months up to the end of December, 2008.

Analysis of Casework from April – September, 2008

	Low Level	**Medium Level**	**High Level**	**Units Achieved**
April – June	25	3	4	82
July - September	177	17	22	492
October-December	27	5	7	131
Totals	229	25	33	705

The approved contract for the Connected Care Service includes targets of casework at different levels of complexity from low level through to high level. The formula for the output target to be achieved assigns a different value according to the complexity of the casework as follows:

- 1 low level case = 1 unit of casework
- 1 medium level case = 4 units of casework
- 1 high level case = 12 units of casework

For the third quarter, following the initial launch of the Connected Care campaign, there has been a decrease in the new cases. This profile of case work was to be expected as in this quarter there was continuing work on the cases which had been generated during the launch phase. Members will also recall that there were concerns about the high level of referrals, given the limited number of Navigators to undertake case work.

Work has progressed well on the second edition of the "Who Cares?" Magazine which it is anticipated will be distributed in February, 2009.

"Who Cares?" The Social Enterprise

At the last Steering Group meeting it was noted that it would be necessary to obtain funding to enable the Social Enterprise to develop capacity to deliver services. Various aspects of modeling the potential services would form part of

this work. An application was subsequently submitted to the Department for Health for funding to develop the capacity of the Social Enterprise. In addition funding has been sought to implement an intensive benefits advice campaign to meet the current demand for this service and assess future needs. This proposal relates to the previous decision of the Connected Care Steering Group to allocate resources to support benefits advice work to complement the work of the Navigators.

Promoting Connected Care

On Thursday 6th November Hartlepool Voluntary Development agency organised a Town wide event entitled "Communities in Control". Voluntary and community organisations were invited to attend. The event was organised primarily to explain the Government's new Empowerment White Paper and in part to celebrate the partnership working taking place in Hartlepool.

Connected Care were invited to make one of the key presentations to the invited audience and Paul McGee outlined the work of Connected Care and the community processes and involvement which had led to the development of the service.

Connected Care Launch 2009

The proposed launch of Connected Care Service has been delayed until the start of the next financial year.

Case Studies

At Appendix 1 and 2 and 3 to this report are three case studies provided by the Connected Care Navigators which illustrate the scope and complexity of the work being undertaken with high level casework clients. Appendices 1 and 3 contain details of new case studies and Appendix 3 is an update for a case study presented at the last Steering Group meeting.

Appendix 1

Steering Group Meeting 21st January, 2009

Case Study A – High Level

Client X self referred into the service in August 2008. She has been ill for a number of years since the death of both her sisters. She has suffered from a stroke, heart problems and has been prescribed Anti Depressants. Client X has been unemployed since 2000 and has been claiming disability living allowance since then. Recently she has struggled to keep up with her mortgage and secured loan repayments. Client X is convinced that her home is due to be repossessed; however there are no reasons to believe that this is in fact the case. She is also concerned about her deteriorating health, has made many visits to both doctors and consultants and is currently awaiting admission to hospital for procedures. In the past Client X has had involvement from debt counsellors and has had some of her previous debt reduced to a minimum payment. Client X is convinced that selling her home and using the equity to pay off her debts is the best course of action. She has approached Housing Hartlepool for alternative accommodation. The alternative provision she has been offered in her opinion was not suitable and is hoping that HH will consider her for a bungalow.

ACTIONS:

- Benefits appointment made
- Solicitors Appointment made
- Credit Union appointment made
- Act as advocate with creditors etc
- Transport client to doctors and hospital
- Attend solicitors meeting
- Draw up Payment plan for creditors
- Discuss payments/ reduced payments
- Liaise with bank, mortgage company, solicitors, estate agents, etc
- Contact loan Insurance company to possibly make a claim
- Contact various agencies to give full consent to act on client xbehalf

OUTCOMES

Client X is now receiving all correct benefits and has support to enable her to attend medical appointments. She also has received a date for her medical procedures. We have negotiated a reduced payment for her loan, mortgage and other debts. Her home is secure and for the moment she is happy and content to live there. However her home is currently up for sale and she is still keen to look into alternative housing from Housing Hartlepool, which we will support her in doing. The Solicitors are handling the concerns with regards to the miss-selling of the mortgage and we are in constant contact with them to ensure we can continue to support client x. We have also negotiated a payment plan to allow her to pay back the arrears. We are also the sole point of contact for debtors etc to come through therefore alleviating the stress the constant contact they were having with client x was causing. She is now happy that things are finally becoming under control.

Appendix 2

Steering Group Meeting 21st January, 2009

Case Study B – High Level

The Duty Social Work Team referred this client to Connected Care. They had received a distressing call from a young single mum who wanted help to resolve an ongoing dispute with her neighbours. The client also struggles with reading and writing and needed support with reading letters and filling out forms.

At our initial meeting, it became apparent that our client had many other support needs then those mentioned in the initial referral. She outlined the following.

- Client had an ongoing dispute with her neighbour, there had been several allegations and counter allegations. The Anti-Social Behaviour Unit was involved and had suggested that mediation may be the best option to resolve the issue. Our client did not want to take part in mediation because she felt intimidated.

- Client wanted to approach her landlord, Housing Hartlepool for a move to a new property but says they wouldn't want to help her because she only moved into this tenancy a year ago.

- Client discussed occasional suicide thoughts. She feels she can't cope with her son and thinks it would be better if she wasn't around and he was taken into care to be looked after properly and by people who can cope with him.

- Client mentioned concerns about her son's behaviour. She states that he's always naughty and never listens to her.

- Client believes that although her son has a Social Worker, Physiatrist, Mental Health Worker and Health Visitor she feels unsupported and that they never contact her.

- Client takes medication for depression and anxiety, which were prescribed by her Psychiatrist. Our client struggles to get repeat prescriptions from her GP because she thinks her GP doesn't think she should have the medication. She believes her GP refuses to sign the repeat prescriptions, meaning there are delays in our client taking her medication.

- Client feels unable to go out on her own. She feels threatened and believes that people are watching and judging her. This is due to her having fallen out with some close friends and her dispute with her neighbour. As a result, she refuses to use public transport and always uses taxis. If she doesn't have her son or someone with her our client tends not to leave the house.

- She states that her son will not sleep in his own room and is often up until 10pm because she can't get him to bed. Now she allows him to fall asleep on the sofa because it's the only way he will sleep. Her son also wakes up frequently in the night demanding attention, saying he needs a drink, is hungry or unwell.

Due to the complex nature of our client's issues and the involvement of many other services, we suggested to our client that we initially act as her advocate. We suggested a multi-agency meeting with everyone involved to consider the concerns she has.

Our client said she'd always wanted somebody to help her in this way. She sees so many different people for different things and tells them all exactly the same information and nothing has ever changed.

Our client's mood changed, she seemed far more optimistic and was pleased to be receiving our support. We assured her that we would contact all the other agencies concerned and set up a meeting with her urgently.

Connected care felt unsure about leaving our client alone with her son in light of her suicidal thoughts. This may have resulted in harm to our client or her son. Therefore we contacted the Social Worker with Children's Services immediately to express our concerns.

She advised us that our client had experienced those thoughts and feelings for some time and they believed it was a cry for help rather than an intention to action it. However, they did agree for someone to call round that day.

Connected Care contacted the Social Worker, Health Visitor, Mental Health Support Worker, Anti-Social Behaviour Team, Unite Mediation Services and Housing Hartlepool on behalf of our client. An emergency multi-agency meeting was arranged. Following consulting with our client we agreed to have the meeting at her home, so she could be present. Our client wanted to hear first hand what was been said so that she could challenge anything that was untrue.

At the meeting Connected Care acted as the lead professional and facilitated the meeting. We started by discussing our clients concerns, which she brought to our attention the previous day. Following lengthy discussions, several positive actions were agreed, to our client's satisfaction.

Actions

Social worker

- Sign client up to a 8 week parenting course to give her the skills – literacy course once she has completed her parenting course to give her the skills and confidence she needs with her son
- Sign client up to a basic skills once she has completed her parenting course. This will help with the clients reading and writing
- Assign 1-1 classroom support for client, due to lack of confidence with reading and writing.
- Source additional funding for 2-3 more half days for clients son to attend Sure Start nursery. He currently attends 2 afternoons per week. Additional funding to be sourced due to our client agreeing to undertake training
- Arrange a Sure Start Support Worker to visit client and her son between 6.30 and 7.30 each day to establish a bedtime routine, which client can them maintain.

Mental Health Worker

- Arrange for repeat prescriptions to be home delivered to avoid delays with receiving medication.
- Assign Support Time Recovery Worker to help improve client's confidence. This Support Worker can help with day-to-day activities such as using public transport, paying bills and advising on parent/child activities and help to facilitate these.
- Arrange an appointment with a Psychologist at Stewart House to provide further support to client about her thoughts towards her son and her self-harm.

Connected Care

- Arrange monthly agency meetings until all the matters are resolved.
- Continue to visit client on a weekly basis providing support, guidance and advice
- Liaise with UNITE and the Anti-Social Behaviour Team regarding the neighbour dispute.
- Liaise with other agencies on a regular basis for updates and feedback to client.

Health Visitor + Nursery Nurse

- Arrange client and son to attend a behaviour group to address any behaviour issues and how to deal with him.
- Sign client onto a Nutrition course through parent co-coordinator to address how client's son's diet may be affecting his behaviour. He eats healthy at nursery and there are no issues there. The client allows her son to eat sweets, chocolate and usually hot dogs and "junk food" for tea. It was suggested both mother and child might benefit from a healthier diet.
- Contact PATCH for another baby gate on clients son's bedroom to help establish a bedtime routine in his own room
- Arrange fridge lock so clients son can't help himself
- Advise of Sure Start fun days and parent groups for client and son to attend to improve their relationship. Support Time Recovery Worker can help client with this.

After an in depth discussion with our client, we wanted to ascertain if she was happy with her home and where she lived, other than her neighbour dispute. She said she was and didn't really want to move but felt she had no choice. We encouraged her to stay for the time being and try the mediation. If this doesn't improve the relationship and our dient still wants to move, we agreed to help her with this.

Each agency agreed to deal with this matter directly and feedback at our multi-agency meetings on a monthly basis.

In the meantime Connected Care continues to work with the client and liaise with other agencies until our client is more able to live independently. We have built a trustworthy, open and honest relationship. Previously she has failed to engage in with other supporting agencies.

We have now held a second multi-agency meeting, however due to sickness there are still several actions outstanding, so a further meeting had been arranged.

Our client is much happier now all the agencies are working together towards a positive outcome for her and her son, she believes Connected Care is to thank for this.

We have discussed an exit plan for the New Year once all of the actions are completed and the Support Team Recovery Worker is in place that can continue to provide support.. She feels unsure about this at the moment but understands that she must learn to work with and trust others.

Appendix 3

Steering Group Meeting 21st January, 2009

Case Study C High Level – Update from previous meeting

At our last Steering Group meeting you'll remember our case study was of a man who was referred to us by Cleveland police. This man had a number of issues, most of which were brought on by has mental ill health.

Connected Care worked with other agencies to ensure a mental health assessment was carried out which resulted in our client being admitted to the Lincoln ward in Sandwell Park for a period of assessment.

Connected Care visited our client on a regular basis and liaised regularly with the staff at Sandwell Park.

After a long period of assessment, our client was diagnosed and prescribed the relevant medication. He remained on the ward whilst the drugs took affect.

Our client was then encouraged to go out and pop back to his flat. A Mental Health Support Worker accompanied him.

Our clients Consultant then decided that he was ready for discharge and a multi-agency meeting was called, to which Connected Care were invited.

Prior to this Connected Care had outlined their concerns to staff at Sandwell Park about the poor condition of our clients flat and the possible adverse effects of sending him back there in its current state. We were advised that unfortunately no help could be given with regards to the condition of his flat. However, we were assured our client would have a support plan in place.

Due to our concerns, we requested funding from the Connected Care emergency fund to have the flat thoroughly cleaned, painted, rubbish removed and some essential items. This was granted and with our clients permission we instructed a contractor to carry out the work. We also reported several repairs to Housing Hartlepool and asked if they could help us replace any of the household items.

Housing Hartlepool kindly offered a cooker to replace the condemned gas cooker in the flat. They also agreed for one of their electricians to connect it up. After the deep clean, rubbish removal and decorating, Connected Care purchased some items from charity shops so that our client could return to his flat.

When the multi-agency meeting took place the following were present.

- Connected Care
- Psychiatrist
- Ward nurse
- Social Worker
- Crisis Resolution and Access Team

The Psychiatrist explained that our client was now ready to be discharged. He explained that Lincoln Ward is only intended as an admission ward and that our client had been there well over a month. He expressed his concerns that our client had not had any overnight leave.

The Psychiatrist also introduced a social worker and Crisis Resolution and Assess Team Member who would support our client in the community.

Connected Care explained our role and how the flat had been cleaned up ready for our client's discharge. We also committed to ongoing support for our client, helping him to integrate into the community.

Our client was then brought into the meeting. He still had reservations about returning home, but reluctantly agreed to overnight leave that night.
He would return to the ward the following day and if everything was ok, he would then be discharged.

Our client was introduced to new members of staff who would be there to help him.

We assisted our client back to his flat for the overnight stay. He was pleased with the work that had been carried out in the flat and felt more at ease being in the flat. His Social Worker also visited to ensure he was settled and give emergency contact details if needed.

The next day our client was discharged, but his Social Worker was unable to take him and his belongings back to the flat, so Connected Care supported him with this. From discharge Connected Care assisted with the following: -

- Help to move back into his flat
- Help with rent arrears and water arrears. Contacted relevant agencies to put arrangements in place
- Checked other bills such as council tax, gas and electric, TV licence which were all up to date
- Ensured client has his medication and repeat prescriptions when they are needed.
- Advice on training and employment

- Ensure that regular home visits were carried out by ourselves or other agencies to prevent any further problems
- Gave several contact names/details
- Helped with letters received through the post

Our client is now well settled in his flat and all his bills are up to date. The flat remains in excellent condition. His personal appearance has also improved. He is well shaven, clean and tidy.

Due to the clients illness he currently receives incapacity benefit, rather than job seekers allowance. However, our client has expressed an interest in returning to work. In order to help him do this, we have advised him of a number of facilities on offer in the resource centre where we are based.

Our client has now enrolled on a computer course and is doing very well. He intends to gather as many skills and qualifications as he can to help in back into work. He also regularly pops into the centre for a cuppa and a chat and often has his lunch in the canteen. He is far more confident and has become more integrated in the community. He also undertakes other community activities with his Mental Health Support Worker who works with him one day per week.

Due to the progress our client has made, we no longer need to carry out regular visits and our client understands that if he needs any advice he can contact us at any time.

He is very appreciative of the work Connected Care has done and regularly thanks us.

END

HEALTH SCRUTINY FORUM

10 February 2009

Report of: Scrutiny Support Officer

Subject: REACHING FAMILIES IN NEED INVESTIGATION: DISCUSSION WITH STAKEHOLDERS – COVERING REPORT

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1. PURPOSE OF REPORT

1.1 To inform Members of the Forum that representatives from a number of groups / bodies who have a role in reaching families in need have been invited to attend this meeting in relation to this Forum's ongoing investigation.

2. BACKGROUND INFORMATION

2.1 To assist the Forum in its last evidence gathering session as part of this investigation, representatives from Hartlepool Families First and Patch have been invited to this meeting to participate in discussions throughout the course of the session. These groups may be joined by others subject to availability and in addition to this a specific slot has also been set aside to give them the opportunity to put forward any views or suggestions they may have.

2.2 During this meeting it is suggested that Members may like to seek responses to the following key questions:-

(a) What are your roles and responsibilities in relation to the provision of targeted intervention for hard to reach families in need?

(b) When hard to reach families in need are identified, with additional issues outside your service area, where and how do you refer them? Is there a co-ordinated approach to facilitating dealing with them?

(c) What are your views on the current multi agency approach to the provision of targeted wellbeing and prevention health services for hard to reach families in need in Hartlepool?

(d) What areas of improvement if any, would you suggest reducing health inequalities and encouraging hard reaching families to take up local health services?

(e) Do you have any other views/information which you feel may be useful to Members in forming their recommendations?

3. RECOMMENDATIONS

3.1 That Members of the Forum consider the views of the representatives in attendance at this meeting in relation to the questions outlined in Section 2.2 of this report.

Contact Officer:- Joan Wilkins – Scrutiny Support Officer
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BACKGROUND PAPERS

No background papers were used in the preparation of this report.

HEALTH SCRUTINY FORUM

10 February 2009

Report of: Scrutiny Support Officer

Subject: SIX MONTHLY MONITORING OF AGREED HEALTH SCRUTINY FORUM'S RECOMMENDATIONS

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1. PURPOSE OF REPORT

1.1 To provide Members with the six monthly progress made on the delivery of the agreed scrutiny recommendations of this Forum since the 2005/06 Municipal Year.

2. BACKGROUND INFORMATION

2.1 In accordance with the agreed procedure, this report provides information of the progress made against investigations undertaken by the Forum since the 2005/06 Municipal Year.

2.2 In doing so, attached as **Appendix A** is a Summary Report that breaks down progress made by investigation and **Appendix B**, provides a detailed explanation of each recommendation that is either 'expected to achieve target' or 'not expected to achieve target'.

2.3 In summary, Members may wish to note that since the 2005/06 Municipal Year 96.9% of this Forum's recommendations have been achieved, 1.5% are expected to be achieved and 1.5% which are no longer deliverable due circumstances beyond the Authority's control.

3. RECOMMENDATION

3.1 That progress against the Health Scrutiny Forum's agreed recommendations, since the 2005/06 Municipal Year, be noted and explored further where appropriate.

Contact Officer:- Joan Wilkins – Scrutiny Support Officer
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BACKGROUND PAPERS

No background papers were used in the preparation of this report.

Scrutiny Enquiry Summary Report

Appendix A

Adult & Community Services & Health Scrutiny Forum

Pandemic Influenza - 'Contingency Planning'

G	Target achieved	1

Access to GP Services

G	Target achieved	48

Social Prescribing

N	No longer deliverable	1
G	Target achieved	12

Withdrawal of Emergency Care Practitioners Service at Wynyard Road

G	Target achieved	2
A	Expect to achieve target	1

Scrutiny Recommendations (Not Completed) Monitoring Report

Appendix B

January 2009

Department: *

Division: *

Scrutiny: Adult & Community Services & Health Scrutiny Forum

Scrutiny Enquiry: *

N	**No longer deliverable**	**1**	1.5%
	Adult & Community Services & Health Scrutiny Forum	1	
A	**Expect to achieve target**	**1**	1.5%
	Adult & Community Services & Health Scrutiny Forum	1	
G	**Target achieved**	**63**	96.9%
	Adult & Community Services & Health Scrutiny Forum	63	
	Total No. of Actions	**65**	

Scrutiny Recommendations (Not Completed) Monitoring Report

January 2009

Progress	Rec. No.	Recommendation	By When / Milestone	Update on progress	Lead Officer
SCRUTINY INVESTIGATION INTO: **ACS/06-7/3 SOCIAL PRESCRIBING**					
Recommendation:					
	ACS/06-7/3c	**As part of this process, detailed consideration should be given during the 2007/08 year to re-allocating funds to the MIND and other social prescribing services from existing activities that service users found less helpful and acceptable.**			
N	ACS/06-7/3c	This recommendation is specifically linked to NDC funding and we do not allocate these funds.		Unable to progress. HBC doesn't allocate NDC funding. However, the PCT has allocated significant funding to be administered by HVDA to support voluntary organisations (in the region of 250 -300k). These resources cover core costs as well as specific funding for projects such as social prescribing (as this is specifically linked in to the Public Health Strategy as a recommendation). MIND has received a significant amount of this funding and has also been allocated some voluntary sector core cost funding by the PCT.	*

Scrutiny Recommendations (Not Completed) Monitoring Report

January 2009

Progress	Rec. No.	Recommendation	By When / Milestone	Update on progress	Lead Officer
SCRUTINY INVESTIGATION INTO:					
ACS/06-7/4		**WITHDRAWAL OF EMERGENCY CARE PRACTITIONERS SERVICE AT WYNYARD ROAD**			
Recommendation:					
	ACS/06-7/4c	**That the creation of a formal set of protocols on consultation be debated between the PCT and the Forum to:- (i) Promote the real improvements in health services in Hartlepool; and (ii) Foster the improved links with Hartlepool PCT, that have developed in the intervening period between the closure of the ECP Service at Wynyard Road and the conclusion of this Forum's investigation.**			
A	ACS/06-7/4c	Draft proposals have been shared. This is being progressed by the PCT and Scrutiny Chairs.		Draft proposals have been shared. This is being progressed by the PCT and Scrutiny Chair.	Ali Wilson

HEALTH SCRUTINY FORUM

10 February 2009

Report of: Scrutiny Support Officer

Subject: TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE

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1. PURPOSE OF THE REPORT

1.1 To inform Members of issues discussed at meetings of the Tees Valley Health Scrutiny Joint Committee held since the last meeting of the Health Scrutiny Forum on the 20 January 2009.

2. BACKGROUND INFORMATION

2.1 A summary is provided below of the issues discussed at recent Tees Valley Health Scrutiny Joint Committee meetings. Further information on these issues is available from the Scrutiny Support Officer and where appropriate clarification can be sought from Hartlepool's Tees Valley Health Joint Committee representatives who are present at today's meeting.

2.2 Issues discussed at the Tees Valley Health Scrutiny Joint Committee on the 30 January 2009:-

(a) Cancer Screening Services – The Joint Committee is as part of its work programme for 2008/09 looking at the issue of cancer screening services across the Tees Valley. The joint committee received at its meeting on the 15 December 2008 a significant amount of information, and to further expand on this additional evidence was provided at the meeting on the 30 January 2009.

(b) Community Based Arrhythmia Service (Briefing) – The Joint Committee received a briefing on developments in the Community Based Arrhythmia Service and was asked to highlight additional issues that they feel may need addressing in informing and involving the local community and how the it wished to be involved. An update on the Joint Committees response will be provided at the meeting; however, a copy of the PCT briefing paper is attached for Members information at **Appendix A**.

(c) North East Ambulance Service – Foundation Trust Application – The Joint Committee received notification of the upcoming public consultation process pertaining to the NEAS move towards Foundation Trust status. Public consultations are to begin in Spring 2009 and the Joint Committee will be receiving a further presentation from NEAS to discuss the consultation and the associated consultation plan.

3. RECOMMENDATION

3.1 That Members note the content of the report and outline any possible comments which they would like the Chair to relay back to the Joint Committee in the future on their behalf.

Contact Officer:- Joan Wilkins – Scrutiny Support Officer
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BACKGROUND PAPERS

No background papers were used in the preparation of this report.

Hartlepool Primary Care Trust
Middlesbrough Primary Care Trust
Redcar and Cleveland Primary Care Trust
Stockton on Tees Teaching Primary Care Trust

Community Based Arrhythmia Service: Hartlepool Primary Care Trust (PCT), Middlesbrough PCT, Redcar and Cleveland PCT, Stockton on Tees Teaching PCT

BRIEFING PAPER

INTRODUCTION

An arrhythmia is an abnormality of the heart's rhythm, either caused by an inherited problem or by an acquired condition that disturbs the electrical impulses which regulate the heart.

In line with national and local drivers, and following a successful pilot south of Tees, it is proposed to establish a community based arrhythmia service offering equitable access for those residing within the four Tees PCTs. The service would be delivered from community facilities in Middlesbrough (already established), Redcar and Cleveland (already established), Hartlepool and Stockton on Tees. The service will ensure that people presenting with arrhythmias will receive timely assessment by an appropriate clinician to ensure accurate diagnosis and effective treatment and rehabilitation. The service will be essentially nurse led with robust links to a Consultant Arrhythmia Specialist for any required advice or further management.

This development will ensure the delivery of an improved quality of initial and early care for patients with arrhythmia and will lead to these cases being managed more quickly, more cost effectively and in appropriate settings with improved quality of life and survival outcomes. A range of national, local and clinical drivers exist for providing a Primary Care Arrhythmia Service – see appendix 1.

PROCESS

In line with national guidance Hartlepool, Middlesbrough and Redcar and Cleveland PCTs and Stockton on Tees Teaching PCT are proposing to commission a Tees-wide community based arrhythmia service.

It is proposed that this specification will be tabled for discussion and negotiation with the community providers as part of the annual negotiations. In the event that the development of this service in North of Tees is not achieved through this route, procurement processes will be considered.

PROPOSALS

The National Service Framework for Coronary Heart Disease (NSF CHD), March 2000, set out a framework for improving the prevention, diagnosis and treatment of coronary artery disease. In 2006, the Department of Health added an additional chapter to this NSF framework which addresses diseases of the heart's electrical system. This chapter included specific recommendations for the treatment of arrhythmia in the community.

In October 2007 Middlesbrough and Redcar and Cleveland PCTs and South Tees Hospitals Trust successfully piloted a community based nurse led arrhythmia service. This service offers triage, assessment, diagnosis, treatment plans and patient support with onward referral as required. A recent clinical and financial evaluation has resulted in the service now being commissioned on a substantive basis. The service has achieved a reduction in waiting times for consultant outpatient appointments with a high level of patient satisfaction – a summary of the results of the patient survey can be found at appendix 2.

No primary care based arrhythmia services currently exist for the remainder of the Tees population. At the moment in North of Tees, patients who are suspected as having an arrhythmia problem are referred to a general cardiologist at either North Tees or Hartlepool Hospitals and if an intervention or an arrhythmia specialist opinion is required, they are then referred to the tertiary centre at James Cook University Hospital.

It is proposed to commission a Tees-wide community based arrhythmia service. Referral will be by GP within specified criteria via the Choose and Book System for any patient in whom they suspect an arrhythmia. Patients will have the choice of attending an initial appointment at one of four clinics located in each of the PCT areas. For south of Tees, this means the substantiation of the pilot scheme, which operates from the One Life Centre, Middlesbrough and Guisborough Primary Care Hospital. For north of Tees, providers will be asked to identify suitable sites in Hartlepool and Stockton on Tees from which services will be delivered.

The service will:

- Adopt a one-stop shop model, providing nurse led primary care clinics to triage, assess and diagnose arrhythmia, minimising waiting times
- Provide education, advice and reassurance for patients with benign conditions
- Undertake and coordinate diagnostic interventions
- Fast-track any patient who requires more specialist opinion, tests or procedures
- Manage appropriate patients within the arrhythmia service, or refer patients back to the GP with recommendations for appropriate management within primary care
- Provide access to an Arrhythmia Helpline

The aims and objectives of the service are to:

- Provide rapid investigation and assessment to suspected arrhythmias to confirm diagnosis and provide a treatment plan as appropriate
- Rapidly reassure patients who have clinically non-significant heart rhythm irregularities
- Provide care as far as possible within a community primary care setting
- Provide equitable standards of care across all four Tees PCTs
- Fast-track patients with potentially life-threatening conditions
- Provide standardised patient pathways and referral criteria across all four Tees PCTs
- Provide timely, high quality patient support and information, based on assessment in accordance with Chapter 8 of the CHD NSF
- Contribute to a reduction in strokes
- Reduce arrhythmia related urgent admissions
- Reduce cardiology outpatient referrals and waiting times
- Achieve national quality standards around delivery and provision of arrhythmia care
- Demonstrate value for money
- Play a key educative role, increasing the knowledge base of primary care in diagnosing and managing arrhythmia

Predicated Activity Levels

South Tees Arrhythmia Service's current demand is approximately 500 new contacts per annum based on a GP registered population (January 2008) of 288,995 (Middlesbrough 152,792 / Redcar and Cleveland 136,203) which equates to 0.17% of their current population.

North of Tees has a combined GP registered population of 285,158 (Hartlepool 94,590 and Stockton on Tees 190,588), similar to that of South of Tees. Therefore based on the South of Tees contact rate of 0.17% of its total population, it is anticipated that Hartlepool's activity will be approximately 163 new cases per annum and Stockton 329 new cases per annum.

South Tees Arrhythmia Service pilot study revealed that 17% of patients (52 individuals) required onward referral to secondary care for opinion or procedure. Of these 52 patients, only 17 (5% of total patients seen) needed to have a second opinion from a consultant – the rest were directly listed for a surgical procedure (at James Cook University Hospital).

Impact

For patients South of Tees, the current service model of initial referral to a community based arrhythmia service and onwards referral where appropriate to James Cook University Hospital will continue.

For patients North of Tees, initial referral will be to the community based arrhythmia service, located in a primary care setting (clinic) instead of

attendance at North Tees or Hartlepool Hospitals. For the minority of patients who require onwards referral (17% of patients) this may take place at North Tees or Hartlepool Hospitals with onward referral to James Cook for any intervention or by direct referral to James Cook Hospital. This will depend upon the hospital's ability to be able offer the necessary specialist consultant expertise described in the service specification.

INVOLVING LOCAL PEOPLE

Building upon the results of the previous patient survey (see appendix 2), the PCTs wish to engage with service users and identified stakeholders to ensure that the arrhythmia service best meets the needs of local communities. It is proposed that this involvement activity take place during January 2009.

Information regarding the establishment of community based arrhythmia facilities, including how patients can access the service and the care they can expect to receive, will be made available and views will be sought on:

- How can we ensure that the community based arrhythmia service best meets the needs of the local population?
- What steps can we take to ensure that the service is easy to access?
- What issues do we need to consider in establishing a community based arrhythmia service?

In addition, patients from the Stockton area who have used the community-based arrhythmia service in Middlesbrough will be contacted to seek their opinions on best practice and areas for improvement.

The engagement will include the following groups:

- Health Overview and Scrutiny Committees
- Local Involvement Networks
- Patients, Carers and Community

Action for Overview and Scrutiny

Overview and Scrutiny are asked to note the content of this briefing and highlight any additional issues that they feel may need addressing in informing and involving the local community and how they wish to be involved.

Drivers for Providing a Primary Care Arrhythmia Service

National and Local Drivers

- NICE Guidance Atrial Fibrillation June 2006 – *clinical guidelines providing guidance on the appropriate treatment and care of people with Atrial Fibrillation (the most common arrhythmia)*
- CHD NSF Chapter 8 Arrhythmia and Sudden Cardiac Death – *blue print for the provision of arrhythmia services covering patient support, diagnosis and treatment and sudden cardiac death*
- Our Health, Our Care, Our Say: a new direction for community service, July 2005 – *White Paper which sets out vision for NHS to become more responsive to patient needs and posed a major challenge to deliver more care out of hospital. This vision is reaffirmed in Our NHS, Our Future, October 2007 (NHS Review – Interim Report).*
- 18 Week Delivery Programme – *the arrhythmia service will have a maximum wait of two weeks*
- 10 High Impact Changes*: contributes to changes number 2 and 9 (improve patient flows)*
- Heart Improvement Programme (HIP) priority – *Atrial Fibrillation is one of the National HIP priorities*
- Quality and Outcomes Framework – Atrial Fibrillation
- North of Tees Joint Health and Social Care Long Term Conditions Strategy 2008/13 – *Deliver more services closer to home, reduce the number of people suffering long term disability from strokes*
- National Stroke Strategy, 2007

Clinical Drivers

- Arrhythmia affects 700,000 people in England
- Atrial Fibrillation (AF) is the most common arrhythmia
- NICE suggests the AF prevalence rate (General population) is 1.28%, QOF data for Tees reveals a higher prevalence rate at 1.37%
- Prevalence increases as adults grow older, the SAFE study 4 suggests prevalence of AF occurs in 7.2% of individuals older than 65 years
- NICE Guidance and CHD NSF Chapter 8 Arrhythmia and Sudden Cardiac Death state that AF is under-diagnosed and treated
- Patients with AF are at an increased risk of Stroke. 5% per year of those with AF have a stroke
- 1:3 patients admitted to hospital in the UK with a stroke was found to be in AF
- Cardiac arrhythmia is regularly one of the top reasons for admission using significant Accident and Emergency time and bed days. The cost of admissions across Tees for non-elective admissions (coded as Arrhythmia or Conductive Disorders - less than 70 and without complications and those over 69 and with complications 2007/08) was found to be over a million pounds at £1126,715. This represents almost 20% of the total cost of non-elective admissions for 2007/08.

Patient Survey Results

As part of the evaluation of the South of Tees pilot scheme, 215 surveys were sent following the discharge of the patient from the arrhythmia service, 148 were completed and returned.

Waiting Times
99% of patients indicated that the time they waited for an appointment was about right.

Location
96% of patients indicated that it was easier for them to attend the community based clinic than attending the tertiary centre (James Cook Hospital) for their appointment, 4% said it made no difference.

Timeliness
86.4% of patients said they were seen on time when they visited the clinic, 3.6% were not.

Nurse led Services
89% of patients indicated that they were satisfied being seen by a nurse rather than a doctor, 11% would have preferred to see a doctor at some point in the proceedings**.**

Information
86% of patients found the information they were given very helpful, 12% found it helpful, 2% found it not helpful.

Did you understand the information you were given?
84% said, yes all of it, 16% said, some of it.

Were the various options of treatment for your condition discussed?
82% said, yes fully, 15% said yes mostly, 3% said no.

Were you able to ask questions?
81% said they asked all the questions they needed to, 16% said they asked most of the questions they wanted to and 3% said they asked some of the questions they wanted to.

Were your questions answered satisfactorily?
95% said yes fully, 5% said yes mostly.

Patients were asked what the worse thing was about the clinics. Comments included:

- Nothing.
- Not enough seats in waiting area.
- There wasn't a worse thing.
- Small waiting room.
- Couldn't find any bad points.

Patients were asked what the best thing about the clinics was. Comments included:

- Local, friendly, efficient.
- Going to the hospital can be quite daunting so much prefer to come to the One Life. The thorough information that I was given.
- I wasn't rushed, the nurse spent a long time explaining everything to me.
- Easy to get to and easy to park.
- Not having to go to the hospital.
- Staff very helpful and knowledgeable.
- It was just like it normally should be.
- Interpreter provided on time.
- Location.
- Nice staff and nice nurses.
- Everyone was very helpful and friendly, made me feel at ease as I was stressed. Everything.
- Helpfulness and interest.
- Very nice place.
- No waiting.
- Friendly and clean surroundings.
- Friendly staff, well informed when tended to by staff of the clinic.
- Whole thing was excellent.
- Nice and clean.
- Could not be improved.
- All of it.
- Size is small so this is more friendly.
- I was seen really quickly and looked after really well, couldn't fault my treatment. Everyone was helpful.
- All very good.
- Made me feel safe.