PLEASE NOTE START TIME

HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL BOROUGH COUNCIL

Tuesday, 1 February 2011

at 2.00 pm

in the Council Chamber, Civic Centre, Hartlepool

MEMBERS: HEALTH SCRUTINY FORUM:
Councillors S Akers-Belcher, Barker, Cook, Fleet, Griffin, A Lilley, G Lilley, McKenna and Simmons

Resident Representatives: Mary Green, Linda Shields and 1 Vacancy

MEMBERS: NEIGHBOURHOOD SERVICE SCRUTINY FORUM (INVITED FOR AGENDA ITEM 7.1)
Councillors Barclay, Cook, Fleet, Flintoff, Gibbon, Griffin, McKenna, Richardson and Thomas

Resident Representatives: John Cambridge, Brenda Loynes and Iris Ryder

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 23 November 2010

PLEASE NOTE START TIME

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

No items

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

No items

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

No items

7. **ITEMS FOR DISCUSSION**

7.1 Dust Deposits on the Headland:-

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

(b) Presentation – *Representatives from NHS Tees*

7.2 North Tees and Hartlepool NHS Foundation Trust - Quality Account 2011/12 :-

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

(b) Presentation – *Director of Nursing and Patient Safety, North Tees and Hartlepool NHS Foundation Trust.*

Scrutiny Investigation into Connected Care

7.3 Setting the Scene:-

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

(b) Presentation – *Connected Care Project in Hartlepool*.

8. **ISSUES IDENTIFIED FROM FORWARD PLAN**

No items

PLEASE NOTE START TIME

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

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

10. **REGIONAL HEALTH SCRUTINY UPDATE**

No items

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

ITEMS FOR INFORMATION

Date of Next Meeting:- Tuesday, 1 March 2011 at 3.00 pm in Committee Room B, Civic Centre, Hartlepool

HEALTH SCRUTINY FORUM

MINUTES

23 November 2010

The meeting commenced at 3.00 p.m. in the Civic Centre, Hartlepool

Present:

Councillor Stephen Akers-Belcher (In the Chair);

Councillors: Caroline Barker, Rob Cook, Mary Fleet, Sheila Griffin, and Geoff Lilley.

Resident Representative: Linda Shields.

Also Present: In accordance with Council Procedure Rule 4.2;
Councillor Christopher Akers-Belcher as substitute for Councillor Simmons, and
Councillor Ray Wells as substitute for Councillor McKenna.

Councillor Jonathan Brash.

Louise Wallace, Assistant Director (Public Health)
Professor Stephen Singleton, Medical Director, NHS North East
Claire Young, North Tees and Hartlepool NHS Foundation Trust
Alex Zielinski, North Tees and Hartlepool NHS Foundation Trust
Sharon Robson, Alcohol Lead (Adults), NHS Hartlepool
Carole Johnson, Head of Health Improvement, NHS Hartlepool
Stephen Thomas, Margaret Wrenn and Ruby Marshall, Hartlepool LINk.

Officers: James Walsh, Scrutiny Support Officer
David Cosgrove, Democratic Services Team

54. Apologies for Absence

Councillors A Lilley, McKenna and Simmons.

55. Declarations of Interest by Members

Councillor Christopher Akers-Belcher declared a non-prejudicial interest as an employee of Hartlepool LINk.

56. Minutes of the meeting held on 12 October 2010

Confirmed.

57. Responses from the Council, the Executive or Committees of the Council to Final Reports of this Forum

No items.

58. Consideration of request for scrutiny reviews referred via Scrutiny Co-ordinating Committee

No items.

59. Consideration of progress reports/budget and policy framework documents

No items.

60. Independent Review into Accident and Emergency at the University Hospital of Hartlepool (*Scrutiny Support Officer*)

The Scrutiny Support Officer reported that at the last meeting of the Health Scrutiny Forum, on 12 October 2010, the Forum agreed to engage with the Independent Review into Accident and Emergency at the University Hospital of Hartlepool, overseen by NHS North East (the Strategic Health Authority for the North East).

Professor Stephen Singleton, the Medical Director from NHS North East was in attendance at the meeting, to provide Members with a verbal update on the progress made in relation to the Independent Review into Accident and Emergency at the University Hospital of Hartlepool.

In response to the recent announcement by the North Tees and Hartlepool NHS Foundation Trust to close the accident and emergency (A&E) services at University Hospital of Hartlepool an independent externally led review will be undertaken on 26th and 27th January 2011.

Professor Singleton outlined the 'Terms of Reference' of the review which were as follows; -

1) The review will determine the appropriateness and safety of the current A&E services being provided at University Hospital Hartlepool.

2) The review will not be constrained by previous reviews or recent decisions, but recognises three important drivers for change:
   i) Safety
   ii) Affordability
   iii) Public acceptability

3) The review will be carried out as a partnership between the North East Strategic Health Authority (SHA) and the Hartlepool Bough Councils Health Scrutiny Forum (HSF).

4) The outcome of the review will be a written report making recommendations to SHA and HSF suggesting the way forward.

To ensure externality and transparency the review would be undertaken by an independent review panel, led by an external clinical expert and chaired by a senior director from the SHA.

To ensure accountability, acceptability, value for money and the public voice members of the panel would include representation from the Hartlepool Bough Councils Health Scrutiny Forum; NHS North East SHA; external national and local expert clinical input; academic and lay membership.

The review panel would be informed through work carried out by NHS Interim Management and Support (IMAS). NHS IMAS would carry out an investigation of the local emergency and urgent care system, to assess current safety and efficacy, recent changes and propose possible future options. The outcome of the investigation would be presented to the review panel in the form of an expert report and testimony.

Proposed membership for the review panel (9 members in total)

- Representative from the senior directorship at the SHA – chair
- External Clinical A&E expert – panel led
- Two representatives from the HSF - providing a lay/public perspective
- Two independent clinical colleagues from within the region, providing both clinical and educational expertise
- An external nurse/matron
- An academic expert with an interest in medical delivery
- An independent GP from within the region

The panel would be supported in the planning and preparation by the Project Manager and during the review by two administrative / note takers.

The Chair thanked Professor Singleton for the work he had undertaken on the review so far and welcomed the terms set out. Members queried the position of an external nurse/matron on the review panel. Professor Singleton indicated that the appointment would be independent of the Trust and some excellent candidates had been identified and it was hoped that one would be available to partake in the Panel.

In terms of the independence of the review, Professor Singleton stressed that the panel was independent of the Trust and the PCT. There had been useful discussions with the Chair of this Forum and the panel members would be sharing information on the review in advance of the meeting dates. If any member of the panel considered that additional information was required, then we would endeavour to get that for them.

The Forum supported the General Practitioner being drawn from Hartlepool and Professor Singleton indicated that he would endeavour to achieve that but highlighted that the dates for the review had been set and there would need to be a commitment from all the review team to be available for the period of the review.

The Chair emphasised to Members that it was also for them to speak to residents and seek and represent their views to the review.

Recommended

1. That Professor Singleton be thanked for his input into the meeting and leading the review panel.
2. That the terms of reference for the review, as reported, be welcomed and approved.

61. Female Life Expectancy in Hartlepool – Update

(*Scrutiny Support Officer*)

The publication of the Health Profile for Hartlepool in 2009 highlighted that female life expectancy in the Town equated to the worst in England, this generated significant media interest; nationally through the Radio 4 programme 'Woman's Hour' and locally via the Evening Gazette and Hartlepool Mail newspapers.

On the 6 October 2009 the Health Scrutiny Forum received a report by the Acting Director of Health Improvement into Female Life Expectancy in Hartlepool. Members agreed at the meeting of 6 October 2010:-

"That the Forum [will continue] to monitor the issue of health inequalities in the town and on doing this receive an update report on an annual basis focussing on those specific wards causing concerns in relation to life expectancy of women."

The Assistant Director for Public Health at NHS Hartlepool gave a presentation to Members in relation to the issue of Female Life Expectancy in Hartlepool.

Members noted that in many of the graphs and tables outlined in the presentation, there appeared to be wide variations in the figures for Hartlepool. The Assistant Director commented that this happened as the numbers from Hartlepool were statistically small, so only two or three more deaths could shift statistics quite markedly. Members recalled the Radio 4 'Women's Hour' programme that highlighted the statistics for the Brus ward. There was concern that cancer screening was not reaching the deprived areas of the town and that not all lung cancers should be attributed to smoking. Residents had great concerns in relation to the former Steetley works and the brake lining factory. The Assistant Director stated that 9 out of 10 lung cancers were directly attributable to smoking or passive smoking but it had to be recognised that there were a whole list of factors that would affect a person's life expectancy. It was indicated that people would often

seek to blame other factors.

There was concern among Members that the statistics for the deprived wards had not changed for over a decade and that these areas should have been targeted by the PCT for preventative input. The Assistant Director indicated that she would provide some statistical information for the Brus and Owton wards highlighted by Members in the debate.

The Chair recognised that there were still many people that despite all the help and advice that was available still wouldn't seek that help or believe the information given to them. There were still parents who prioritised alcohol and cigarettes ahead of their children when it came to money.

Members acknowledged that unfortunately deprivation and poor health seemed to go hand in hand. Not all the issues were down to alcohol and smoking but housing, early years input, genetics, environmental and social issues. What was needed were the correct information and advice and role models. Members commented that it didn't help when in one school in the town, had a staff member as a 'smoking monitor' who themselves was a smoker and directed children to the where they wouldn't be caught and disciplined by the school.

Recommended

That the Assistant Director for Public Health at NHS Hartlepool be thanked for her very informative presentation.

62. Minimum Price per Unit of Alcohol (*Scrutiny Support Officer*)

The Scrutiny Support Officer reported that at the meeting on 3 August 2010, the Chair provided the Forum with feedback from the presentation of the 'Alcohol Abuse – Prevention and Treatment' Final Report at the NHS Hartlepool Board meeting of 29 July 2010. During the consideration of the report by the NHS Hartlepool Board, the Executive Director for Public Health made representations seeking the Forum's support for the introduction of a minimum price per unit of alcohol. The Chair proposed that due to the change in Members who were involved in the 'Alcohol Abuse' investigation and were now serving on the Forum, more time was needed to consider this matter before making a decision.

Following the Forum meeting of 3 August 2010, the Final Report into 'Alcohol Abuse – Prevention and Treatment' and documentation relating to the proposed minimum price per unit of alcohol had been circulated to all Members of the Health Scrutiny Forum.

Subsequent to an offer from made the Forum met on 12 October 2010 the Assistant Director for Public Health, NHS Hartlepool gave a presentation to the Forum in relation to the Minimum Price per Unit of Alcohol.

Members were split in their views on the merits of a minimum price per unit for alcohol being introduced in Hartlepool. Those in support of the introduction of such a bye-law referred to the costs to the town in terms of

long-term health issues and policing. Those against reflected on the potential affects on the lives of heavy drinkers who may simply reduce other spending, particularly on their families, to support their dependency.

The debate focussed on the social and health costs of alcohol. Members were concerned at some of the price rises that the minimum price per unit of 50p would bring; a bottle of vodka being a minimum of £14 and a two-litre bottle of strong cider rising from £2.73 to £7.95. The concerns centred around how those with an alcohol dependency would fund alcohol; crime, taking from other household expenditure and resorting to underground sales.

The Assistant Director commented that an important part of this issue was that it was being discussed and it was recognised that consuming too much alcohol was causing us harm. The problem was increasing right across the country and the affects were clearly visible in Hartlepool in terms of the health problems associated with consuming too much alcohol. What was needed was a range of measures to help people with alcohol problems or health issues caused through alcohol consumption.

Members were particularly concerned at the potential for illegal alcohol selling in the town. There was already an issue with illegal cigarette sales and Members indicated that they could only see the problem of illegal sales becoming worse after a minimum pricing policy. There was also great concern at the number of young people drinking alcohol illegally.

The Chair highlighted that much of the issue faced due to high alcohol consumption was a cultural one. The Chair referred to a recent personal experience when the high price of alcohol in hotel had not resulted in anyone reducing their alcohol consumption; rather, they simply sought cheaper venues.

Following the debate, the Chair sought an indication of those Members of the Forum whether they supported the introduction of a minimum price per unit of 50p per unit. Following a vote of the Members present, the Scrutiny forum resolved as follow: -

Recommended

That the Health Scrutiny Forum does not support, at present, the introduction of a minimum price per unit bye-law in Hartlepool.

63. Scrutiny Investigation Into Connected Care – Scoping Report (*Scrutiny Support Officer*)

The Scrutiny Support Officer reported that when Members determined their work programme for the 2010/11 Municipal Year, the topic of 'Connected Care' was selected as a scrutiny topic for consideration during the current Municipal Year.

Connected Care was developed by Turning Point, who are a social enterprise organisation specialising in the provision of specialist and

integrated services to meet the health and social care needs of individuals, families and communities. Turning Point Indicate that Connected Care was a "model for community led commissioning…bring[ing] the voice of the community to the design and delivery of all health, housing, education and social service delivery."

The Connected Care service was established as one of the first national pilots in the Owton Ward of Hartlepool in 2006 and was jointly funded by the Authority and the PCT. The premise of Connected Care in Hartlepool was to integrate health and social care with strategies for social inclusion and then linking Connected Care to locality based commissioning.

In April 2009 the Health Scrutiny Forum completed an investigation into 'Reaching Families in Need' where Members recommended:-

"That learning from the Connected Care Scheme is rolled out to other areas of deprivation in the Town."

The response from NHS Hartlepool was that the Connected Care programme roll out would be considered once an evaluation was completed by Durham University.

In February 2010, the evaluation undertaken of Connected Care in Hartlepool by Durham University was electronically circulated to Members of the Forum and a hard copy deposited in the Members Library by the Chair of the Health Scrutiny Forum.

Connected Care is currently being delivered in the Owton Ward of Hartlepool, by 'Who Cares', which was a Social Enterprise model of delivery operated by residents and local community organisations. There were plans to extend Connected Care into other areas of the Town, although the major barrier to the development of Connected Care in Hartlepool is "access to working capital".

The following Terms of Reference for the investigation/review are proposed:-

(a) To gain an understanding of the development and current delivery model of Connected Care in Hartlepool;
(b) To examine the impact of Connected Care on the communities where it has been operational;
(c) To analyse the lessons learned from the Durham University evaluation and how these and other lessons have been / might be applied to the development of Connected Care;
(d) To gain an understanding of the impact of current and future budget pressures on the way in which Connected Care is provided in Hartlepool;
(e) To explore how Connected Care could be provided in the future, giving due regard to:-
    (i) Improving the effectiveness and efficiency of the way in which the service is currently provided; and
    (ii) If / how the service could be provided at a reduced financial cost

(within the resources available in the current economic climate).

The proposed timetable for the review to be undertaken was set out in the report together with the potential sources of evidence and areas of enquiry.

Members questioned who would be involved in the focus group that was programmed in the inquiry. The Chair indicated that while he normally would have wished to have as much of the investigation evidence brought forward in public, there was concern that many of the users of the service were vulnerable people and in order to be sensitive to their needs it was considered that after discussions with those involved in the project that a more informal approach where small groups of councillors visited service users would be more appropriate. Some Members were concerned that the investigation was being scheduled over a relatively short period of time for what was a very significant service area. The Chair commented that he believed that the programme of meetings was adequate for the purposes of the inquiry.

Recommended

That the remit of the Scrutiny investigation into 'Connected Care', as detailed above, together with the proposed timetable be approved.

64. Service Transformation Project (*Scrutiny Support Officer*)

The Scrutiny Support Officer reported that at the meeting on 22 June 2010, the Forum agreed to receive regular updates in relation to the Service Transformation Project which emanates from the Momentum: Pathways to Healthcare Programme. Members were also reminded of the agreement by the Forum at the meeting on 12 October 2010, to be involved in an Independent Review into Accident and Emergency at the University Hospital of Hartlepool.

In light of the involvement of Members of the Forum in the Independent Review into Accident and Emergency at the University Hospital of Hartlepool, developments through the Service Transformation Project in terms of Accident and Emergency and Minor Injuries would be postponed until a future meeting of the Forum.

Recommended

That the report be noted.

65. Issues identified from the Forward Plan

No items.

66. Tees Valley Health Scrutiny Joint Committee Update (*Scrutiny Support Officer*)

The Scrutiny Support Officer submitted a report providing a summary is of the issues discussed at a recent Tees Valley Health Scrutiny Joint Committee Meetings. Further information on these issues was available

from the Scrutiny Team and where appropriate clarification could be sought from Hartlepool's Tees Valley Health Scrutiny Joint Committee representatives who are present at today's meeting:-

The Tees Valley Health Scrutiny Joint Committee met on 23 August 2010 when the following issues were discussed:-

(i) Mental Health Services – Capacity of Community Services
Members had agreed at the meeting of the Committee held on 19 July 2010 that they would undertake an investigation into Mental Health Service Provision across the Tees Valley. Subsequently, representatives from Tees, Esk and Wear Valley NHS Foundation Trust provided Members with an update, particularly in relation to the development of Roseberry Park to replace the provision at North Tees and St Luke's sites.

(ii) White Paper – Equity and Excellence: Liberating the NHS
Members of the Committee examined the key developments suggested in the NHS White Paper. Concerns were raised on a number of issues and it was agreed that constituent Authorities would submit their comments back to the Joint Committee, once they had held discussions within their own Health Overview and Scrutiny Forums.

The Tees Valley Health Scrutiny Joint Committee met on 13 September 2010 when the following issues were discussed:-

(i) Momentum Update
The Momentum Programme Director provided Members of the Committee with an update in terms of the Momentum Programme. It was noted that the decision by the Treasury in relation to the funding of the Hospital at Wynyard was likely to delay developments by at least one year. Currently North Tees and Hartlepool NHS Foundation Trust were actively seeking funding through private businesses that it was hoped would have interest rates which were less than the traditional PFI route. It was, however, noted that the overall footprint for the Hospital and single bed occupancy may have to change to reduce the overall cost of the project, although there was reassurance that there were no plans not to deliver all the services from the Hospital which had been originally consulted on in 2008.

(ii) Cancer Screening – An Update on Progress
The Executive Director for Public Health provided the Committee with an update in relation to Cancer Screening Services. It was noted that there had been improvements in the number of patients accessing Cancer Screening Services across the Tees Valley, although encouraging take-up in certain communities (particularly where health inequalities existed) were still challenging.

(iii) White Paper – Equity and Excellence: Liberating the NHS
The Committee agreed that a final draft submission from the Committee should be collated by the Chair of the Committee from representations at the Joint Committee meeting and those constituent Authorities who had provided written summaries.

2.4 The Tees Valley Health Scrutiny Joint Committee also met on 8 November 2010 when the following issues were discussed:-

(i) Sexual Health Services Across Tees
Members were informed that there had been a slight delay in signing the contract between NHS Tees and the provider Assura Stockton LLP, due to complexities around the employment model. The Committee was informed that One Life Hartlepool currently provided a full range of CASH services and there were plans to integrate GUM services in the future. There was also an acknowledgement that success would be difficult to measure and initially there maybe an increase in detection rates for the current baseline, which did not necessarily mean that the service was not working. Members agreed to receive an update at a future meeting of the Committee.

(ii) Mental Health and Wellbeing in the BME Community
As part of the Committee's on-going inquiry into Mental Health Services across the Tees Valley, Members received an update from NHS Tees in relation to the provision of services to the BME communities. Representatives informed Members that the withdrawal of Community Development Workers was being offset with a movement towards contracts ensuring providers of mental health services were open to all members of communities, although Members were circulated a letter from Middlesbrough and Stockton Mind which raised concerns about the developments.

Recommended

That the report be noted.

67. Regional Health Scrutiny Update

No items.

68. Any Other Items which the Chairman Considers are Urgent

The Chairman ruled that the following items of business should be considered by the Committee as a matter of urgency in accordance with the provisions of Section 100(B) (4)(b) of the Local Government Act 1972 in order that the matter could be dealt with without delay.

69. Meetings of the Scrutiny Forum and Tees Valley Health Scrutiny Joint Committee

A Member questioned the number of meetings of the Health Scrutiny Forum being held during the year and whether sufficient meetings were being held to complete the forum's workload. The Chair commented that to date in this municipal year, the forum was on schedule to hold a similar number of

meetings to that held in the last three municipal years and therefore did not feel the number of meetings was an issue.

The attendance at the Tees valley Joint Scrutiny Meetings was also questioned. It was highlighted that should any appointed Member be unable to attend, substitutes could be appointed.

The meeting concluded at 5.20 p.m.

CHAIR

HEALTH SCRUTINY FORUM

1 February 2011

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Support Officer

Subject: DUST DEPOSITS ON THE HEADLAND – COVERING REPORT

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1. PURPOSE OF REPORT

1.1 To introduce representatives from NHS Tees who will be present at today's meeting to present a report entitled 'Health Profile of the Population Living in the Headland of Hartlepool'

2. BACKGROUND INFORMATION

2.1 On 24 May 2010 the Health Scrutiny Forum presented its Interim Report into 'Dust Deposits on the Headland' to the Authority's Cabinet. Amongst the recommendations culminating from the interim report was recommendation (a) which stated:-

"That the Health Scrutiny Forum receives results of further investigations into dust deposits on the Headland by the Executive Director of Public Health into cancer rates."

2.2 At the meeting of Cabinet on 24 May 2010, the Neighbourhood Services Scrutiny Forum presented its Final Report into 'Possible Environmental Impacts of Dust Deposits on the Headland and Surrounding Areas', amongst its recommendations was recommendation (k) which stated:-

"That Members of the Neighbourhood Services Scrutiny Forum and residents be invited to attend the meeting of the Health Scrutiny Forum when it considers the additional information which has been requested from Professor Kelly."

2.3 Subsequently, representatives from NHS Tees will be present at today's meeting to present their findings entitled 'Health Profile of the Population Living in the Headland of Hartlepool' and attached as **Appendix A** to this report. In addition, Members of the Neighbourhood Services Scrutiny Forum have been invited to attend this meeting.

3. RECOMMENDATIONS

3.1 That Members note the content of this report and the report of the Executive Director of Public Health attached as **Appendix A** to this report, seeking clarification on any issues from the representatives from NHS Tees present at today's meeting.

Contact Officer:- James Walsh – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
Tel: 01429 523647
Email: james.walsh@hartlepool.gov.uk

BACKGROUND PAPERS

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

(a) Minutes of the meeting of the Cabinet held on 24 May 2010.

NHS
Tees

7.1 (a)
Appendix A

Health profile of the population living in the Headland of Hartlepool

NHS Tees
Directorate of Public Health
Prof Peter Kelly
Dr Tanja Braun

Contents

Executive Summary

Background

Health concerns about the possible effects of dust from the docks close to the Headland of Hartlepool (area within the St Hilda ward) have been raised for many years. Previous meetings between residents, Hartlepool Borough Council, Public Health, responsible companies and other agencies have resulted in agreements to mitigate the dust emission and travelling and information on health and lifestyle.

In October 2009 the health scrutiny committee of Hartlepool Borough Council asked Prof Peter Kelly for evidence of possible health effects of dust and noise originating from the docks. Professor Kelly presented information on respiratory, liver and skin disease contained in this report and agreed to further investigate respiratory disease in children, mental health, cancer incidence and prevalence and asbestos related disease.

Primary and secondary care information, cancer registry information and other sources were used to compile this report.

Key findings

- The Headland of Hartlepool has a **population** of 1744.
- The Headland is part of the St Hilda Ward which ranks within the 3% most **deprived** wards in England, the Headland area is less deprived than other areas in the St Hilda ward (rank 6964 of 32482 Lower Super Output Areas).
- The **living environment** (air quality and housing) in the Headland is better than the English average (rank 24,641of 32,482).
- The **life expectancy** of the St Hilda population is below the national average but similar to the Hartlepool average.
- The **general health** of the Headland population is below the national average but similar to the Hartlepool average.
- Information about **lifestyle choices** of the adult population in St Hilda shows that 40% are smoking, 29% are binge drinking, 27% are obese and only 12% consume the recommended daily fruit and vegetables.
- **Common mental illnesses**, such as depression and anxiety are generally more frequent in women. Compared to the neighbouring wards of Brus and Stranton the population of St Hilda has a lower burden of disease.
- **Respiratory disease:** Hospital admissions due to lower respiratory disease in St Hilda are comparable to the Hartlepool average and higher in the Headland. Information from the Headland GP practice shows an increase between 2004 and 2008 and a slightly higher but not statistically significant proportion of patients from the Headland (18,1%) compared to patients living elsewhere (16,9%) suffering from respiratory disease.
- **Skin disease** has increased between 2004 and 2008 and is similar for patients of the Headland, St Hilda and Hartlepool.

- **The combined burden of disease from respiratory, liver and skin disease** of patients seen in general practice is similar for the Headland, St Hilda and patients living elsewhere in Hartlepool.
- **Cancer incidence** has been stable for men and rising for women in the North East. There is no significant difference between St Hilda, Hartlepool and the North East.
- **Lung cancer incidence** decreased in men and increased in women. There is no significant difference between St. Hilda, Hartlepool and the North East.
- **Cancer mortality** has been declining for men and women in the North East. In 2003/06 there has been a higher mortality for both men and women in Hartlepool. There is no statistical difference between St. Hilda and Hartlepool.
- **Lung cancer mortality** has been declining for men and stable for women across the North East. There is no significant difference between St Hilda, Hartlepool and the North East.
- Mortality from **mesothelioma,** the asbestos related malignant disease has been increasing over the last 30 years. Hartlepool is the 16th most affected area in the UK (SMR 240).

Conclusions
The health of the population in the Headland of Hartlepool is influenced by the local socio-economic and living environment as well as lifestyle choices.

The level of deprivation, smoking, binge drinking and obesity in St Hilda are particularly high, while the air quality and housing is comparably good. The life expectancy and general health are similar to the Hartlepool average and the burden of disease seen in general practice is similar for patients from the Headland and patients from elsewhere in Hartlepool. Cancer incidence is similar in St. Hilda, Hartlepool and the North East whilst cancer mortality, particularly for women in St Hilda, has been higher in Hartlepool than in the North East in the period 2003/06.

The evidence presented in this report suggests that the burden of disease of the population of the Hartlepool Headland is consistent with the age of the population, level of deprivation and proportion of smokers in the population. There is no indication of any excess ill health caused by environmental factors.

Definitions

Age-standardised Rate (ASR)	The ASR for mortality is the number of deaths (or cases if it is an incidence rate), that would occur in an area if that area had the same age structure as the standard population (European) and the local age-specific rates of the area applied.
Crude Rate	Crude rate for mortality is the number of deaths which occurred in an area in a specific time period, over the population of this area. This is expressed per 100,000 population. Crude rates reflect the "true" percentage of deaths/cases in a population.
Confidence Intervals	95% confidence intervals are usually calculated for ASRs or Relative Survival rates to give an indication of the level of uncertainty of the calculation. The LCL and UCL (or LCI, UCI) are the confidence limits of a 95% confidence interval. This means that there is 95% chance that the rate is between the LCL (Lower Confidence Limit) and UCL (Upper Confidence Limit). This is a way of conveying the stability of the rates which are subject to random fluctuations over time. The confidence intervals should be used to identify whether the difference between the rates is statistically significant (or not). When the confidence intervals overlap this means that there is no significant difference between the rates of these areas; when they don't overlap, then the difference is statistically significant; when they partly overlap then we cannot drive any conclusions and a statistical test is required to investigate that further. When calculating ASRs for different PCTs or electoral wards, the information is subject to random fluctuations over time or between local PCTs\electoral wards. The smaller the confidence interval, the more stable the rate. More events lead to a smaller interval.
Incidence	Number of new cases arising over a specified period of time
LSOA	Lower super output area
Morbidity	Occurrence of disease usually measured in rates or proportions. Measures of morbidity are incidence and prevalence.
Mortality	Occurrence of death usually measured in rates or proportions. A measure of mortality is the SMR.
Prevalence	Total number of existing cases of a disease in a defined population over a defined period of time
SMR	The standardised mortality ratio is the Ratio of actual deaths to expected deaths from a given condition or event.

1. Background

1.1 Health concerns at Hartlepool Headland

In July 2009 concerns were raised about the health effects of dust originating from scrap metal handling and storage of *Van Dalen UK limited* at the Victoria docks in Hartlepool. The Van Dalen UK site is located opposite Town Wall on the Hartlepool Headland only a short distance across the water. Scrap metal is piled up high on the dock and dust is regularly blown to the residential areas of the Headland by the prevailing south-westerly wind, particularly when ships are loaded or unloaded. Residents of Town Wall complain that the dust covers cars, yards, paintwork and windows of houses and causes considerable damage. Residents are also very concerned about the possible impact upon their and their families' health and report respiratory, skin and liver problems.

Concerns about possible health effects of the dust have been raised since many years and regular liaison meetings with residents took place until 2001/ 2002. A petition to stop the dust was received by Hartlepool Borough Council (HBC) on the 2nd March 1995 and passed to the Environmental Committee. At this point of time it was stated that there was no evidence of any toxic nature of the dust. Sprinkling to mitigate the travelling of the dust was considered as too difficult.

In 2007/08 multi-agency meetings were held again between residents, local councillors from Hartlepool Headland, Port Authority, Environment Agency, Health Protection Agency, Envoy environmental consultants and Public Health department of Hartlepool PCT.

In 2008 the independent technical environmental consultancy Envoy was commissioned by the metal recycling company Van Dalen UK limited to conduct dust and particulate monitoring. Envoy proposed to monitor and collect dust during a ship loading event, which occurs approximately every two weeks. Dust and samples from personnel and at the ship site were collated and subsequently analysed. In addition samples randomly collected by residents were submitted for analysis. Emissions during the ship loading event were found to be at a level below environmental significance. Personnel monitoring found that exposure limits have not been exceeded. Three samples submitted by residents show a morphology and chemical composition of high levels of iron and titanium oxide which is considered consistent with rutile sand. The report therefore concludes that a cross contamination with rutile sand from an unknown but nearby source is the root cause of the dust and that there is no health risk for the population or personnel from the emissions of the metal recycling company. The analysis of the samples also showed the presence of aluminium, zinc and TEM.

Envoy recommended the company to

- contact the source of rutile sand and request action to stop the cross contamination
- to complete a clean-down of stock and residual sand should be completed once the measures are in place

- to conduct a monitoring exercise after the clean-down to examine the effectiveness of the actions taken

At subsequent meetings of the multi-agency group it was agreed that an effect of the port activities on resident's health cannot be established and that the PCT can help residents to prevent and address health problems. A "Healthy Hartlepool, Healthy Lives" leaflet has been produced by the PCT in cooperation with the HPA and the Hartlepool Ports management.

In 2009 Prof Peter Kelly, Executive Director of Public Health for Teesside, was contacted by Cllr John Marshall and invited to present health information at a public meeting on the 6th of October 2009 at the Headland. The information was also presented to the health scrutiny committee of Hartlepool on the 27th of October 2009 where possible health effects of dust and noise originating from the scrap metal were discussed. Peter Kelly agreed to collate further information on the health of the population living on the Hartlepool headland including information on cancer and sequelae of asbestos. A final judgement on the health effects of the dust has been postponed until more detailed information is available.

1. 2 Health Effects of Substances found in the Environment

The following paragraphs describe the potential health effects of substances found in the samples taken by Envoy. Asbestos has not been found in the samples but has been included here because concerns about asbestos related disease have been raised at the public meetings in October 2009.

Aluminium

Aluminium is the most abundant metal on the earths crust. Environmental exposure to Aluminium normally occurs through food, air, water and soil. Increased exposure occurs at places where aluminium is naturally high, e.g. at workplaces where aluminium is processed and near waste sites. Only a very small amount of inhaled or ingested aluminium enters the bloodstream. High levels of inhaled aluminium in aluminium workers can lead to respiratory symptoms such as impaired lung function or fibrosis, although there is some discussion if the effect is caused by the aluminium or by the dust overload. Aluminium dust is not reported to cause any skin reactions. High levels of ingested aluminium can cause symptoms of the nervous system. However this applies largely to patients with renal failure who need haemodialysis or patients with gastrointestinal symptoms using aluminium containing antacida over many years. There is no evidence that aluminium could cause cancer.[1]

Iron

Iron oxide (rust) is not considered hazardous to health.[2]

Titanium

Titanium dioxide is a product of titanium mineral. No negative health effects have been reported for ingestion and skin absorption. Inhalation of Titanium particles has been studied among groups of titanium exposed workers and included impaired lung function, pleural disease and mild fibrotic changes. However the workers were

simultaneously exposed to asbestos and silica. Titanium dioxide is possibly carcinogenic.[3]

Zinc

Zinc is a common element which is found in the air, soil and water. Zinc is present in all foods but also in medications and food supplements. Zinc in the air is present mostly as fine dust particles. Exposure to zinc is generalised. Occupational exposure is highest in workers in the zinc mining, smelting and processing industry as well as in the construction and automobile industry. Inhalation of very large amounts of zinc dust can cause an acute metal fume fever which is reversible once the exposure stops. Long term effects of inhaling zinc dust have not been reported. Ingestion of large doses can cause stomach cramps, nausea and vomiting. Taken longer it can cause anaemia. Zinc is not reported to cause cancer.[4]

Particles in the air

The environment Action 1985 and the Air Quality Regulations require regular monitoring of the air quality. PM10 particulates, which are very small particulates (less than 10 microns in diameter) can entre the lungs. Levels should not exceed an annual mean 40 µgm3 and a 24 hour mean of 50 µgm3. PM10 concentrations above these limits are considered as a risk to health. Short term health effects of high PM10 concentrations are irritation of eyes, nose, throat and lungs. People with chronic respiratory and cardiovascular disease might experience breathing problems and exacerbation of their condition. Children and the elderly are most vulnerable. Studies have also linked increased particulate pollution to increased hospitalisation, cardiovascular disease, heart attacks and cardiovascular mortality. [5]

Asbestos related disease

Asbestos containing materials have been used for many decades in the construction trade and other industries. Exposure to asbestos has been widespread and is thought to have reached highest level in those who worked amosite insulation boards without effective dust control.

Four main diseases are associated with inhalation of asbestos fibres:

1. Asbestosis which is a scarring of the lung tissue caused by asbestos;
2. Mesothelioma;
3. Asbestos-related lung cancer and
4. Diffuse pleural thickening.

Current evidence suggests that asbestos can also cause laryngeal cancer and may be contributing to causing pharyngeal, stomach and colorectal cancers. [6] In 2006 there were 2056 mesothelioma deaths in Great Britain. The number of mesothelioma deaths has steadily increased over the last 40 years and is estimated to peak in 2050.

Lung cancer deaths caused by asbestos are clinically indistinguishable from those caused by other agents such as tobacco smoke. This means that the exact number of cases cannot be determined. Estimates expect approximately one asbestos related lung cancer death per mesothelioma each year. The ten occupations found to have the highest risk of mesothelioma for males were Carpenters, plumbers, electricians, labourers in other construction trades, metal plate workers, pipe fitters, contraction operatives, managers in construction, construction trade and energy plant operatives. Non occupational exposure to asbestos such as living within a mile

of a potential environmental hazard such as an asbestos factory disposal site, shipyard or power plant caused no additional risk before the age of 30 and a slight but not significant increased risk when being exposed more than 20 years.

2. Purpose of this report

To inform the population of the Hartlepool Headland, Hartlepool Borough Council and the Hartlepool Health Scrutiny Committee about the health status of the population and the possibility of negative health effects through dust originating from the *Van Dalen UK* site.

The report aims to

- Establish a heath profile of the population of the St Hilda Ward and where possible of the Hartlepool Headland with special consideration to respiratory, skin and liver disease.
- Compare the level of ill health of the population of the Hartlepool Headland with neighbouring areas and wards as well as the Hartlepool average.
- Determine if there is a greater burden of disease than expected for the population living in the Hartlepool Headland.

3. Methods

The health profile includes population, socioeconomic and environmental information for the Lower Super Output Area of the Hartlepool Headland (LSOA 002C or E01011991), St Hilda ward and Hartlepool Local Authority based on information from the Office for National Statistics, Neighbourhood Statistics and the Joint Strategic Needs Assessment for Hartlepool 2009.

Health information includes general health and lifestyle information from the Office of National Statistics and the Joint Strategy Unit and disease related information based on primary and secondary care data and the Northern and Yorkshire Cancer Registry and Information Service. Primary care health information is derived from the Headland GP Practice and the Exeter System[1], by comparing the practice population of the Headland, the area close to Northsands, the area of Middleton and Cleveland Road and the whole of St Hilda to the population living elsewhere in Hartlepool. The practice population in September 2009 was 6125 patients. Approximately one third (1960) lived in the St. Hilda ward, of which 803 patients lived on the Hartlepool Headland. The remaining 4165 registered patients lived elsewhere in Hartlepool.

Graph 1: Map of Hartlepool GP practices and wards

[1] The Exeter system is a database of all patients registered with an NHS GP in England and Wales. It is used by all health authorities.

Map showing Hartlepool GP practices and wards

The prevalence of respiratory, skin and liver disease (liver disease not associated with alcohol) combined is shown for all patients registered with the Headland Practice in comparison with patients living in the areas of the Headland, Northsands area, Middleton/Cleveland Road Area and the complete St. Hilda ward. The report also presents the prevalence of respiratory disease in patients of all ages, respiratory disease in children and young people under 18 and skin disease in people of all ages for the above areas separately.

Health information based on secondary care hospital data (Hospital Episode Statistics) provides information on respiratory disease and cancer. Hospital admission were counted only once per year per patient regardless of the number of readmissions. The morbidity of people in living in St Hilda was compared to the neighbouring wards of Brus, Dyke House and Stranton as well as the whole of Hartlepool.

Information on cancer mortality (all cancers) for the Headland, St Hilda and Hartlepool was obtained from the Northern and Yorkshire Cancer Registry and Information Service (NYCRIS).

Information on asbestos related disease and mesothelioma mortality for Hartlepool have been obtained from the Asbestosis and Mesothelioma Register of the Health and Safety Executive.

The following list includes the ICD-10 (International classification of diseased) codes used in searching for secondary care information. Corresponding read codes were used for searching primary care data.

Table1: ICD – 10 codes for secondary care	
Liver disease (non alcohol related)	
K71	Toxic liver disease
K72	Hepatic failure, not elsewhere classified
K73	Chronic persistent hepatitis, not elsewhere classified
K74	Fibrosis and cirrhosis of liver
K75	Other inflammatory liver diseases
K76	Other disease of liver
Respiratory disease	
J40	Bronchitis, not specified as acute or chronic
J41	simple and mucopurulent chronic bronchitis
J42	Unspecified chronic bronchitis
J43	Emphysema
J44	Other chronic obstructive pulmonary disease
J45	Asthma
Skin disease	
L23	Allergic contact dermatitis
L24	Irritant contact dermatitis?
L25	Unspecified contact dermatitis
L30	Other dermatitis
Cancer	
C 00- C97	Malignant neoplasms
Asbestos related	
C45	Mesothelioma

Table 2: Read code groups for primary care	
Liver disorders	
J61..	Cirrhosis and chronic liver disease
B15..	Malignant neoplasm of liver and intrahepatic bile ducts
BB5D5	[M]Hepatocellular carcinoma NOS
BBL8.	[M]Hepatoblastoma
B1501	Hepatoblastoma of liver
B1502	Primary angiosarcoma of liver
BB5D1	[M]Cholangiocarcinoma
J635.	Toxic liver disease
J625.	[X] Hepatic failure
J6000	Acute hepatic failure
J6010	Subacute hepatic failure
J614.	Chronic hepatitis
J61y.	Other non-alcoholic chronic liver disease
J62..	Liver abscess and sequelae of chronic liver disease
R091.	[D]Hepatomegaly
25G..	O/E - liver palpated
R092.	[D]Splenomegaly
2C5..	O/E - splenomegaly
R0241	[D]Icterus NOS
R024.	[D]Jaundice (not of newborn)
R1040	[D]Transaminase or lactic acid dehydrogenase raised
44C91	Serum acid phosphatase raised
R1042	[D]Alkaline phosphatase raised
R1043	[D]Amylase, serum level raised
R1044	[D]Lipase, serum level raised
J615.	Cirrhosis - non alcoholic
J616.	Biliary cirrhosis
J61z.	Chronic liver disease NOS
Respiratory disorders	
H0...	Acute respiratory infections
H1...	Other upper respiratory tract diseases
H3...	Chronic obstructive pulmonary disease
H4...	Lung disease due to external agents
H5...	Other respiratory system diseases
Hy...	Other specified diseases of respiratory system
Hz...	Respiratory system diseases NOS
Skin disorder	
M11..	Atopic dermatitis and related conditions
M12..	Contact dermatitis and other eczemas
Myu2.	[X]Dermatitis and eczema

4. Health Profile

4.1 Population

The population of the Hartlepool Headland is 1744. In comparison to the Hartlepool average the Headland has a higher proportion of women and people over 65 years and a lower proportion of children and young people under 18 years and the non white population.

Table 3 : Population

	All	Male		Female		Under 18		Over 65		Non white	
	n	n	%	n	%	n	%	n	%	n	%
Hartlepool	88586	42547	48	46039	52	21825	25	14368	16	1031	1.2
St Hilda	5485	2637	48	2848	52	1330	24	1002	18	39	0.7
Headland	1744	827	47	917	53	400	23	336	19	13	0.7

Source: ONS, Neighbourhood Statistics, 2001

4.2 Wider determinants of health

Health and ill health is determined by gender, age, ethnicity, the individual genetic make up as well as socioeconomic and environmental factors. The wider determinants of health are best summarised by the index of multiple deprivation. The index reviews information on a number of indicators, such as income, employment, health and disability, education, skills and training, barriers to housing and services, living environment and crime. The information is weighted and combined into a single deprivation score for each small area in England. This allows each area to be ranked relative to one another according to their level of deprivation.

Deprivation

Hartlepool was ranked 23 out of 354 local authorities in Britain in 2007, which was an improvement from rank 14 in 2004. This still means a high level of deprivation, particularly with regards to income, employment, health, education and crime.

Table 4: Index of multiple deprivation

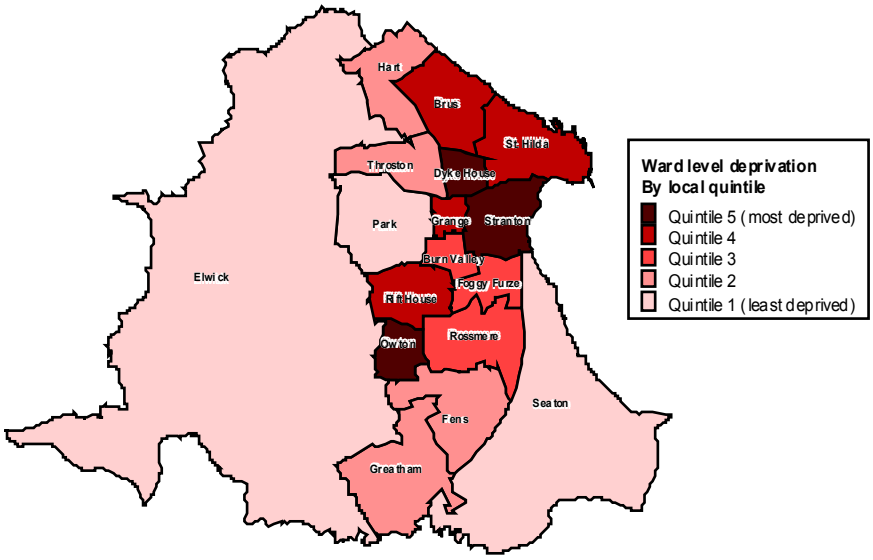
	Index of Multiple Deprivation	Income deprivation	Health deprivation
Headland	6,964 (of 32,482)	-	-
Hartlepool	23 (of 354)	-	-
St Hilda	153 (of 7936)	172	73
Stranton	49 (of 7936)	69	43
Dyke house	63 (of 7936)	86	94
Brus	222 (of 7936)	200	121

Source: ONS, Neighbourhood Statistics,2007

Compared to the whole of Hartlepool the St Hilda ward is within the fourth most deprived quintile, which means that the population in 60% of all wards in Hartlepool is less deprived. But it also means that the population in 20% of all wards in

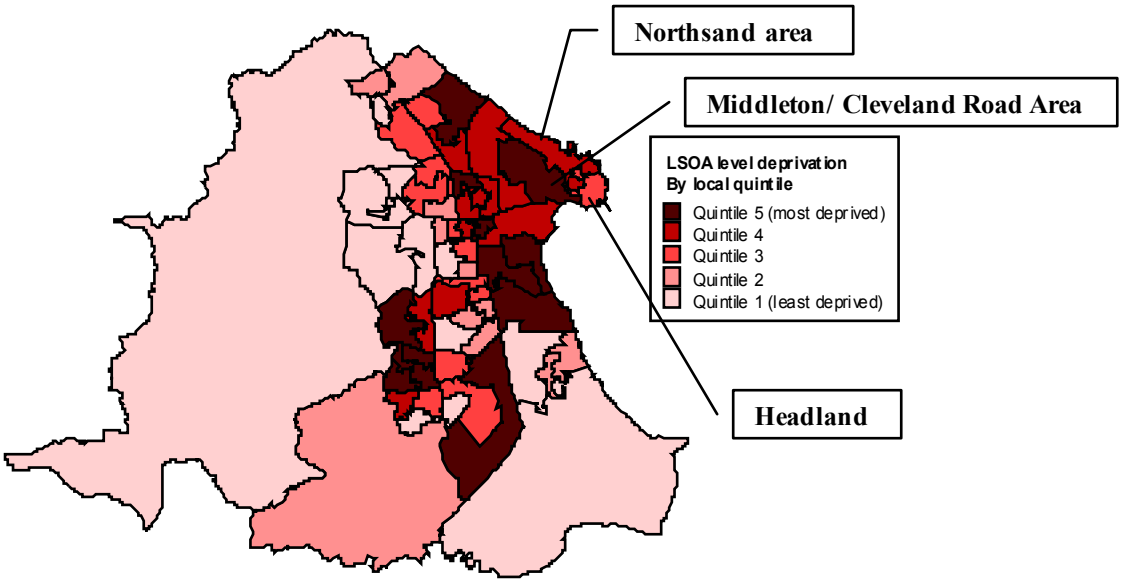
Hartlepool is more deprived. In total there are 7936 wards in Britain. The wards are ranked in order with rank 1 meaning the most deprived ward. Stranton, Dyke House, St Hilda and Brus are within the 3% most deprived wards in Britain. Stranton (49) and Dyke House (rank 63) have a higher level of deprivation than St Hilda (rank 153) and Brus (rank 222).

Graph 2: Deprivation in Hartlepool on ward level by local quintile



The index of multiple deprivation is also produced on a smaller geographical level the Lower Super Output Area (LSOA) level, of which there are 32,482 in the country. The headland LSOA ranks 6,964th (with 1 being the most deprived) and is the 3rd local quintile which means that the population is less deprived than in neighbouring areas and experiences an average level of deprivation for Hartlepool.

Graph 3 : Deprivation in Hartlepool on super output area level by local quintile



Environment

The quality of the living environment of an area is measured by the quality of housing, road traffic accidents and air quality (PM 10, Nitrogen Dioxide, Sulphur Dioxide and Benzene) of an area. The living environment in the Headland of Hartlepool is ranked high in comparison with other areas in England which indicates a good quality of housing and air quality. The neighbouring area of Northsands ranks lower while Middleton/Cleveland Road ranks higher.

The air quality in the Headland is also rated as better than average the PM 10 indicator which measures particles (dust) in the air. The Headland has better scores for most indicators than the neighbouring areas.

Table 5: Living environment

	Rank of living environ-ment	Housing	Combined air quality	Nitrogen Dioxide	Particu-lates PM10	Sulphur dioxide	Benzene
	Rank*	Score**	Score**	Ratio***	Ratio***	Ratio***	Ratio***
Headland	24,641	0.25	0.96	0.7	0.45	0.11	0.03
North-sands area	17,149	0.25	1.06	0.44	0.47	0.11	0.04
Middleton /Cleveland Road	30,143	0.15	1.02	0.41	0.46	0.11	0.04

Source: Index of multiple Deprivation 2007

* Rank 1 is the most deprived and rank 32,482 is the least deprived LSOA in England

** A higher value implies poorer quality

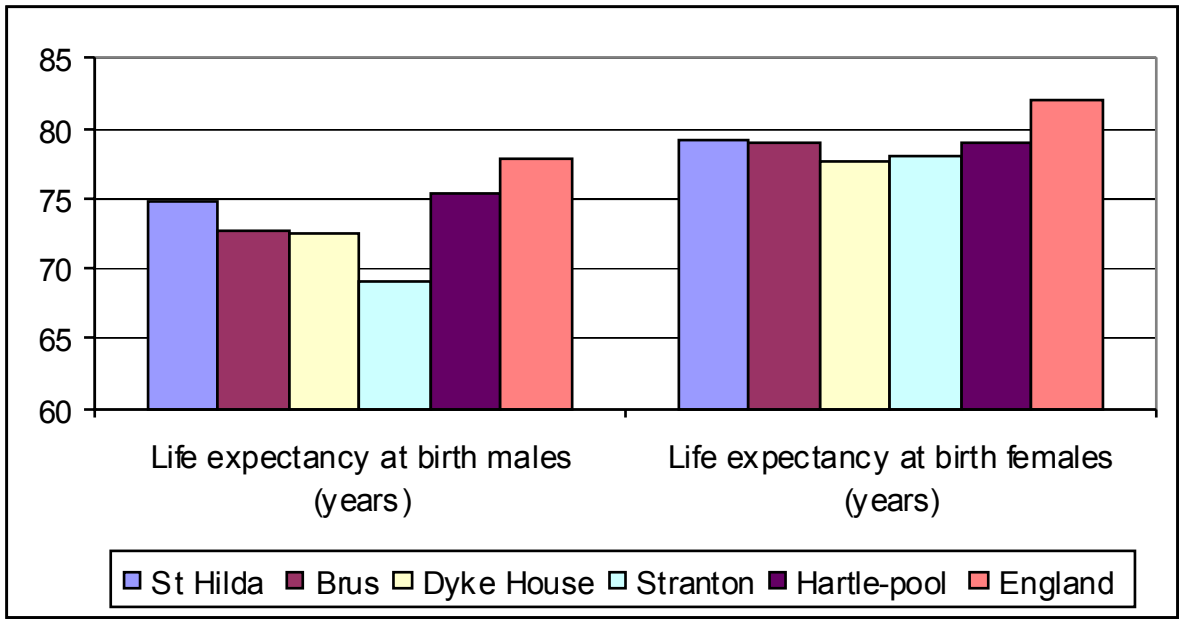
*** A ratio of less than 1 indicates that the area has lower values of pollution

4.3 Health Status

Life expectancy

Life expectancy for men and women in Hartlepool is lower than the English average. Life expectancy in the St Hilda ward is comparable to the Hartlepool average. There is no information for life expectancy on a smaller area level.

Graph 4: Life expectancy at birth by sex and wards



Source: ONS Neighbourhood Statistics

Table 6: Life expectancy

	Head-land	St Hilda	Brus	Dyke House	Stranton	Hartle-pool	England
Life expectancy at birth males (years)	n/a	74.8	72.7	72.5	69.0	75.3	77.9
Life expectancy at birth females (years)	n/a	79.1	78.9	77.7	78.1	79.0	82.0

Source: ONS Neighbourhood Statistics, 2006-2008

General health

The general health of the population can be demonstrated by how many people see themselves to be in good, fairly good or bad health and how many people suffer from a limiting long term illness. The population of the Headland of Hartlepool has a higher proportion of people in good health compared to the St. Hilda ward. The Headland population is comparable to the Hartlepool average but experiences poorer health than the England average.

Graph 5: General health by wards
Source: ONS Neighbourhood Statistics

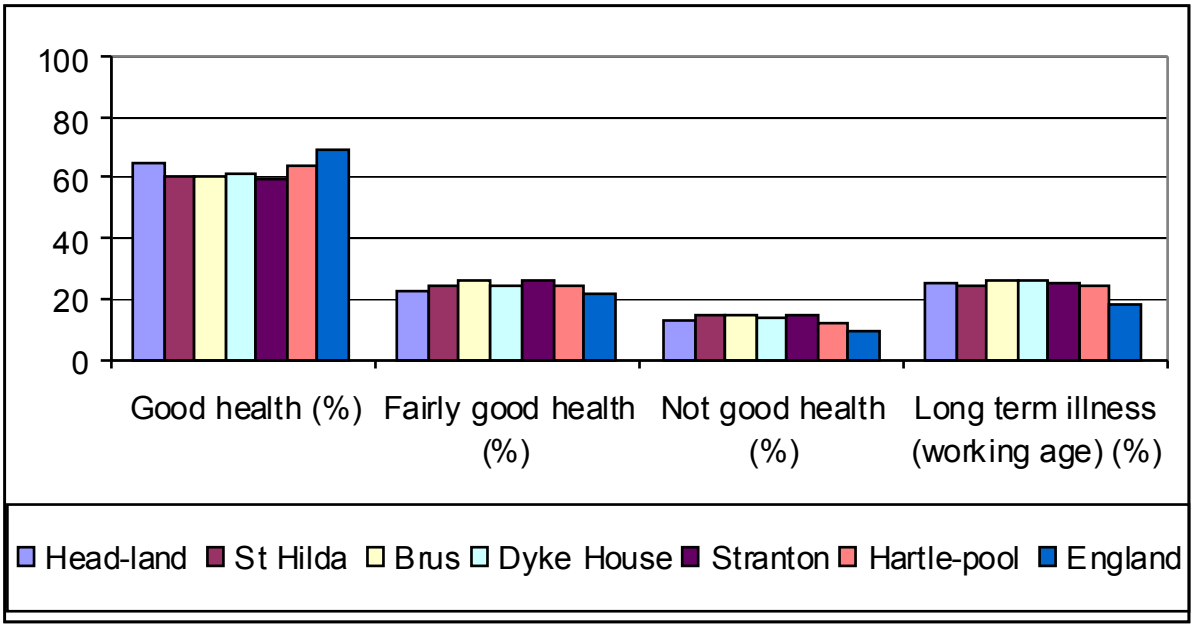


Table 7: General health

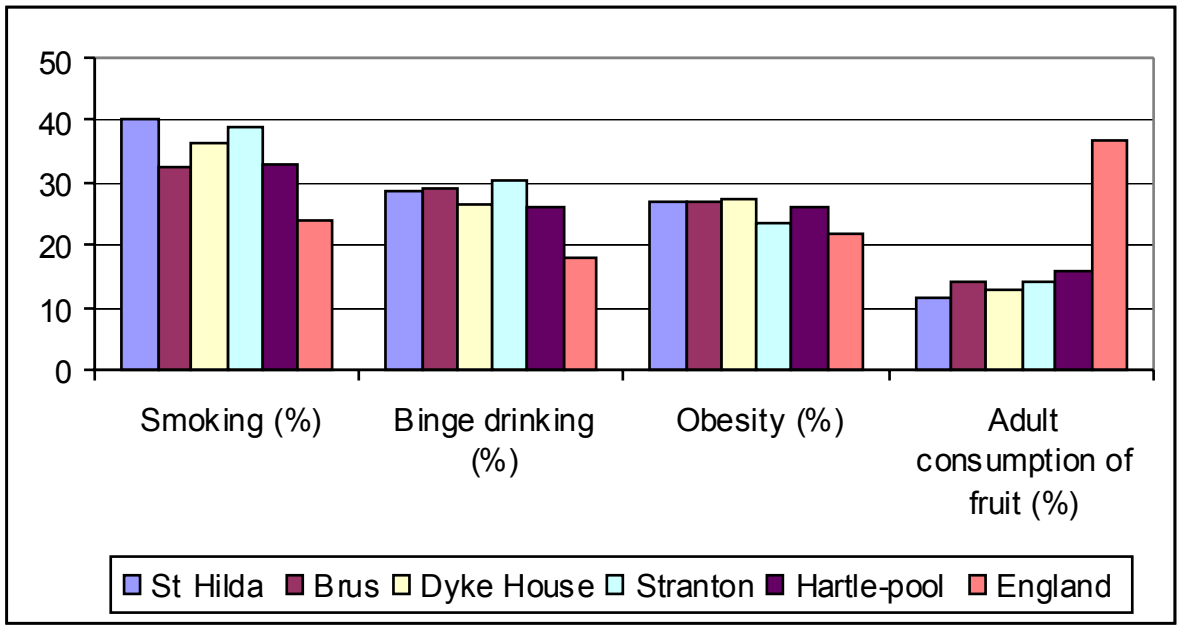
	Head-land	St Hilda	Brus	Dyke House	Stranton	Hartle-pool	England
Good health (%)	65	61	60	62	59	64	69
Fairly good health (%)	23	24	26	24	26	24	22
Not good health (%)	13	15	15	14	15	12	9
Long term illness (working age) (%)	25	24	26	26	25	24	18

Source: ONS Neighbourhood Statistics

Lifestyle behaviour

Lifestyle behaviour such as smoking, alcohol consumption and diet has an influence on health and well being but also on the development of diseases such as respiratory illnesses, cancer and cardio vascular disease. The synthetic estimates, which is the most detailed information available is based on national survey and local population information. The estimates for smoking, binge drinking, obesity and fruit consumption show that the population of Hartlepool more often smokes and binge drinks, has a higher proportion of obese people, and less often eats the recommended amount of fruit per day. This lifestyle behaviour is even more common in the St Hilda ward, where 40% of the population are estimated to smoke and 28.7% to binge drink. 27% are estimated to be obese and only 11.9% eat the recommended amount of fruit per day.

Graph 7: Lifestyle behaviours by ward



Source: based on information in JSU ward data 2003-05 synthetic estimates for healthy behaviour

Table 8: Lifestyles

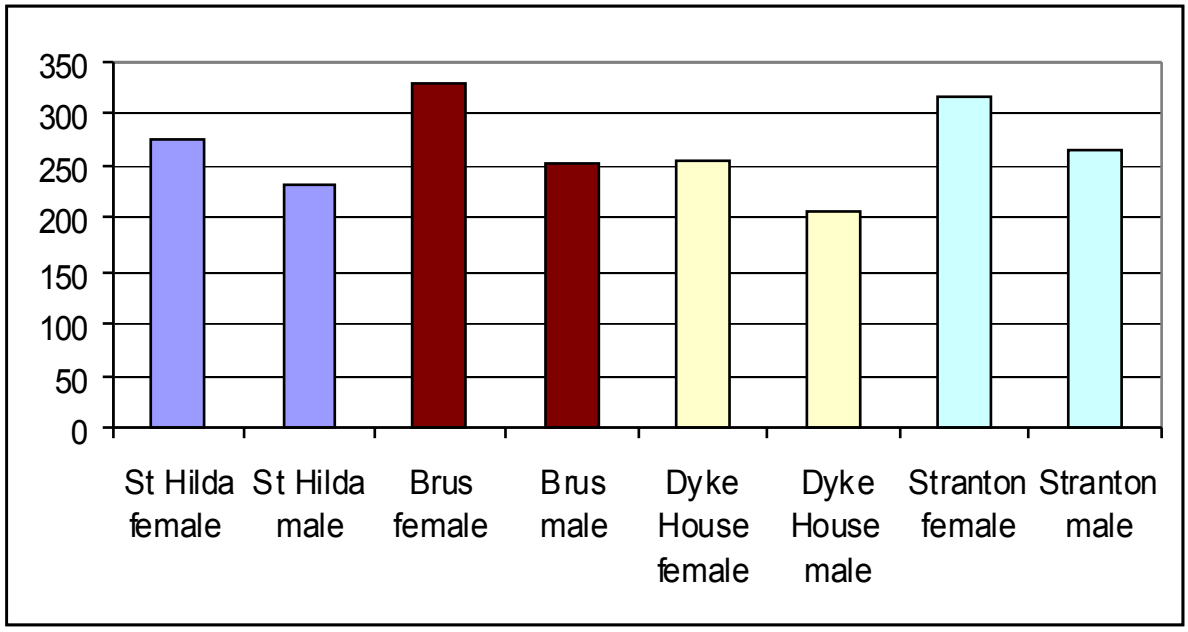
	Head-land	St Hilda	Brus	Dyke House	Stranton	Hartle-pool	England
Smoking (%)	-	40.3	32.6	36.5	38.8	33.2	24
Binge drinking (%)	-	28.7	29.2	26.8	30.5	26.3	18
Obesity (%)	-	27.0	27.1	27.6	23.6	26.2	22
Adult consumption of fruit (%)	-	11.9	14.2	12.8	14.0	15.8	37

Source: JSU ward data 2003-05 synthetic estimates for healthy behaviour, not available for LSOAs

Mental Health

Mental health and wellbeing is influenced by the socio- economic and physical environment. Common mental illness (formerly neurotic disease) such as anxiety, depression, phobias, obsessive- compulsive and panic disorders is widespread. On average 16% of adults between 16- 74 suffer from a common mental illness. Prevalence rates of common mental illness show that women in general are more susceptible to suffer from common mental illness. Compared with St Hilda prevalence rates are higher in Brus and Stranton and lower in Dyke House.

Graph 8: Common mental illness (n/1000) by sex and ward



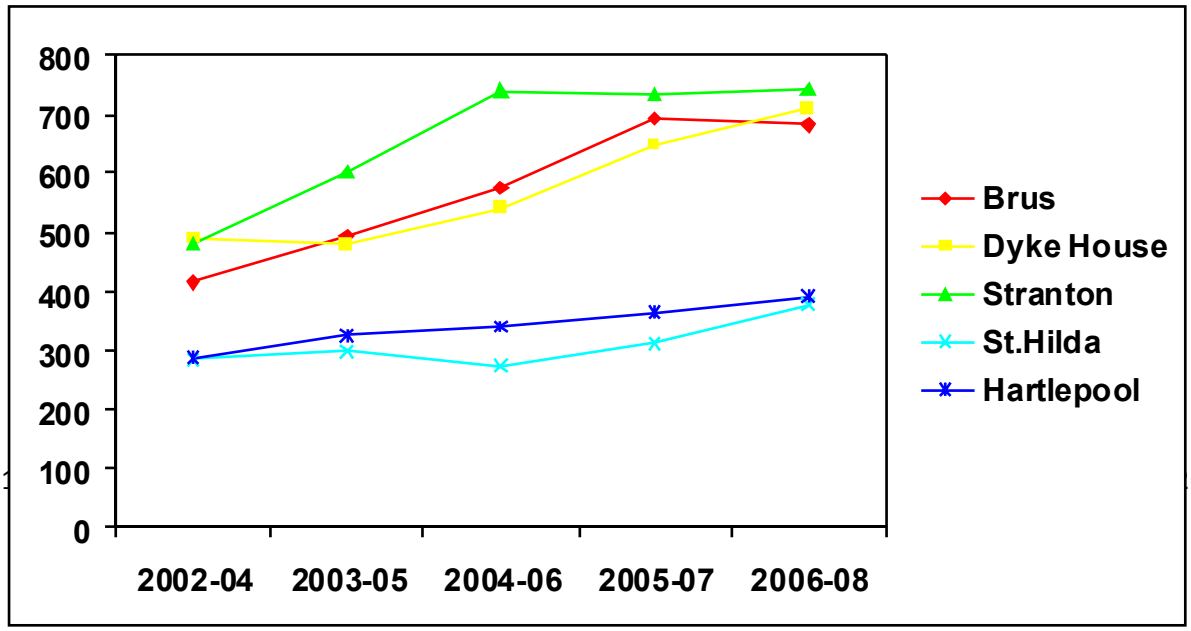
Source: based on information from NEPHO (2008) and NOMIS (2002)

Respiratory disease

Respiratory disease includes illness in the lower respiratory tract such as sore throats and sinusitis as well as the lower respiratory tract such as bronchitis, Emphysema, COPD and Asthma. Respiratory illness may be caused by infectious, chemical and physical agents or by allergic reactions. Symptoms range from sore throats and mild cough to severe symptoms with dyspnoea and high fever. Most respiratory tract disease can be treated in the community. However more severe cases of lower respiratory disease are admitted to the hospital.

The analysis of hospital admissions for lower respiratory tract disease shows less hospital admissions for the St Hilda ward compared to neighbouring wards for the years from 2002 to 2008. The rate of hospital admissions for patients from St Hilda was comparable or below the Hartlepool average.

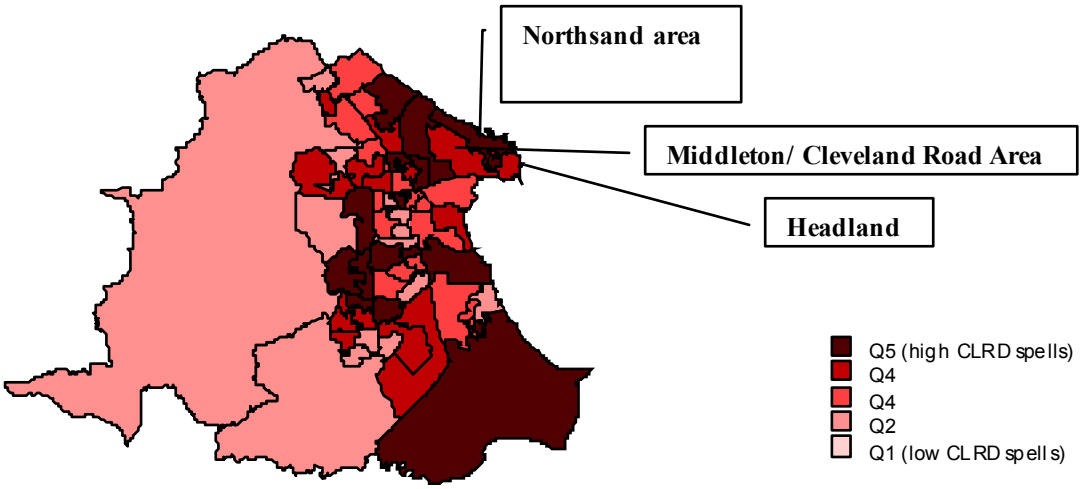
Graph 9: Directly age-standardised hospital admission rate per 100,000 for lower respiratory disease (J40-J45) in Hartlepool 2002-2008



Source: Hospital Episode Statistics/ Health Information NHS Tees

More detailed analysis of hospital admissions by smaller areas such as Lower Super Output Areas shows that the Headland is in the 4th quintile for Hartlepool, which means that the rate of hospital admissions for lower respiratory disease is higher than in 60% of Hartlepool. However hospital admissions in the Headland are similar or lower than neighbouring areas.

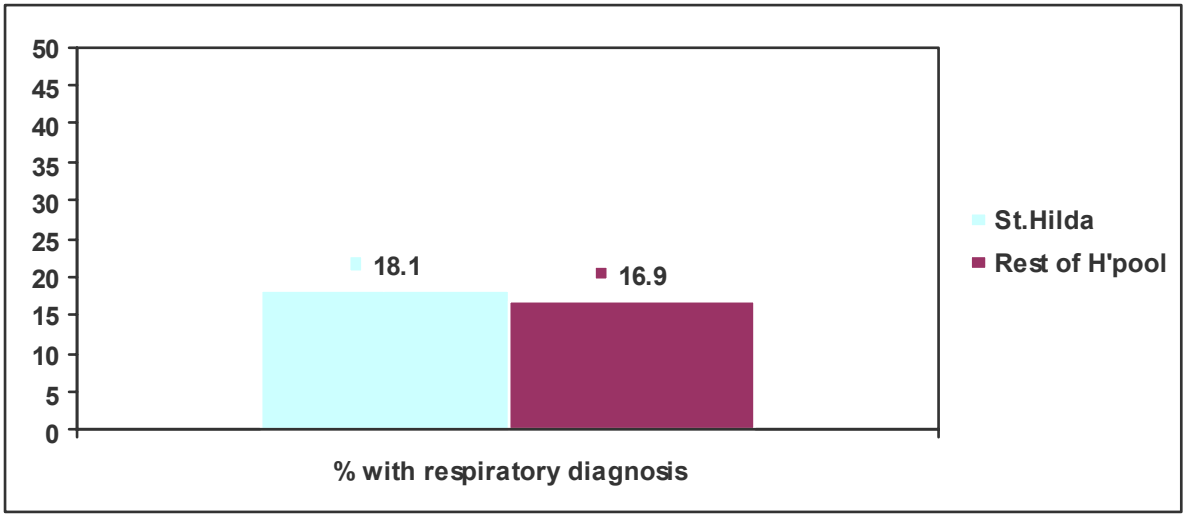
Graph 10: Directly age-standardised Chronic Lower Respiratory Disease spells /100,000 by LSOA and quintile



Source: 2004/5-2008/9 pooled data from Hospital Episode Statistics/ Health Information NHS Tees

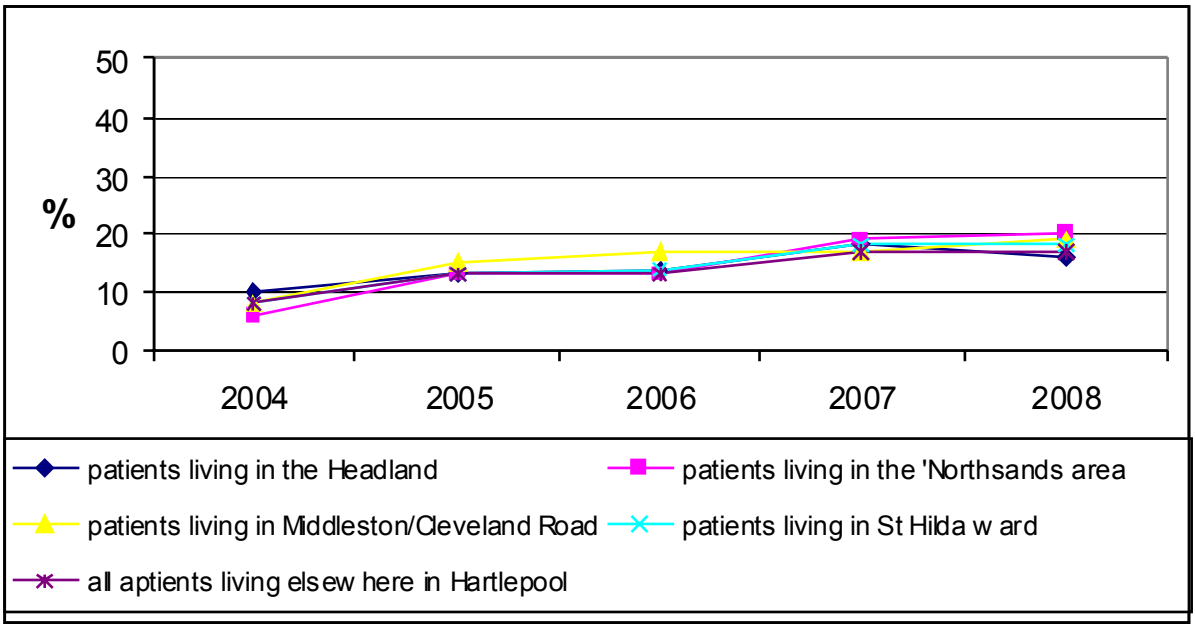
Information on respiratory disease including upper respiratory diseases seen in general practice (Headland Practice) shows that in 2008, 357(18.1%) out of 1972 patients living in St. Hilda have been diagnosed with respiratory illness compared to 708 (16.9%) out of 4191 patients registered with the practice who live in other areas of Hartlepool.

Graph 11: Prevalence rate of respiratory disease (all ages) in the Headland Practice in 2008
Source: Headland Practice/ Health Information NHS Tees, 2008



The proportion of patients diagnosed with respiratory disease has risen for all patients registered with the practice between 2004 and 2008. The increase has been slower in the Hartlepool Headland than elsewhere.

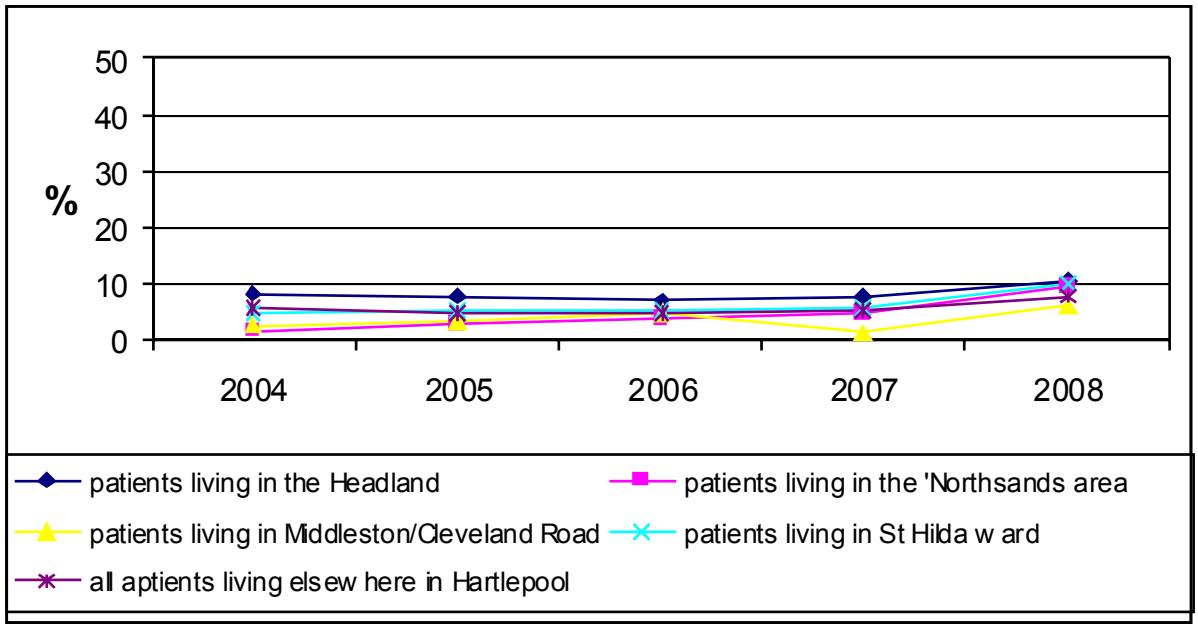
Graph 12: Prevalence rate of respiratory disease (all ages) in the Headland Practice 2004-2008



Source: Headland Practice/ Health Information NHS Tees

Respiratory disease in children and young people under 18 treated in the Headland practice needs to be interpreted with caution because of the small number of children on which this analysis is based. Initially prevalence of respiratory disease has been decreasing and subsequently increasing during the period 2004-2008. Prevalence rates for children living in the Hartlepool Headland have been higher compared to other areas.

Graph 13: Prevalence rate of respiratory disease (children and young people <18years) in the Headland Practice 2004-2008

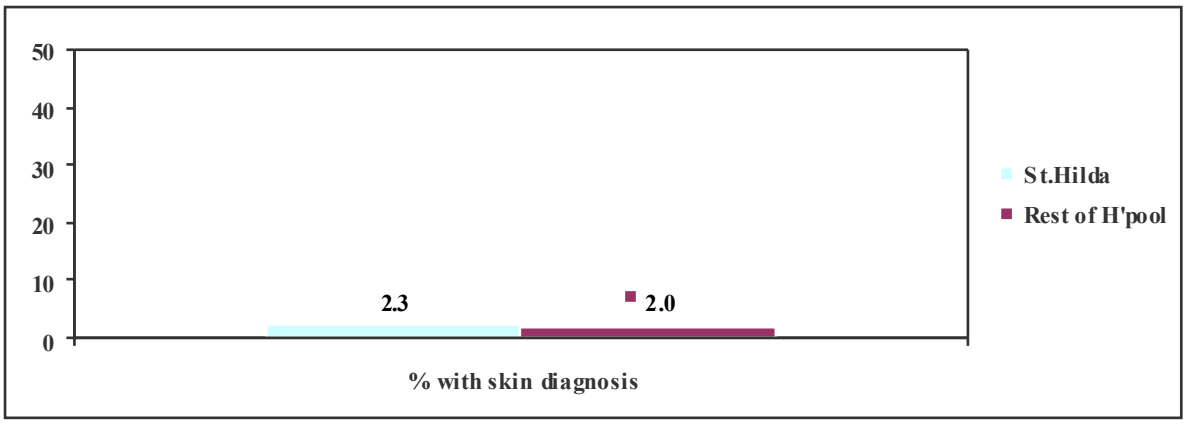


Source: Headland Practice/ Health Information NHS Tees

Skin disease

Information on skin disease in general practice (Headland Practice) shows a comparable prevalence between patients living in St Hilda and elsewhere in Hartlepool. In 2008 45(2.3%) out of 1972 patients living in St Hilda are suffering from skin diseases such as dermatitis or eczema. In comparison 84 (2.0%) out of the 4191 patients of the practice living in other areas of Hartlepool have been diagnosed with a skin condition.

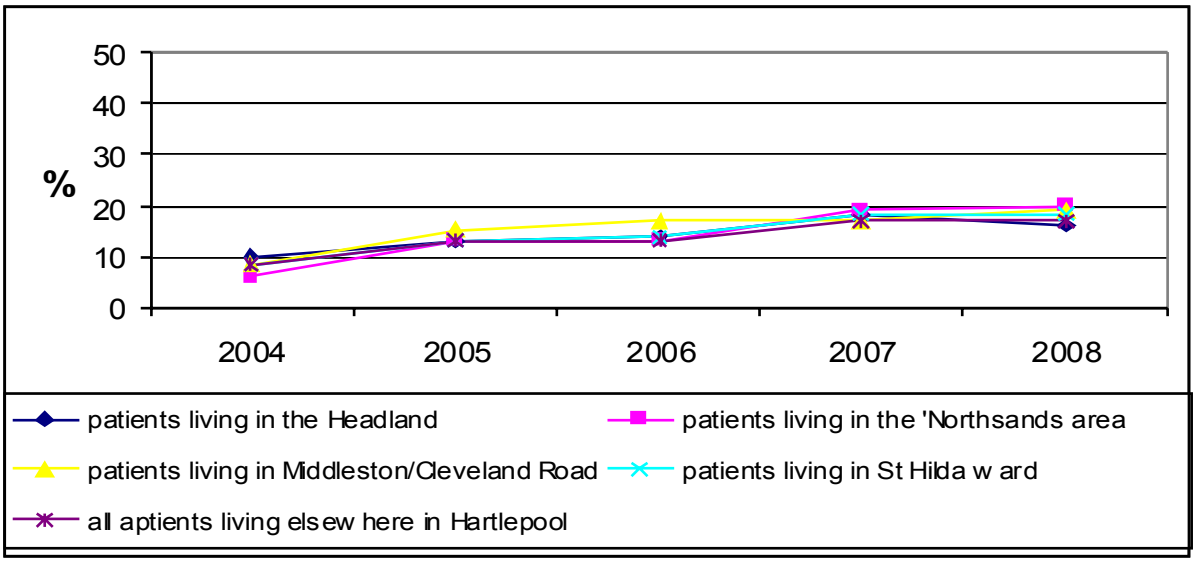
Graph 14: Prevalence rate of skin disease in the Headland Practice population 2008



Source: Headland Practice/ Health Information NHS Tees

The prevalence of skin disease has increased between 2004 and 2008. The increase has been steeper between 2004 and 2005. Prevalence rates for the Headland have increased from an initial lower level to a similar level as patient living in the Northsand area and patients living elsewhere in Hartlepool.

Graph 15: Prevalence rate of skin disease in the Headland Practice 2004-2008



Source: Headland Practice/ Health Information NHS Tees

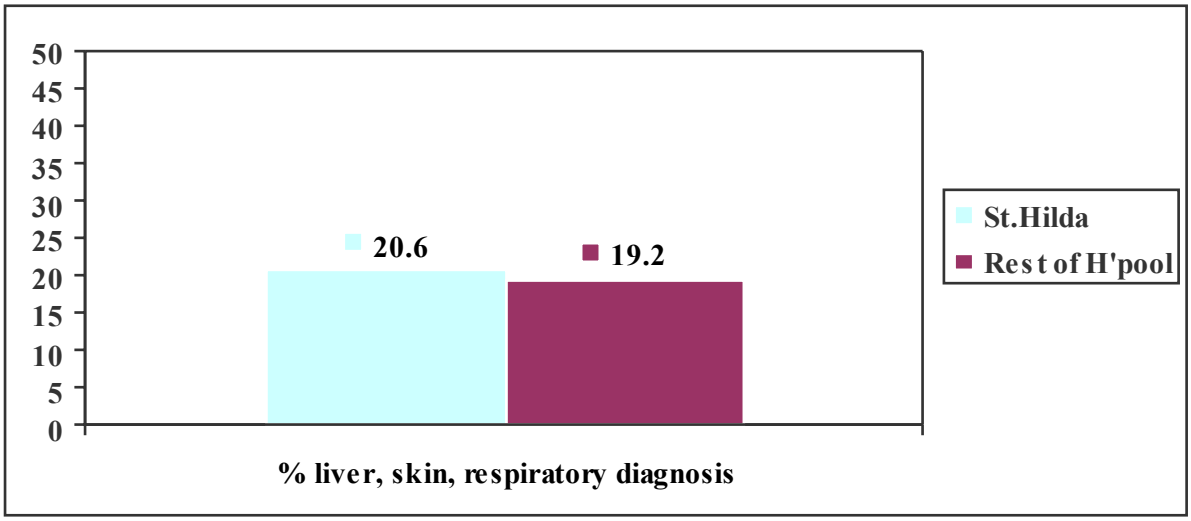
Liver disease

Liver disease not related to alcohol is relatively rare. In the years from 2004 to 2009 there were between 2 and 11 cases diagnosed with non alcohol related liver disease among all patients of the Headland practice.

Respiratory, skin and liver disease

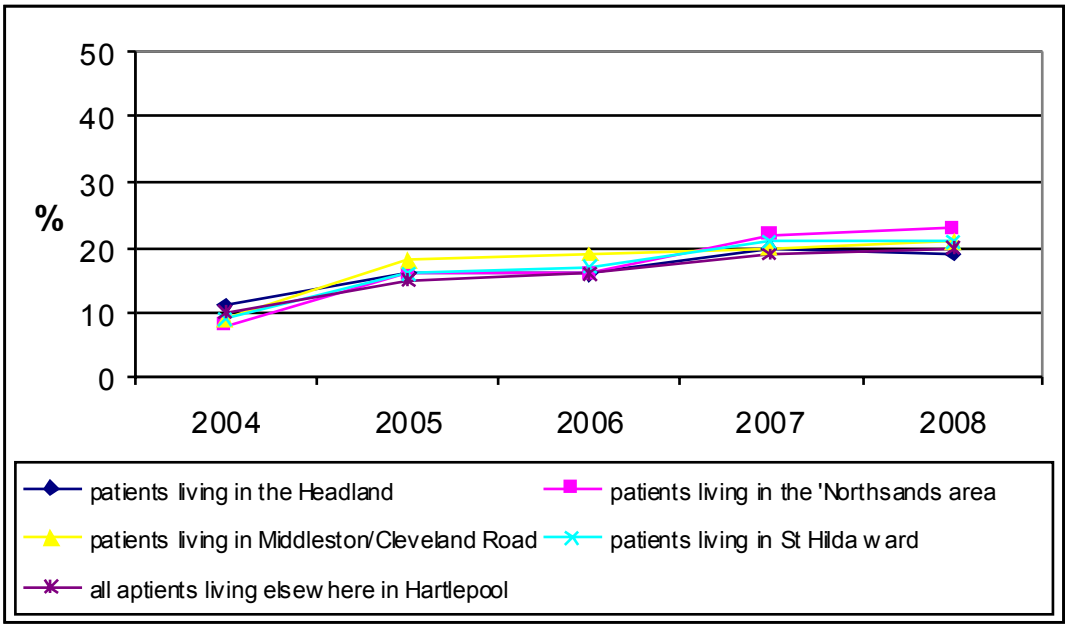
403 (20.6%) out of 1972 patients registered with the St. Hilda's practice in 2008 are suffering from either respiratory (18.1%), skin (2.3%) or liver disease compared to 800 (19.2%) out of 4191 patients of the practice living in other areas of Hartlepool.

Graph 16: Prevalence rate of respiratory, skin and/or liver disease in the Headland Practice population 2008
Source: Headland Practice/ Health Information NHS Tees



The prevalence of respiratory, skin and liver disease (combined) has increased between 2004 and 2008 in patients living in the Headland, the St Hilda ward and elsewhere in Hartlepool.

Graph 17: Prevalence rate of respiratory, skin and liver disease in the Headland Practice 2004-08



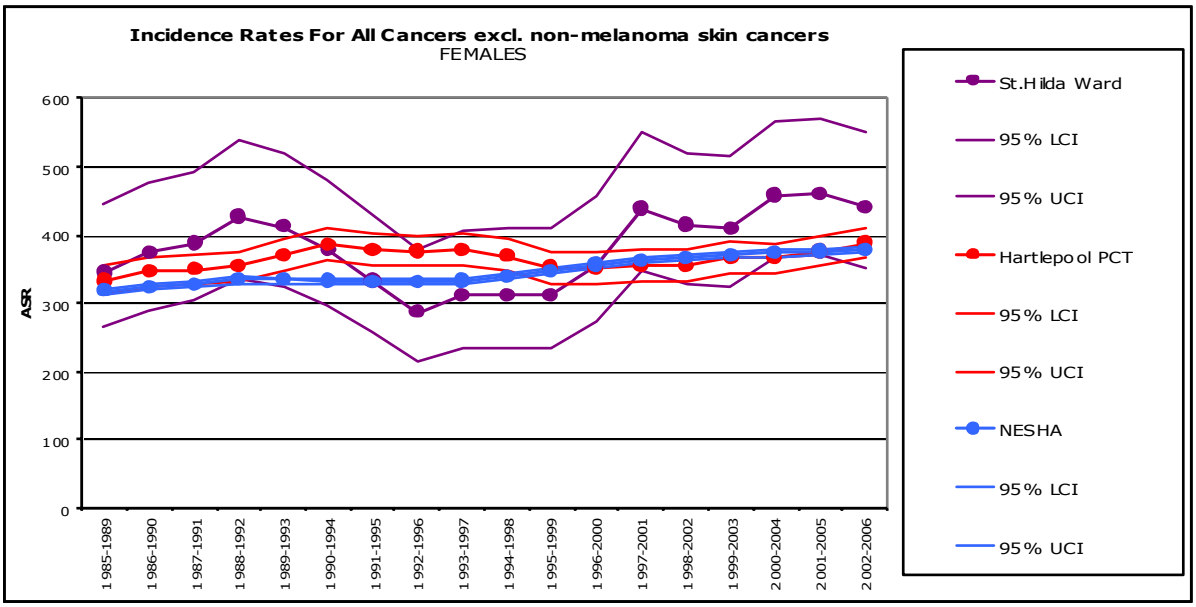
Source: Headland Practice/ Health Information NHS Tees

Cancer

The incidence and mortality of all cancers (with the exception of non-melanoma skin cancers) and in particular of lung cancer for women and men is shown for the years 1985 to 2006.

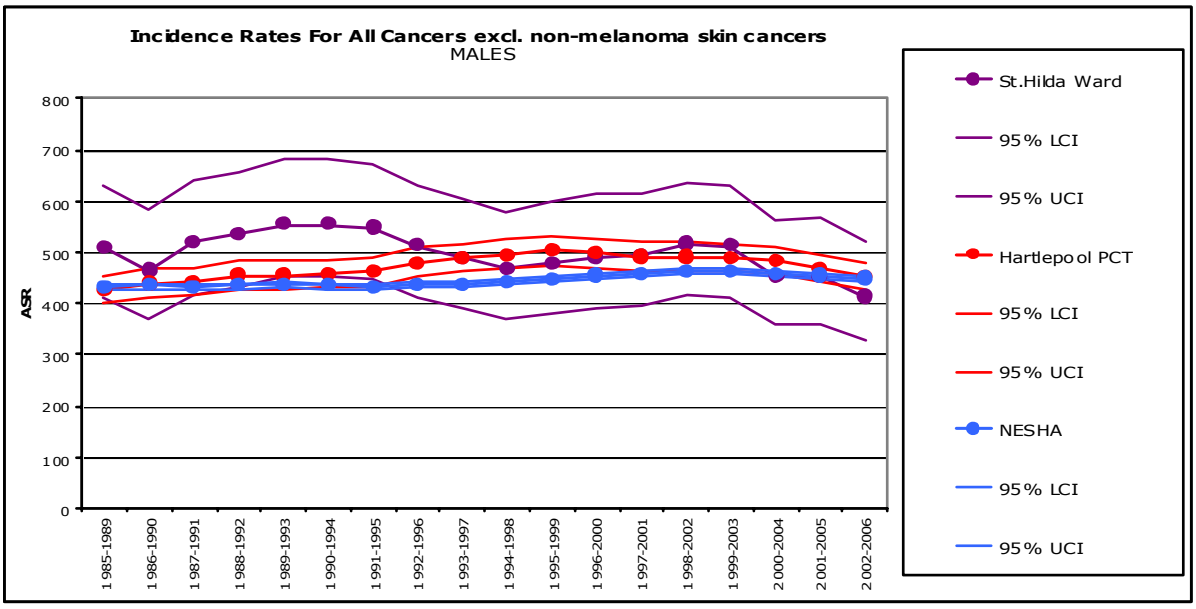
Cancer incidence has been rising for women and remained stable for men in the North East.
Cancer incidence in Hartlepool has been higher for many years but is similar to the North East in 2003-2006. Cancer incidence in St Hilda appears higher, especially in women, but the confidence intervals show no significant difference.

Graph 18: Cancer incidence (age standardised rate) for all cancers in women in St Hilda



Source: NYCRIS (Northern and Yorkshire Cancer Registry and Information Service)

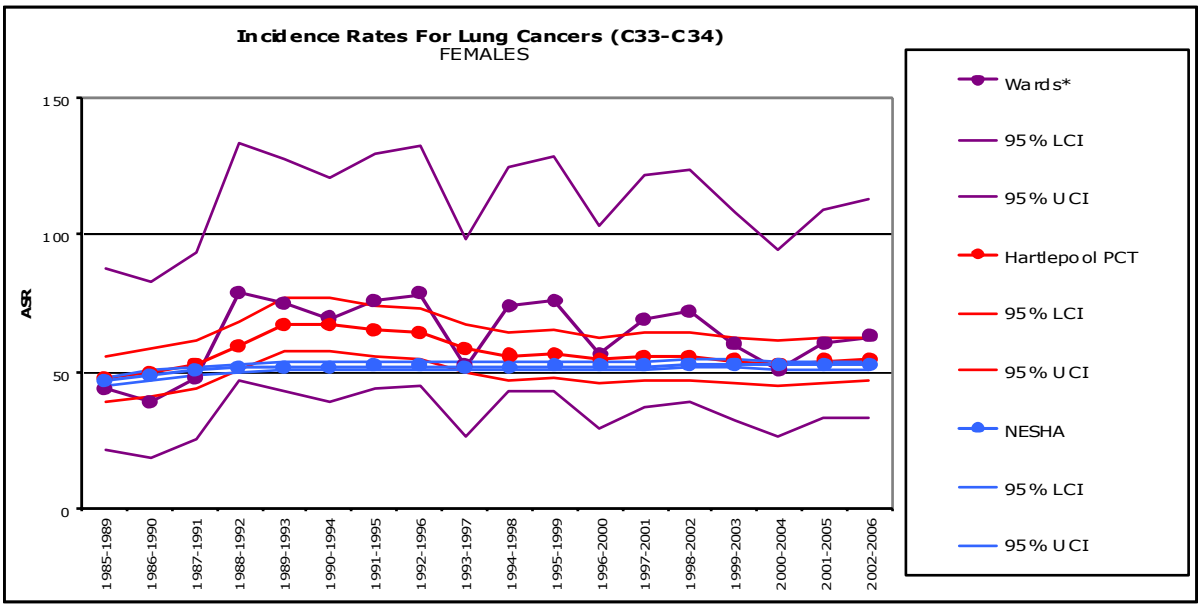
Graph 19: Cancer incidence (age standardised rate) for all cancers in men in St Hilda



Source: NYCRIS (Northern and Yorkshire Cancer Registry and Information Service)

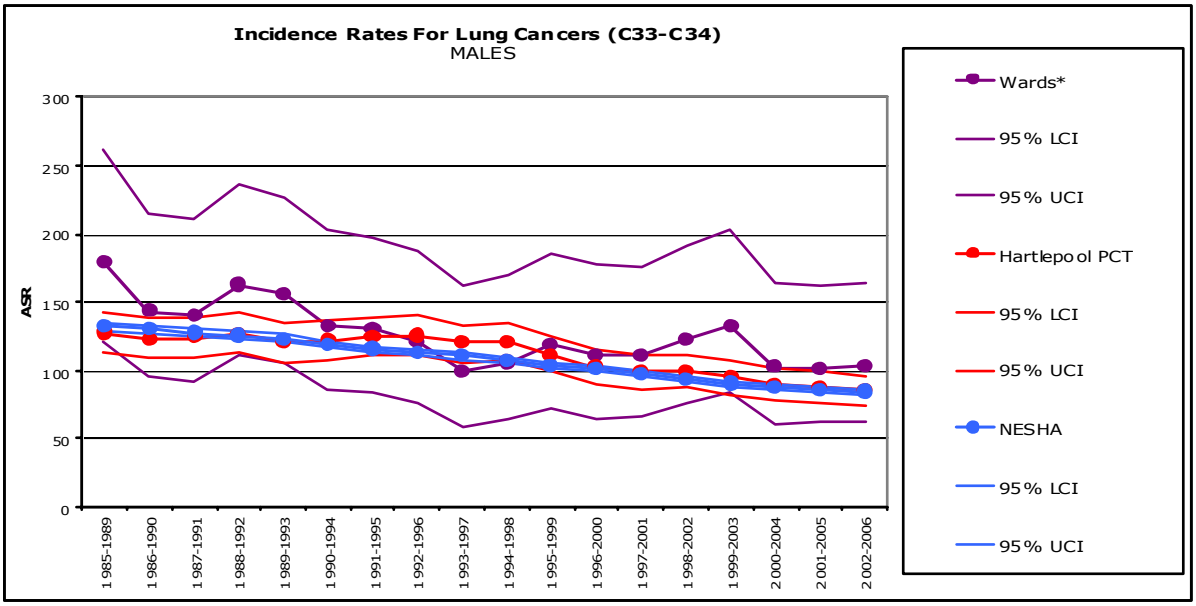
The incidence of lung cancer in St Hilda, Hartlepool and the North East has increased slightly for women and decreased notably for men. Lung cancer incidence for women in Hartlepool has been higher in the mid-1990s but is now similar to the incidence in the North East for both men and women. Lung cancer incidence appears higher in St Hilda for both women and men but the confidence intervals show no significant difference.

Graph 20: Lung cancer incidence (age standardised rate) in women in St Hilda



Source: NYCRIS (Northern and Yorkshire Cancer Registry and Information Service)

Graph 21: Lung cancer incidence (age standardised rate) in men in St Hilda



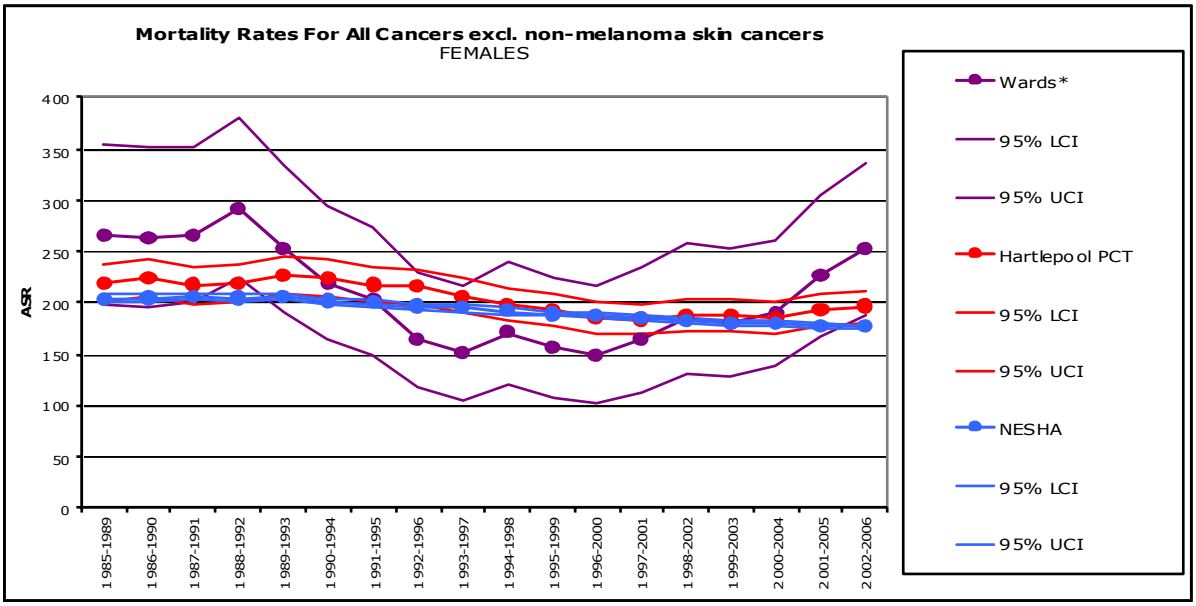
Source: NYCRIS (Northern and Yorkshire Cancer Registry and Information Service)

Cancer mortality

Cancer mortality has been declining in the North East for both men and women, but more markedly for men. Cancer mortality in Hartlepool has been declining but is higher than the cancer mortality in the North East for both men and women in 2003-2006. Cancer mortality in Hartlepool has been significantly higher for men since 1992. In St Hilda cancer mortality has been declining for men and is similar to the mortality in the North East and Hartlepool. Cancer mortality for women in St Hilda

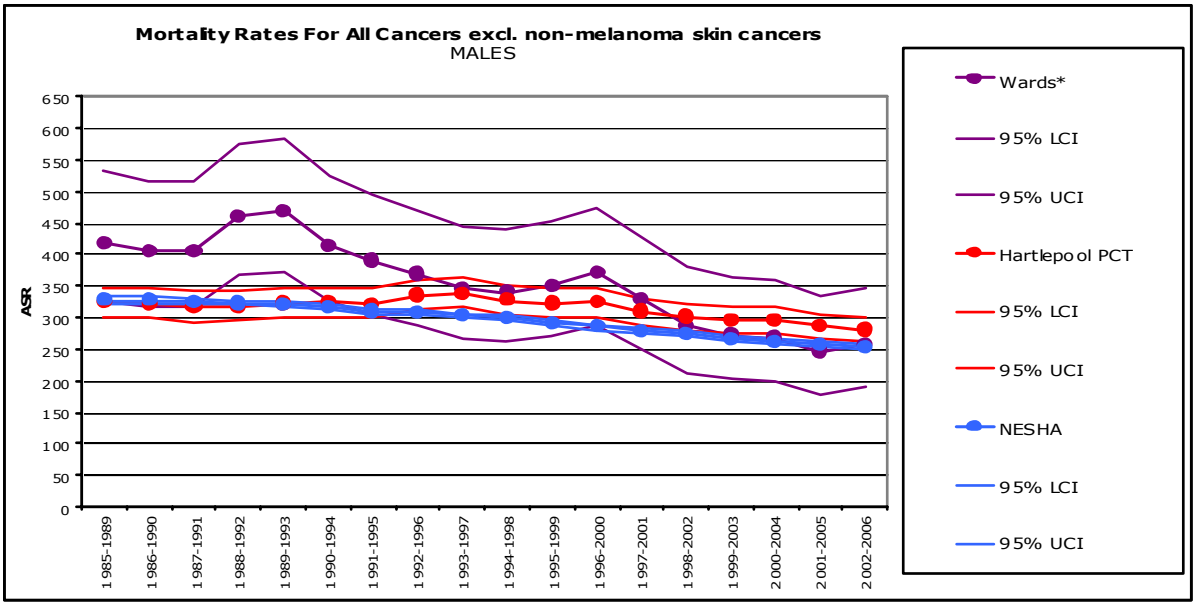
has declined between 1985 and 1997 but increased since 1997. In 2003-2006 mortality has been significantly higher than in the North East, but similar to Hartlepool.

Graph 23: Cancer mortality (age standardised rate) for all cancers in women in St Hilda



Source: NYCRIS (Northern and Yorkshire Cancer Registry and Information Service)

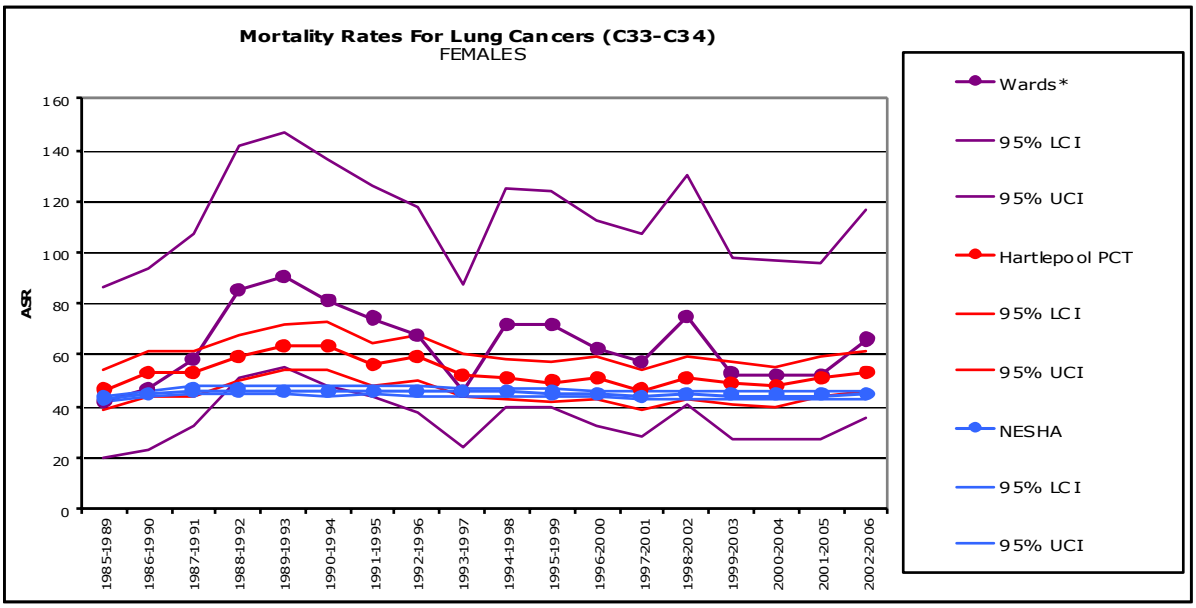
Graph 24: Cancer mortality (age standardised rate) for all cancers in women in St Hilda



Source: NYCRIS (Northern and Yorkshire Cancer Registry and Information Service)

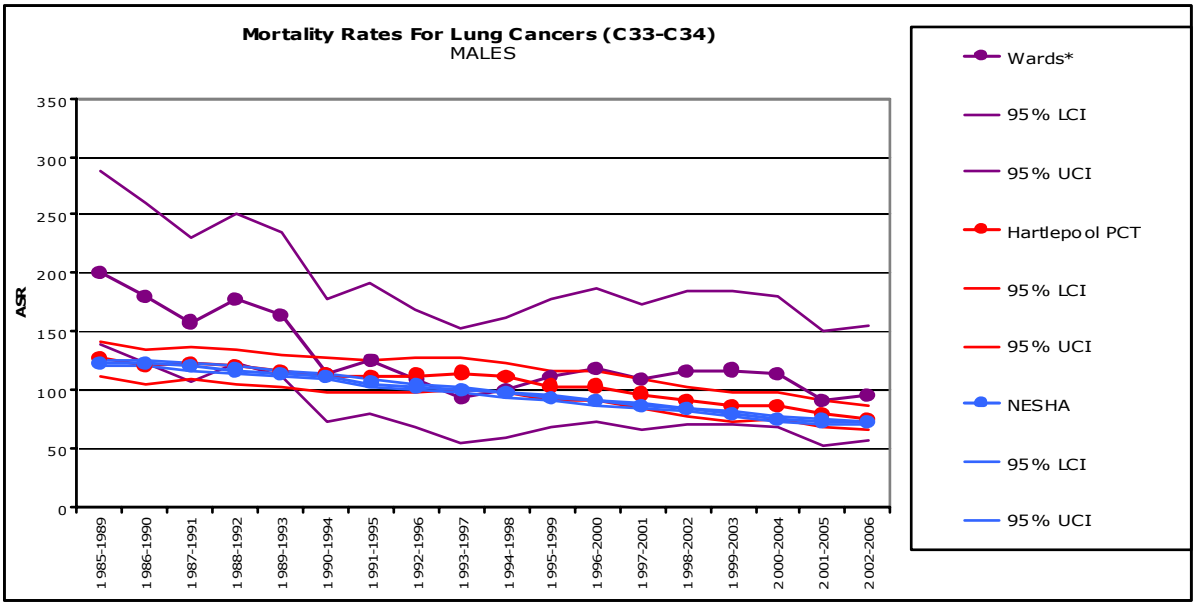
Lung cancer mortality in Hartlepool and the North East has remained the same for women and has declined for men between 1985 and 2006. Lung cancer mortality in St Hilda over the same period appears to have decreased in men and rising and falling in women, but the confidence intervals show no significant difference to the North East and Hartlepool.

Graph 25: Lung cancer mortality (age standardised rate) in women in St Hilda



Source: NYCRIS (Northern and Yorkshire Cancer Registry and Information Service)

Graph 26: Lung cancer mortality (age standardised rate) in men in St Hilda



Source: NYCRIS (Northern and Yorkshire Cancer Registry and Information Service)

Asbestos related disease

Mesothelioma deaths in Great Britain have been increasing in the last 30 years. The areas with the highest mortality are West Dunbartonshire (SMR 537), Barrow in Furness (SMR 540) and Plymouth (341). Hartlepool has a SMR of 240 and is the 16th most affected area in the UK.

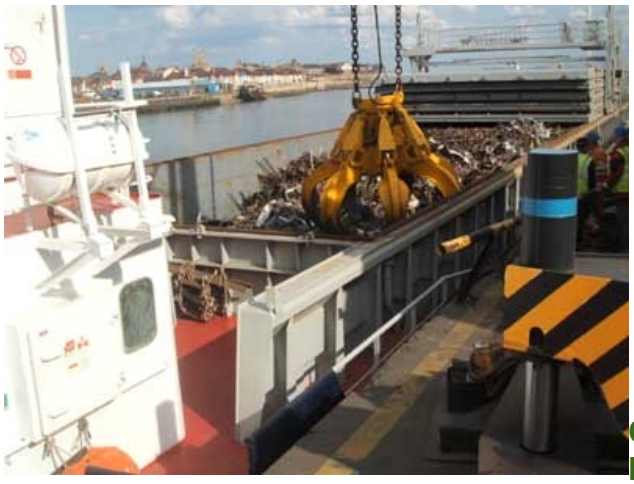
Table 9: Mesothelioma mortality: number of deaths and SMR for males by area 1981-2005				
Area	**Deaths (1981-2005)**	**SMR**	**95%CI upper and lower**	
Great Britain	25716	100	99	101
England	22166	100	99	102
North East	2087	177	169	184
Hartlepool	***97***	***240***	***195***	***293***
Middlesbrough	82	140	111	173
Redcar and Cleveland	108	167	137	201
Stockton	154	211	179	247
Easington	36	78	55	108

Since 1981 the absolute number of death from mesothelioma has increased approximately fourfold in Great Britain as well as in Hartlepool. The SMR for Hartlepool has increased during the period indicating a steeper increase in mortality over the same period.

Table 10: Mesothelioma number of deaths and SMR for males and five year time periods 1981-2005										
Area	**1981-1985**		**1986-1990**		**1991-1995**		**1996-2000**		**2001-2005**	
	Deaths	**SMR**	**Deaths**	**SMR**	**Deaths**	**SMR**	**Deaths**	**SMR**	**Deaths**	**SMR**
Great Britain	2356	100	3619	100	5066	100	6478	100	8197	100
England	2033	100	3078	99	4322	99	5606	101	7127	101
North East	241	216	317	187	427	182	500	169	602	162
Hartlepool	7	180	15	260	23	286	22	218	30	235
Middlesbrough	6	105	17	198	17	146	18	122	24	132
Redcar and Cleveland	15	257	15	164	22	169	25	150	31	145
Stockton	15	257	15	164	22	169	25	150	31	145
Easington	3	67	2	76	8	87	8	70	12	84

5. Appendix

envoy case study



Case study - Environmental Nuisance Particulates

Van Dalen Recycling Ltd operate a export terminal for metal wastes in Hartlepool, part of a larger, busy, port facility. After reviewing a number of complaints in resident liaison meeting, the company felt that they should appoint an independent consultant to examine the issues and proactively engage with local regulators and the public to explore the concerns. Envoy was appointed and our work revealed some surprising issues.

What did we offer?

- Air Monitoring, Analysis and Regulator/Public Liaison

Envoy attended group liaison meetings with regulatory bodies, the Port Authority and local residents. The concerns related to ship-loading activities in particular and deposits of particulates noted by the residents. Concerns were expressed about potential health impacts to local residents. The company had proactively introduced suppression techniques, but questions about their effectiveness were still evident.

Envoy developed a monitoring strategy that would seek to directly measure the particulates emitted at the source using pump samplers and multi-fraction particulate cyclone sampling heads. This strategy was reviewed and agreed in the liaison


envoy report

REPORT NUMBER: 08-1072.02

DUST AND PARTICULATE MONITORING
SCRAP METAL LOADING OF 'BLUE BAY' – 2ND MAY 2008

ON BEHALF OF

VAN DALEN (HARTLEPOOL) LTD, IRVINES QUAY, HARTLEPOOL, TS24 0UZ.

Report Prepared by:
Envoy
12 Cherry Hills, Darton, Barnsley, South Yorkshire, S75 5NZ

meeting by all parties before implementation. In addition, Envoy agreed to perform analysis on samples collected by residents that had been deposited on surfaces.

Sampling of the loading event was extensive, with particulate grading and subsequent chemical and mineral analysis. The results were released to all parties and a subsequent liaison meeting allowed all parties to discuss the report and pose questions to the Envoy consultant. The exercise demonstrated relatively low levels of particulates during loading (much lower than statutory controls), but also demonstrated that the nature of the particles released was significantly different than those collected by the residents. The actual source was traced to a nearby port facility handling mineral sands.

Lessons Learned

Van Dalen acted proactively and engaged with the Public during the process. When commissioning Envoy they requested that we deal directly with the parties involved to increase confidence in the process. The result demonstrates the difficulty in assigning responsibility for nuisance events in complex industrial surroundings.

5. References

[1] Aluminium Production, IARC vol 34, 1984

[2] Haematide and Ferric oxide. IARC Monographs Supplement 7, 1987

[3] Titanium Dioxide, monograph, IARC 2006

[4] Public Health Statement Zinc, Cas 7440-66-6, ATSDR, 2005

[5] Environmental Protection Agency. PM 10 Fact Sheet.2007. www. Epa.gov/wtc/pm10/pm_fact_sheet.html

[6] Asbestos related disease. Health and Safety Executive. 2009
http://www.hse.gov.uk/statistics/causdis/asbestos.htm

HEALTH SCRUTINY FORUM

1 February 2011

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Support Officer

Subject: NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST – QUALITY ACCOUNT 2011/12 – COVERING REPORT

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1. PURPOSE OF REPORT

1.1 To introduce representatives from North Tees and Hartlepool NHS Foundation Trust who will be in attendance at today's meeting to discuss the Trust's Quality Account for 2011/12.

2. BACKGROUND INFORMATION

2.1 In November 2009 the Government published the Health Bill which required all providers of NHS healthcare services to provide an annual Quality Account, initially by the end of April 2010.

2.2 Members of the Health Scrutiny Forum met on 12 October 2010 where initial discussions were held in relation to the North Tees and Hartlepool NHS Foundation Trust's Quality Account for 2011/12.

2.3 At the meeting of the Health Scrutiny Forum on 12 October 2010, the Director of Nursing and Patient Safety at North Tees and Hartlepool NHS Foundation Trust agreed to provide Members with the opportunity to comment on the final Quality Account when it was produced in early 2011.

2.4 Subsequently, the Director of Nursing and Patient Safety at North Tees and Hartlepool NHS Foundation Trust will be present at today's meeting to provide a presentation in relation to North Tees and Hartlepool NHS Foundation Trust's Quality Account for 2011/12.

3. RECOMMENDATIONS

3.1 That Members:-

(i) Note the content of this report and the presentation, seeking clarification on any issues from the representatives from North Tees and Hartlepool NHS Foundation Trust present at today's meeting; and

(ii) Formulate a response from the Health Scrutiny Forum to be included in the North Tees and Hartlepool NHS Foundation Trust's Quality Account for 2011/12.

Contact Officer:- James Walsh – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
Tel: 01429 523647
Email: james.walsh@hartlepool.gov.uk

BACKGROUND PAPERS

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

(a) Minutes of the meeting of the Health Scrutiny Forum held on 12 October 2010.

HEALTH SCRUTINY FORUM

1 February 2011

Report of: Scrutiny Support Officer

Subject: SCRUTINY INVESTIGATION INTO CONNECTED CARE – SETTING THE SCENE - COVERING REPORT

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1. PURPOSE OF REPORT

1.1 To inform Members that representatives from the Connected Care Project in Hartlepool have been invited to attend this meeting to provide evidence in relation to the investigation into 'Connected Care'.

2. BACKGROUND INFORMATION

2.1 Members will recall that at the meeting of this Forum on 23 November 2010, the Terms of Reference and Potential Areas of Inquiry / Sources of Evidence for the scrutiny investigation into 'Connected Care' were approved by the Forum.

2.2 Consequently representatives from the Connected Care Project have agreed to attend this meeting to provide a presentation to outline the development, current delivery model and impact of Connected Care in Hartlepool.

3. RECOMMENDATION

3.1 It is recommended that Members note the content of this report and the presentation under 7.3(b) on the meeting agenda, seeking clarification on any issues from the representatives from the Connected Care Project in Hartlepool present at today's meeting.

Contact Officer:- James Walsh – Scrutiny Support Officer
Chief Executive's Department – Corporate Strategy
Hartlepool Borough Council
Tel: 01429 523647
e-mail: james.walsh@hartlepool.gov.uk

BACKGROUND PAPERS

The following background papers were used in the preparation of this report:-

(i) Report of the Scrutiny Support Officer entitled 'Scrutiny Investigation into Connected Care – Scoping Report' Presented to the Health Scrutiny Forum on 23 November 2010.

(ii) Minutes of the Health Scrutiny Forum held on 23 November 2010.

HEALTH SCRUTINY FORUM

1 February 2011

Report of: Scrutiny Support Officer

Subject: TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE UPDATE

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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 update provided at the meeting of the Health Scrutiny Forum on 23 November 2010.

2. BACKGROUND INFORMATION

2.1 A summary is provided below of the issues discussed at a 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 Scrutiny Joint Committee representatives who are present at today's meeting:-

2.2 The Tees Valley Health Scrutiny Joint Committee met on 13 December 2010 when the following issues were discussed:-

(i) Child and Adolescent Mental Health Services (CAMHS) – Learning Disability – Short Break Service for Tees

Members were presented with details to relocate services for CAMHS from their current locations at Piperknowle, Stockton and 179 Normanby Road, South Bank to a single proposed site as part of the buildings already partly utilised at Roseberry Park. Although this would effectively reduce the number of beds, in real terms more beds would be available due to the current inaccessibility of some beds at the current existing sites.

(ii) Electronic Paper Report Form – North East Ambulance Service (NEAS)
Members of the Committee received a detailed presentation from NEAS on the Electronic Paper Report Form (ePRF) which was being phased in to replace the current paper based system. The ePRF would enable ambulance crews to provide 'real time' information to hospitals of the current health statistics of the patient, as well as record what medical intervention or treatment had taken place. Members were informed that if the system electronically failed, then paper based reporting was available on-board ambulances, as currently utilised. NEAS highlighted that this system was the first in the country to be rolled out to all ambulance crews and had garnered interested from other ambulance trusts in the UK as well as overseas.

2.3 The Tees Valley Health Scrutiny Joint Committee also met on 17 January 2011 when the following issues were discussed:-

(i) The Capacity of Community Mental Health Services – Further Evidence from Tees, Esk and Wear Valley NHS Trust (TEWV)
The Joint Committee as part of its continued investigation into Mental Health Services across the Tees Valley, received further information from TEWV to questions raised by Members in previous meetings. Although Members were pleased that people with mental health problems were having reduced stays in Hospital and within community facilities, there was some concern about the increased workload on community support workers and the Crisis Team.

(ii) Changes to Ambulance National Targets
Members of the Committee were briefed by representatives from NEAS about the changes proposed by the Government to ambulance national targets. Members were informed that for Category B (serious, but not immediately life threatening) calls the 19 minute response time was being scrapped, but that emphasis was now clinical quality indicators, which were aimed at improving treatment and the overall patient experience.

(iii) Out of Hours Service – Information Request
Members received written information in relation to a recent concern raised about the changes to Out of Hours Service and accessibility to the service for patients in disadvantaged groups. Northern Doctors who are currently commissioned to deliver the Out of Hours Service, provided reassurance of the level of training provided to call handlers. It was noted by the Committee that Hartlepool was currently the first area in the Tees Valley for a full roll-out of the Out of Hours Service and it was suggested that an update be provided to the Committee out once that roll-out was complete.

(iv) Recent Policy Publications from the Department of Health
The TVHSJC considered the publication of recent documents by the Department of Health on Public Health and a response to the recent white paper consultation on the future of the NHS. Members were pleased to hear that the Department of Health had retracted their original thoughts to subsume statutory health scrutiny powers into the Health and Wellbeing Boards. The Department of Health had agreed with consultation responses and concluded that it was more appropriate to hand those powers directly to local authorities.

3. RECOMMENDATION

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

Contact Officer:- James Walsh – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
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BACKGROUND PAPERS

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