HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL BOROUGH COUNCIL

Tuesday, 29 March 2011

at 3.00 pm

in 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, Norma Morrish and Linda Shields

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 1 March 2011.

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 External Review of Hartlepool Accident and Emergency Services – *Scrutiny Support Officer*

Scrutiny Investigation into Connected Care

7.2 Additional Evidence from Hartlepool Carers – *Scrutiny Support Officer*

7.3 Evidence from Focus Group – *Scrutiny Support Officer*

7.4 Draft Final Report – Connected Care – *Scrutiny Support Officer*

7.5 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 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: To Be Arranged.

HEALTH SCRUTINY FORUM

MINUTES

1 March 2011

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

Present:

Councillor: Stephen Akers-Belcher (In the Chair)

Councillors: Mary Fleet, Sheila Griffin, Alison Lilley, Geoff Lilley and Chris Simmons.

In accordance with Council Procedure Rule 4.2 (ii), Councillor Ray Wells was in attendance as substitute for Councillor Chris McKenna.

Resident Representatives:
Norma Morrish and Linda Shields

Also Present: Councillor Christopher Akers-Belcher
Kevin Cranney and Marjorie James, OFCA
Angie Wilcox, Manor Residents' Association
Helen Iveson, Housing Hartlepool
Elizabeth Carroll, Intrahealth
Richard Harrety, Commissioning Manager, NHS Tees
Deborah Gibbin, Teenage Pregnancy Co-ordinator, NHS Hartlepool
Tracy Jeffries, Hartlepool Carers

Officers: Louise Wallace, Assistant Director, Public Health
Annie Wallace, Breastfeeding Co-ordinator
James Walsh, Scrutiny Support Officer
Angela Hunter, Principal Democratic Services Officer

83. Apologies for Absence

Apologies for absence were received from Councillors Rob Cook and Chris McKenna.

84. Declarations of Interest by Members

None.

85. Minutes of the meeting held on 1 February 2011

Confirmed.

The Chair provided clarification on the A&E Review Panel Report into the Accident and Emergency Department at the University of Hartlepool

Hospital, which had been mentioned briefly at the meeting on 1 February 2011. Members were informed that the report was due into the public domain on 14 March 2011, with the Forum formally receiving it at their meeting of 29 March 2011. The Chair highlighted that the purdah period for the forthcoming local elections was due to start on 25 March 2011.

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

None.

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

None.

88. Consideration of progress reports/budget and policy framework documents – Suspension of Greatham Clinic *(Scrutiny Support Officer/ Commissioning Manager)*

The Commissioning Manager from NHS Tees was in attendance to provide an update to the Forum's Action Plan into the 'Suspension of Greatham Clinic'. It was highlighted that NHS Tees had examined the health outcomes of the residents of Greatham against areas of better and poor outcomes and had ascertained that the use of health services was found to be higher than those compared to but no higher than what would be expected for that population. An assessment had been undertaken which identified the following options for the provision of health services within Greatham:

- Decommission the clinic and commission GPs to provide local health services;
- Return back to the original service provision from within Greatham clinic;
- Provide a reduced service removing the provision of any clinical services.

In relation to the availability of suitable premises, the clinic's previous premises were unsuitable as they were unable to be made compliant with the Disability Discrimination Act. However, use of part of the local community centre was being examined as a viable option. The views of local GPs and residents were sought and the Board considered that the provision of services within Greatham should continue albeit without any clinically invasive services eg blood samples.

Discussions were ongoing in relation to accessing the community centre to make the necessary physical changes to the building and it was hoped that

the services provided would ensure better value for money such as through the provision of preventative services.

It was highlighted that there were areas that require clarification regarding the dilapidations of the community centre between the outgoing tenant and the building owner (Hospital of God). Until this was resolved the PCT was unable to enter into a formal agreement with the building owner and make the required changes to deliver the service. However, Members were asked to note that the Primary Care Trust was alongside the building owners and Greatham Community Association in their commitment to find a solution that would continue the provision of health services for Greatham residents.

A Member noted that the withdrawal of this service was a great miss to the local community and it was considered to have had a detrimental affect on older people and children's health.

In response to a comment from a Member regarding communicating progress to date with the wider community, the Commissioning Manager agreed to provide an update at the next NHS Hartlepool board meeting.

The Commissioning Manager was thanked for providing an update for the Forum and for answering Member's questions.

Recommended

The report was noted.

89. Breastfeeding in Hartlepool (*Scrutiny Support Officer*)

The Scrutiny Support Officer informed Members that the Breastfeeding Co-ordinator was in attendance to provide an update in terms of breastfeeding outcomes in Hartlepool. The Breastfeeding Co-ordinator gave a detailed and very informative presentation which highlighted the impact breastfeeding had on the child and mother's lives and it was noted that the number of mothers breastfeeding in Hartlepool was below the national average. Local data was now being gathered to assist in the planning and positioning of services to encourage breastfeeding. A number of planned initiatives had been put forward including ensuring places were breastfeeding friendly, mum to mum support groups were established and more advice and information on breastfeeding was available during pregnancy and immediately following the birth of the baby.

A number of measures had been put in place to respond to the suggestions and areas of concern highlighted as part of the data gathering process and these were detailed in the presentation. These included the continued involvement of health visitors, health team nursery nurses and Children's Centre staff. The building blocks to more successful breastfeeding were facilitated by the UNICEF Baby Friendly process and was evaluated and audited regularly. The Co-ordinator commented that

increasing breastfeeding rates was a complex long-term piece of work and this was reflected in the Council's Breastfeeding Strategy.

A discussion ensued which included the following issues:

(i) A Member sought clarification on what performance management measures had highlighted since the appointment of the Co-ordinator. The Assistant Director, Public Health confirmed that whilst it was recognised that improving breastfeeding rates in Hartlepool was part of a long term strategy, there had been an increase in the number of mothers breastfeeding from 22% to 24%. The dedicated capacity of the appointment of a Co-ordinator enabled the culture of bottle feeding to be challenged as well as promoting the benefits of breastfeeding.

(ii) It was acknowledged that one of the main issues was changing the established culture of not breastfeeding as this was passed on from generation to generation. This included recognising that just because baby milk was purchased did not automatically mean it was the best option. The co-ordinator responded that this was an on-going challenge but enhanced provision of advice and support was now included as part of ante-natal contacts by midwives.

(iii) It was also suggested that the number of 'celebrities' breastfeeding their children might also encourage the younger generation. The Co-ordinator confirmed that the power of the 'celebrity voice' had also been recognised.

(iv) A Member questioned what the £50k funding allocated from the Department of Health had been used for. The Co-ordinator confirmed that this funding which has yet to be released, was to be used to create a peer support pilot programme as there was no mum to mum support available at the moment. Mothers will be recruited to be part of the breastfeeding support groups and will receive appropriate training. The Assistant Director of Public Health added that there had also been a need for staff education and for a strategy to be researched and written. It was noted that one of UNICEF's recommendations was that a peer support programme be in place.

(v) There was some concern that a lot of the work was being undertaken as part of back office functions. The Co-ordinator reassured Members that all the work undertaken as part of the Breastfeeding Strategy was through the provision of front line services with professionals providing appropriate advice and support to pregnant women and mothers and listening to any issues raised by mothers or mothers to be.

(vi) It was noted that some mothers' stay in hospital was extremely short and it was questioned whether they missed out on support that would have been provided in the hospital. The Co-ordinator confirmed that to address this, feeding needs were addressed by maternity services and health visiting who visited the mothers in their homes on discharge from hospital.

(vii) A Member sought clarification on the take up of breastfeeding across the different wards in the town and questioned whether deprivation was a factor in this. The Co-ordinator confirmed that statistics were

available on a post code basis and converting them into ward based data would be examined and circulated to Members as requested. It appeared that the higher deprived areas had little history of breastfeeding and therefore had a lower rate of take up. The importance of breaking this inter generational pattern without reducing the value of the instilled family values was emphasised.

(viii) It was highlighted that some of the companies that produce baby milk offered incentives for mothers to use their products and it was suggested that incentives should be provided to mothers who breastfeed at particular milestones such as 10 days, 3 months and 6 months.

(ix) It was recognised that educating young people in schools of the benefits of breastfeeding was the place to start to encourage young people to accept it as the norm in society. The Co-ordinator confirmed that the Breastfeeding Strategy did address the issue of the education of young people within the school environment in relation to the benefits of breastfeeding.

The Breastfeeding Co-ordinator was thanked for her informative presentation and for answering Members' questions.

Recommended

(i) The update on the outcomes of breastfeeding in Hartlepool was noted.
(ii) The Assistant Director of Public Health to ensure that the breastfeeding rates broken down by ward areas of the town be circulated to Members of the Forum.

90. Teenage Pregnancy in Hartlepool (*Scrutiny Support Officer/Teenage Pregnancy Co-ordinator*)

The Teenage Pregnancy Co-ordinator from NHS Hartlepool was in attendance to provide an update in terms of teenage pregnancy levels in Hartlepool. The Teenage Pregnancy Co-ordinator provided Members with a detailed and comprehensive presentation which included statistics for conception data for under 18s from 1997-2009 and for live births and terminations from 2005-2010. Although it was recognised that the rate of under 18s conception was higher than the regional and national figures it had still reduced from 80 to 57 per 1000 teenagers. The number of live births and terminations were also continuing with that trend reducing from 105 live births and 68 terminations in 2005 to 61 live births and 35 terminations in 2010.

In terms of prevention it was noted that sex and relationship education was undertaken in all secondary schools and all but one primary schools within the town with vulnerable young people targeted through the Integrated Youth Support Service. The Teams Around Schools were also involved in the early identification of teenagers in need of support.

A discussion ensued which included the following issues:

(i) The statistics showing the under 18 conception data seemed to reduce significantly in 2002/3 and a Member questioned whether there was a specific reason for this reduction and why it had not continued. A representative from Owton Fens Community Association (OFCA) confirmed that during this period, OFCA ran a teenage project using baby simulators and empathy bellies. This had a dramatic affect on a lot of young people but unfortunately the funding for this project had ceased.

(ii) A Member referred to the above scheme and remembered it worked well and asked that the community and voluntary sector should always be considered for the provision of this kind of service as they could often deliver them very effectively.

(iii) A Member expressed concerns that the fact that teenagers were aware of the easy availability of emergency contraception had a detrimental affect on their choice to have unprotected sex. The Co-ordinator recognised this concern but gave a reassurance that the pharmacist providing the emergency contraception automatically referred them to NHS Clinical Services to ensure their contraceptive needs were addressed.

(iv) Clarification was sought on the number of teenage parents accessing support. The Co-ordinator indicated that Connexions currently had a large case load of teenage parents aged 19 or under but would provide the detailed figures to Members.

(v) A Member requested further detailed information on the statistics provided to highlight the number of live births to an individual who had already had a termination or where there individuals were having repeat terminations. Whilst it was recognised that personal data would not be provided, it was felt that the number of these cases would be sufficient to give Members a more detailed overview of the situation and may help identify the measures needed to address these issues.

(vi) The Co-ordinator highlighted that when someone has a termination, their consent was sought to forward their details clinical services to ensure their contraception needs for the future were addressed.

(vii) In addition, it was suggested that an additional breakdown of number of births to the number of mothers be identified to provide more realistic figures in relation to multiple births.

The Teenage Pregnancy Co-ordinator and Assistant Director of Public Health were thanked for their informative presentation and for answering Members' questions.

Recommended

(i) The update on the teenage pregnancy levels in Hartlepool was noted.

(ii) That further information be forwarded to Members on the following:

- The number of teenage parents accessing support;
- A further breakdown of the figures in relation to live births and terminations highlighting the number of live births where the

individual has already undergone a termination; along with the number of repeat terminations being carried out;
- A breakdown of the number of live births to mothers to highlight multiple births.

91. Scrutiny Investigation into Connected Care – Partner Organisations (*Scrutiny Support Officer*)

The Scrutiny Support Officer informed Members that representatives from organisations involved with Connected Care were in attendance to provide evidence in relation to the investigation into 'Connected Care'.

A representative from Intrahealth gave a very informative presentation which detailed the provision of primary care provided by Intrahealth and how it engaged with the community and GPs through Connected Care. Intrahealth works very closely with the Navigators and SAILS (Supported Access to Independent Living) at Connected Care at the Wynyard Road Primary Care Centre. The benefits of Connected Care from Intrahealth's viewpoint were detailed in the presentation and were summarised as follows:

Impact on the community – Connected Care fits with the localism agenda and empowers the local community whilst being flexible and responsive to the needs within the locality.

Benefits – The Navigators bring a wealth of knowledge in relation to the health and well being challenges within the locality and were committed to being part of that community.

Development in the future – It was noted that the roll out of Connected Care across the town could only improve the service, working in partnership with the General Practitioner Community Consortia, other health care professionals, the local authority and patients. It was recognised however, that the service would need to be adopted to ensure the needs of each particular locality were addressed.

A discussion ensued which included the following issues:

(i) A Member sought clarification on whether Intrahealth would be keen to be part of any roll out of Connected Care across the town. The representative from Intrahealth indicated that they would like to be involved without any doubt.
(ii) Clarification was sought on how the impact of Connected Care on the Owton Ward was being measured. The representative from Intrahealth informed Members that patient surveys were undertaken along with patient participation groups and events. However, discussions were ongoing with the London School of Economics to look at ways of providing hard facts and figures identifying the impact of this service on the local community.
(iii) It was recognised that there were a number of organisations providing similar services and an effort would be made with any

provision of Connected Care services to ensure there was no duplication of service provision. The establishment of partnership working with other organisations would ensure that needs were met in the most efficient and effective way. The Centre Manager from Hartlepool Carers in particular highlighted the Low Level Support Service they operated in other areas of the Town and its similarities to some of the work of Connected Care.

(iv) Members were asked to note that Connected Care in Hartlepool was seen as a model of good practice nationally and out performs the 13 other Connected Care services in the country.

(v) A key to the success of Connected Care was that it was provided through a social enterprise with full involvement and ownership to the residents in that locality, co-ordinating the services needed in that area.

A represent from the Accent Foundation was in attendance and provided an update to Members on the Glamis Walk Supported Living Project. It was noted that through the effective partnership working with Connected Care and Housing Hartlepool the number of tenancies and provision of support to those tenants to sustain those tenancies and stabilise their life had increased.

(vi) A Member sought clarification from the representative from Intrahealth if there was anything in place to measure the value of the preventative/intervention measures in place? The representative confirmed that the number of people taking part in the community call back scheme was measured but further work was needed to calculate how much was saved in reduced emergency hospital admissions. Members were asked to note that positive feedback had been received from all patients but it was recognised that more tangible evidence was needed. The representative from Housing Hartlepool indicated that there was some information available on added value that had been undertaken by Connected Care and this could be circulated to Members.

The representative from Housing Hartlepool provided Members with an update on Housing Hartlepool's involvement with Connected Care. Housing Hartlepool did work closely with the navigators from Connected Care to sustain tenancies including court attendance and ensuring the tenant was accessing their full benefit entitlement. Members were asked to note that through this partnership working, the eviction levels had reduced. In addition to this, Housing Hartlepool funded a handy man scheme which had been well received in the area and included the clearing of paths during the recent bad weather. There had been around 430 tenants using the service with a huge satisfaction level reported. Housing Hartlepool were currently in discussions with a view to fund a navigator/intervention programme worker. Housing Hartlepool were committed to Connected Care and hoped very much that this programme was rolled out across the whole town especially as the areas most likely to benefit had a high level of Housing Hartlepool housing stock within them.

Members were asked to note that the Manor Residents' Association were also exploring the possibility of bidding for funding for a local inclusion LAB area which would enable a community champion to be employed to ensure that national funding opportunities were maximised.

In summary whilst it was recognised that the service provided by Connected Care was very worthwhile, it was noted that promotion of this service may need to be improved to ensure that all organisations were aware of the services provided within the Connected Care Programme to enable effective signposting to enable all those in need to access the appropriate support and services provided.

A representative from Owton Fens Community Association (OFCA) commented that the Connected Care model had made a huge difference to the lives of residents in the area. It was acknowledged that the work being undertaken by the London School of Economics would provide statistical evidence to show this. However, in relation to the financial implications for other organisations, it was noted that any prevented eviction would save Housing Hartlepool around £6k in a similar way that any measures put in place to avoid residents attending Accident and Emergency such as clearing of paths in bad weather, would also save the NHS money. Although it was noted that identifying these cost savings was a huge piece of work, it would be beneficial in quantifying the costs associated with the provision of Connected Care.

In relation to rolling out Connected Care across the town, it was recognised that this would need to be tailored to the specific needs within each individual area or it would not be as effective as the current Connected Care model does.

The Chair thanked everyone in attendance for providing detailed information on how their own organisations worked and supported the provision of services through the Connected Care model. It was hoped that the success of the current model would be replicated across the town as it was rolled out to maintain the fabric of communities.

Recommended

(i) The presentations and information received would be used to inform the investigation into Connected Care.
(ii) That further information on the added value of the preventative and intervention measures provided by Connected Care be provided to Members.

92. Issues identified from the Forward Plan

None.

93. Feedback From Recent Meetings of Tees Valley Health Scrutiny Joint Committee

The Scrutiny Support Officer presented a report which updated Members on discussions at the Tees Valley Health Scrutiny Joint Committee including a seasonal flu update and the redesign of the Out of Hours Service and the Sexual Health service provision.

Members were asked to pass on any issues they wised to be raised at the next meeting of the Committee to the Chair or Scrutiny Support Officer.

Recommendation

The report was noted.

94. Regional Review of the Health of the Ex-Service Community – Final Report *(Scrutiny Support Officer)*

Members were presented with the final report agreed by the North East Joint Health Overview and Scrutiny Committee after their recent scrutiny investigation entitled 'Regional Review of the Health of the Ex-Service Community'. Councillors Fleet and Griffin had attended meetings of the Joint Committee and informed Members that it had been a very useful exercise which had highlighted a number of issues.

One of the main issues highlighted was that a lot of the ex-service community were unaware of the provision of services in place for them, including priority being given for their housing needs and this was due to the lack of communication and information available to them on leaving the service. The important of organisations signposting people to local organisations where necessary was emphasised. A Member referred to the SAFA organisation that was located in the town and suggested that this was another organisation that could usefully be linked into the Connected Care model and be part of the delivery of services.

Recommendation

The report was noted.

95. Any Other Items which the Chairman Considers are Urgent

None.

The meeting concluded at 5.21 pm.

CHAIR

HEALTH SCRUTINY FORUM

29 March 2011

Report of: Scrutiny Support Officer

Subject: EXTERNAL REVIEW OF HARTLEPOOL ACCIDENT AND EMERGENCY SERVICES

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1. PURPOSE OF REPORT

1.1 To present to Members the findings of the External Review into Accident and Emergency Services at the University Hospital of Hartlepool.

2. BACKGROUND INFORMATION

2.1 As Members will be aware at the 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).

2.2 Subsequently the Medical Director from NHS North East will be in attendance at today's meeting, to provide Members with the findings of the External Review of Hartlepool Accident and Emergency Services; attached as **Appendix A** to this report.

3. RECOMMENDATIONS

3.1 That Members note the content of this report and the findings of the External Review of Hartlepool Accident and Emergency Services (attached as **Appendix A**). Seeking clarification on any relevant issues from the Medical Director, NHS Tees where felt appropriate

Contact Officer:- James Walsh – Scrutiny Support Officer
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BACKGROUND PAPERS

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

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

External Review of Hartlepool Accident and Emergency Services

14 March 2011

External Review of Hartlepool Accident and Emergency Services

1. Summary and introductory remarks

1.1. The NHS organisations in Hartlepool have developed and consulted upon a strategy for the future, based on a single new hospital serving both Hartlepool and Stockton together with more services closer to people's homes in each community. However, there appears to be little knowledge of and inadequate consultation about the "steps along the way" towards this future.

1.2. The new hospital is a key part of the strategy, and doubt about how it will be financed after public funding was withdrawn has contributed, with the lack of knowledge about "steps along the way", to a situation where there is apparently little public faith in either the process or the plans – exemplified by the rejection of recent proposals to close the A&E at Hartlepool hospital.

1.3. There is no clear consensus among staff at the hospital, or between the hospital, the Primary Care Trust, the GPs and the public about the right way forward for the A&E and about the detail of the plans for new services at the One Life Centre.

1.4. There clearly is a need for services that cope with the full range of urgent needs that people in Hartlepool will have – from needing to see a GP out-of-hours to coping with major trauma. The rationale for centralising services for major illness and injury and providing less specialised services closer to home is well understood by professionals and many members of the public, but so far the plans to develop these services are at best confusing and at worst weak.

1.5. The existing plans to close the A&E at Hartlepool and build up a portfolio of new services at the One Life Centre appear to have a number of significant gaps, both in overall planning (for example in lead time to get up and running, affordability, the development of supporting transport arrangements etc.) and in detailed operational planning (for example opening times, methods of triage, skill-mix of staff etc.).

1.6. It seems that the local NHS "wasn't ready" with sufficient detail and confidence in its plans when the proposals to shut the A&E in Hartlepool were made in July 2010. This review makes a number of recommendations to the NHS on how to proceed.

2. Background

2.1. The North Tees & Hartlepool NHS Foundation Trust (NTHFT) and their commissioning partners announced in July 2010, in the context of the Momentum Project[1], that it was intended to close the Accident and Emergency (A&E) Department at University Hospital of Hartlepool with effect from December 2010.

2.2. In response to this announcement the Hartlepool Borough Council's Health Scrutiny Forum (HSF) wrote to the Rt Hon Andrew Lansley MP, Secretary of State for Health on 17th September asking for the matter to be considered formally by the Secretary of State.

2.3. Following discussion between both parties on 12 October 2010 the HSF members were told by NTHFT that the proposed changes planned for the A&E department had been withdrawn with immediate effect. It was agreed that an independent review would be undertaken into A&E services, overseen by the North East Strategic Health Authority (SHA).

3. Terms of Reference for the review

3.1. Terms of reference were agreed between the HSF, NTHFT, Hartlepool Primary Care Trust (PCT) and SHA and the review was to determine the appropriateness & safety of the current A&E services being provided at University Hospital Hartlepool.

3.2. The review was not to be constrained by previous reviews or recent decisions, but recognised three important drivers for change:
- 3.2.1. Safety
- 3.2.2. Affordability
- 3.2.3. Public acceptability

3.3. The review was to be carried out as a partnership between the North East SHA and the Hartlepool Borough Council's Health Scrutiny Forum (HSF).

3.4. The outcome of the review is this written report, making recommendations to the FT, PCT and HSF, suggesting the way forward.

4. Ways of working

4.1. To ensure impartiality and transparency the review was undertaken by an independent review panel, led by an external medical expert and chaired by a senior director from the SHA.

4.2. To ensure accountability, acceptability, value for money and the public voice, members of the panel included representation from the Hartlepool Borough Council's HSF; North East SHA; external national and local expert clinical input; academic and lay membership.

4.3. The review panel was informed through work carried out by NHS Interim Management and Support (IMAS). At the request of the SHA, NHS IMAS carried out an investigation of the local emergency and urgent care system in November 2010[2], to assess current safety and efficacy, recent changes and to propose possible future options. The outcome of the investigation was presented to the review panel in the form of an expert report and testimony.

4.4. Further written evidence from the PCT and NTHFT was collated[3] and reviewed by panel members between Christmas and the review visit, which took place on 26th and 27th January 2011.

4.5. The panel took verbal submissions over the two day period and were able to visit the relevant sites (A&E at Stockton not visited), meet staff and members of the public. All

of the verbal and written evidence was used by the panel in deliberations during and in preparing its findings.[4]

5. Membership of the review panel[5]

5.1. Representative from the senior directorship at the SHA – Chair of the review panel:
Professor Stephen Singleton, Medical Director

5.2. External medical A&E expert:
Dr Ed Glucksman, Consultant in Emergency Medicine, King's College Hospital FT, London

5.3. Two representatives from the HSF:
Councillor Stephen Akers-Belcher, Chair of Hartlepool Borough Council HSF
Councillor Sheila Griffin, Vice-chair of Hartlepool Borough Council HSF

5.4. Two independent doctors from within the region, providing both clinical and educational expertise:
Dr Colin Doig, Consultant Cardiologist (Northumbria FT) and Training Programme Director for General Internal Medicine in the Northern Post-graduate Deanery
Mr Derek Cruickshank, Consultant Gynaecological Oncologist (South Tees FT) and Head of School for Obstetrics and Gynaecology in the Northern Post-graduate Deanery

5.5. External nurse A&E expert
Mrs Sandra Collinson, Nurse Consultant in Emergency Care (City Hospitals Sunderland FT)

5.6. An academic expert with a social sciences perspective
Professor Tim Blackman, Director of the Wolfson Research Institute, Durham University

5.7. A local GP
Dr Paul Pagni, GP Partner in Hartlepool for 23 years

6. Findings

6.1. The panel found that a broad strategy for the way forward for the NHS in Hartlepool (Momentum) was well known and whilst there was evidence of extensive consultation, there was little detail in that consultation about A&E services.

6.2. Everyone the panel spoke to knew that there was a problem in completing the new single hospital part of this strategy - as previously promised public capital to fund the build had been withdrawn by the new government. The panel heard evidence from NTHFT that plans were proceeding on the basis of trying to secure private finance. They were confident this would happen but no deal was yet concluded. The panel noted it was possible that the Trust were optimistic on timescales for the new build.

6.3. There was also clear evidence that many people, including senior NHS managers, clinical staff and members of the public, did not understand the interim steps needed to implement Momentum. It appears that these steps haven't been sufficiently consulted upon. Some steps have happened already (changing the pathway for sick children for example, and building the One Life Centre) and some are still at the proposals stage. There is some evidence that people saw these steps as unconnected events – which to some extent is true, for example the paediatrics changes were part of a previous external review - but not part of an overall Momentum strategy, which most people saw as the "new plan" for local services.

6.4. Local NHS managers and doctors see the A&E closure at Hartlepool as primarily a safety issue, but also as a logical step towards the longer term vision of a single hospital site and enhanced locally available services - such as those proposed at the One Life Centre.

6.5. Whilst there is no doubt and no dispute that local urgent care services are required in Hartlepool – and indeed an understanding, by most of the people the panel interviewed, of the rationale for change in existing urgent & emergency care services – there are differing views on the "what, how and when". There is dispute and lack of awareness about the affordability of the options and even a lack of consensus between professionals on what the best "next step" is.

6.6. **Evidence about safety:**

6.6.1. There was a clear consensus amongst senior medical staff that there were significant safety issues[6] in the current A&E department. The problems are explained in Appendix 6 but fall into two overlapping categories:

- insufficient numbers of medical staff to cover the two rotas at Stockton and Hartlepool
- although very junior medical staff at Hartlepool have a level of supervision overnight, this was not adequate to meet guidance criteria for A & E.

6.6.2. It was clear from members of the public that they were not aware that sustaining a safe overnight A&E service at Hartlepool was one of the primary concerns of the doctors.

6.6.3. Despite a great deal of effort, appropriate staffing for a safe A&E service overnight has proved impossible to secure. Forward planning showed, partly because of reduced numbers of doctors in training, that this problem will get worse. From the evidence the panel heard, neither the hospital management team nor the PCT appear to have made clear to the public, at the time the "closure" was first raised with the Health Scrutiny Forum last year, the degree of future insolubility of the safety concerns they had raised.

6.6.4. The majority of the nursing staff from A&E at Hartlepool that the panel interviewed did not agree with the doctors and felt the safety concerns were overstated. They reported that, as far as those present were aware up to that time, there had not been any major incidents related to these staffing problems. They reported that when they did have urgent needs in the department at night, there were other more senior doctors available in the hospital.

6.6.5. Local GPs, now important in commissioning decisions, did know of the problems and supported the closure on safety grounds and supported the range of services proposed at the One Life Centre as a suitable alternative. They did have concerns, however, about the affordability of the changes and they had not yet been widely involved in the detail planning of the options.

6.6.6. Clearly some arrangements are already in place to manage the safety issues. This includes careful planning of the medical staffing and provision for some patients to be taken directly to and/or transferred to Stockton A&E. Previous changes to the configuration of hospital services between Hartlepool and Stockton also mean admissions and potential admissions have to be diverted. Children, major trauma cases and patients with emergency surgical problems are already on a care pathway which bypasses Hartlepool A&E.

6.6.7. The Ambulance control and Paramedic staff followed protocols to decide destinations for patients and this was reported to be working well, although inevitably there are some difficult clinical decisions for front-line staff and the over-riding policy is to take patients to the nearest A&E. For the types of patient the Ambulance service takes to Hartlepool, they reported confidence in the A&E department.

6.6.8. Most patients arrive at A&E using their own transport and therefore may present with problems (such as a surgical problem) or as a type of patient (sick child) that needs to be transferred to Stockton.

6.6.9. The risks associated with night-time rotas that depend upon very junior doctors (albeit supported by experienced nursing staff) is likely to get worse as the number of doctors on training rotations is reducing.

6.6.10. The new services proposed at the One Life Centre were generally supported by the panel. The facility is well designed and excellently equipped. A number of issues caused some concern however:

6.6.10.1. The waiting room is to be shared by Walk-in services, Minor Injuries and the GP out-of-hours. Whilst the services are designed around a continuous flow for patients, does the modelling show it will always be big enough?

6.6.10.2. The public may not need to understand the difference between these three services (as they report to one common reception) but it does feel potentially confusing and a single name for the proposed unit could be helpful.

6.6.10.3. The planned arrangements for the "triage" (sorting patients by urgency of need) were not convincing. The panel understood the service is still being planned, but this critical step needs to be clear to ensure the population, the staff and ambulance crews can have confidence in how the process works, training staff have had and who does which component of it. Ambulance staff further noted the design layout itself wasn't ideal for patients they brought to the proposed service.

6.6.10.4. As highlighted in the IMAS report, the planned integrated service will need a single integrated governance arrangement (irrespective of who and how many separate organisations are the providers of the services)

6.6.10.5. As the planning is not yet completed, there were inevitably different proposals about which part of the service had what opening time(s) and therefore, as currently described, the components of the service did not offer 24 hour integrated services.

6.6.11. The panel heard evidence that various options had been considered with respect to a way forward and those had also been explored in the IMAS report. For example:

6.6.11.1. As already highlighted above, strenuous efforts to recruit more medical staff together with the reducing numbers of doctors on training rotations meant that the "do nothing" option – or try and carry on "as is" – is not viable

6.6.11.2. The possibility of closing Hartlepool A&E at night only was the cheapest option but clearly could be even more confusing for the public and even less safe for patients (and staff) if people turned up anyway

6.6.11.3. Using more staff from the Stockton A&E to support the Hartlepool A&E had been considered but only resulted in both units being de-stabilised and potentially less safe for everyone served by NTHFT

6.6.12. Further wide and transparent debate about the future of services is clearly required.

6.7. **Evidence about affordability:**

6.7.1. The Trust Director of Finance gave us evidence that all of the various proposals were relatively expensive.

6.7.2. Although potentially very confusing, it should be noted that the cost of the services needs to be seen from two different perspectives, how much is available to pay for a service and how much a service costs. The PCTs (and the GP consortia of the future) have a budget to procure the service and have a contract with NTHFT to provide the service. The PCTs' perspective on affordability is based on what they have to pay for the contract for the service. The hospital gets

revenue from many sources (mainly the PCT contracts) and sets an internal budget to provide the service – to pay for staff, equipment and buildings etc.. The hospital's perspective on affordability is therefore based on the cost of actually running the service. The price paid for the contract and the cost of delivering the service are not necessarily the same thing.

6.7.3. The current arrangements for A&E on two sites within the Trust (Hartlepool and Stockton) cost significantly more than the revenue available from PCT contracts. Clearly the longer-term plan to have single site working at a new hospital (Momentum) is important to solve this deficit position, as well as to address quality and safety concerns.

6.7.4. However, closing the Hartlepool A&E and creating a set of services both at the hospital (an enhanced emergency medical admissions unit) and at the One Life Centre (a minor injuries unit to go alongside the walk-in centre and the GP out-of-hours centre) is also more expensive than either current commissioning budget or indeed the cost of existing services. For example, against a total cost of A&E services in Hartlepool and North Tees of more than £9.5m, providing new and replacement services in the One Life Centre and enhancing capacity at North Tees Hospital and enhancing the Emergency Admissions Unit at Hartlepool will cost in the region of £1.4m more.

6.7.5. The staffing problems – particularly the shortage of "middle grade" doctors – are not related to any budget shortage. NTHFT gave assurances that more cash would not ease the recruitment difficulties.

6.7.6. It is clear that the proposals are not about saving money and the additional costs will have to be committed, albeit as one of the transition costs of the overall Momentum project.

6.8. **Evidence about public acceptability:**

6.8.1. Representatives of the community, members of LINKs[7], made it very clear that they were passionately opposed to the closure of the Hartlepool A&E.

6.8.2. They gave evidence of their recent day-time visit to the department which they were happy to report had given them no concerns.

6.8.3. They paid particular attention to the problems local people would have with transport to and from Stockton if the Hartlepool A&E was to shut. The local bus service was inadequate – indeed a "Hospital Bus"[8] service between the hospitals was about to be cut. Late at night there was no public transport service. The vast difference in cost of using a taxi was raised, where the cost of a journey to Hartlepool Hospital was obviously much less than a return taxi journey to Stockton. Furthermore, the difference, both in cost and time, of "a good neighbour" (for example) giving someone a lift in their car could mean patients calling 999 where previously they were helped to get to the local hospital by family or friends. Basically, they felt Hartlepool Hospital A&E was near and convenient to use, Stockton was far, inconvenient and costly to use.

6.8.4. Some concerns were also raised about public transport access to the One Life Centre although it was acknowledged that for many local residents this was a more convenient site than Hartlepool Hospital itself.

6.8.5. Some members of staff, speaking in their capacity as residents of Hartlepool, also spoke passionately about the need to keep open a local A&E. Again, they compared the journey times from most of the town to Hartlepool Hospital with journey times to Stockton.

6.8.6. General concerns were also raised on behalf of East Durham residents who found it easier to travel to Hartlepool than to the alternatives of Stockton or Sunderland. It was noted that if local people did get initial emergency services in Sunderland there was a possibility of them being transferred to Newcastle with potential further transport concerns for patients and family.

6.8.7. Another key concern was the connection in people's minds between the closure of A&E and the gradual, inexorable decline of the hospital as a whole. Witnesses reported a genuine feeling that the hospital would die "from a thousand cuts". On the other hand, NTHFT managers reported new investments in the hospital and the clear assertion that it was vital to their plans until the new hospital was built.

6.8.8. Even if the rationale was fully understood by the professionals, as the current proposals for A&E appear to the public and to some staff not to constitute part of a clear plan for urgent and emergency care, it is inevitably very difficult for local people to understand. It seems, therefore, extremely likely that the proposed alternatives to the existing A&E service would not be believed.

6.8.9. There were concerns expressed that the 'voice of the people' had not been listened to, in particular a petition undertaken several years previously of 33,000 residents stating that they did not want their hospital to close had not been adequately considered.

6.9. The panel heard evidence from the Ambulance Trust that if modelling of patient flows showed that they needed another fully crewed emergency vehicle in the area, then that required a long lead time of up to two years. The interim could be covered by overtime and temporary/agency staff, but any permanent increase in capacity would take time to deliver.

6.10. As noted, there is lack of clarity between key partners on the detail of many of the proposals being planned for services based in the One Life Centre. This strongly suggested to the panel that NTHFT and the PCT were not yet ready to change A&E services. Furthermore, the early impasse reached at the initial discussions concerning the proposed closure of the Hartlepool A&E inevitably slowed down - and indeed stopped - any of the detailed planning work that was going on.

6.11. The review panel recognised that to do the necessary planning to be able to explain the detail to the public may well feel to everyone concerned as if the proposal to close A&E was a done deal. At the same time, to consult with the public at a very early stage when there is little detail in some of the plans risks that the PCT and NTHFT look very unprepared. Then, worse still, appearing to be unprepared may precipitate for the public a perception that no one is bothering and all that is happening is a "downgrade" of services based in Hartlepool generally and the hospital in particular.

6.12. This dilemma about what stage in the planning is the right time to consult more widely is further complicated by the transition between PCT commissioning and the new GP commissioning arrangements[9] – the public might justifiably be confused about who is taking this important decision.

6.13. It was clear to the panel that the local GPs supported the proposals to move services from the A&E to the One Life Centre – but it was not clear that staff or local people knew that the GPs supported it.

6.14. People may see the "closure" as loss and do not always see the enhanced local services as a "gain", so much more effort has to go into describing the benefits and advantages of the service developments that have been proposed and planned so far. For example, the panel noted:

6.14.1. The locality of the One Life Centre. Stockton may seem far away and inconvenient but the proposed new services were to be based at Hartlepool town centre.

6.14.2. The design of the One Life Centre, and the services so far planned by the NHS, appeared to be a potentially very good facility – not only for the GP practices, out-patient and community services, but also for the Walk-in and Minor Injuries service sitting alongside primary care services both in and out of hours. From the data given to the panel, a clear majority of patients still using the Hartlepool A&E[10] would have their needs met by this new service.

6.14.3. The enhanced "Emergency Admissions Unit" at Hartlepool Hospital would be a better environment for assessing and potentially admitting patients with acute medical problems. For example, for elderly patients with complex problems to go directly to a bed in the unit is preferable to a trolley-based assessment in A&E.

6.15. The panel agreed it could not ignore the safety concerns about the current A&E department in Hartlepool. However, it was also clear that despite some strengths, the alternative services proposed were not yet planned in sufficient detail – or indeed planned to meet legitimate concerns already expressed - for the public to be able to come to an informed decision about the acceptability of those proposals.

7. Recommendations

7.1. There needs to be further wide and transparent dialogue with the public about the future of all services in Hartlepool – and resolution of the urgent care services plan should not stop that dialogue which must continue with sufficient detail for people to understand the "steps along the way" as well as the end point "vision".

7.2. In partnership with patient representatives, the GP Commissioning Consortium, PCT and NTHFT must rapidly develop a single and clear set of proposals for urgent and emergency care and explain these services to the public, together with clear discussion of the "pros and cons" and the rationale for change. At a minimum, this needs to include:

7.2.1. Explaining the role of the enhanced Emergency Admissions Unit (EAU) and medical emergency service and then complete its planned development

7.2.2. Taking time to remind people of and properly explain the pathways that already mean people do not use Hartlepool A&E (trauma, surgical emergency, paediatrics etc.)

7.2.3. Sharing the safety issues openly and explaining why they cannot be resolved without moving to single-site A&E working at Stockton, explaining at the same time the benefits of the new services that will be based in Hartlepool

7.2.4. Immediately talking to the Foundation School of the post-graduate Deanery to ensure the current arrangements are acceptable now, whilst a medium and longer term solution is planned.

7.2.5. Getting "up and running" - as soon as possible - a 24 hour integrated minor injuries, out-of-hours and walk-in service

7.2.6. Demonstrate that access to the services planned will not be compromised by difficulties of transport and supporting transport services are planned and available where necessary.

7.3. Primarily for safety and training reasons, the A&E at Hartlepool Hospital should close. Whilst this is urgent, NTHFT and PCT should consult and set timescales to ensure that the way in which local services are developed is properly understood and that these new services are available before the A&E closes.

7.4. A joint steering group between NTHFT, the PCT, the emerging GP commissioners and the HSF should be set up to steer this process forwards to ensure the development of the new services proceeds without unnecessary delay and provide assurance to the SHA that future services meet the "4 tests" of the Department of Health in their development:

- support from GP commissioners
- strengthened public and patient engagement;
- clarity on the clinical evidence base
- consistency with current and prospective patient choice

List of appendices

[1] Momentum: Pathways to Healthcare Programme – summary and web-link

[2] IMAS report: A Review of Urgent and Emergency Care Provided by the North Tees and Hartlepool Local Health Community. November 2010

[3] Documents received and reviewed by panel

[4] Programme for externally led review of A&E services, University Hospital of Hartlepool, (26 and 27 January 2011)

[5] Panel members biographical details

[6] Why is safety an issue for Hartlepool A&E?

[7] Hartlepool LINK - summary

[8] Transportation – information provided by Hartlepool Borough Council

[9] Summary of move to GP commissioning

[10] Numbers modelling of patients currently using A&E in Hartlepool

Appendix 1

1. Momentum: Pathways to Healthcare Programme - summary

Momentum: Pathways to Healthcare Programme, is a whole systems approach to address the poor health and inequalities of the area, implement best practice in primary, community and acute services, be at the leading edge of implementing public sector policy and introduce new models and patterns of healthcare that are evidence-based and more appropriate to the 21st century.

The Momentum: Pathways to Healthcare Programme, supports the development of a 'single site' hospital and a significant transfer of care provided to a community setting.

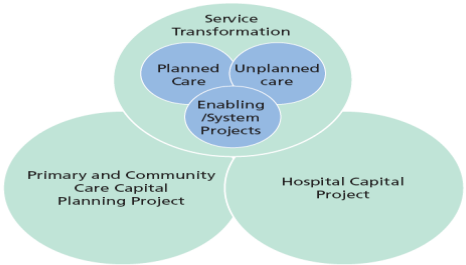
The stated aims of Momentum: Pathways to Healthcare Programme are to provide:

- services in or close to people's homes;
- local clinics, where much of what was previously provided in hospital can take place;
- a new hospital which is within easy reach of everyone living in the area.

The Momentum programme is made up of three key elements:

- **Service Transformation** – which covers all the service models and care pathways which will be re-modelled and redesigned throughout the duration of the programme.
- **Hospital Capital Planning Project** – which covers the design, procurement, build and commissioning of a new hospital to replace the existing two hospitals, University Hospital of Hartlepool and University Hospital of North Tees.
    - The North Tees and Hartlepool NHS Foundation Trust received Department of Health (DH) and Treasury approval in March 2010.
    - As a result of the change in administration the coalition government withdraw the approved 93% public funding for the scheme shortly after coming into power (June 2010).
- **Primary and Community Care Capital Planning Project** – which covers the design, procurement, build and commissioning of new community based facilities from which to provide existing community services as well as those being relocated from hospital settings.

The diagram depicts the three major projects which make up the Momentum: Pathways to Healthcare.



Further information can be found on the Momentum: Pathways to Healthcare website www.momentum.nhs.uk .

Appendix 2

Interim Management and Support

A Review of Urgent and Emergency Care Provided by the North Tees and Hartlepool Local Health Community

November 2010

Review of Urgent and Emergency Care Provided by the North Tees and Hartlepool Local Health Community

NHS IMAS Visitors:

- Dr Ian Sturgess, Consultant Physician,
  Kent and Canterbury Hospital
- Mr. Russell Emeny, RGN, Director,
  Urgent and Emergency Care Intensive Support Team
- Mr. Mark Ellis, RGN,
  Urgent and Emergency Care Intensive Support Team

Dates of Visit: 3-4 November 2010

1. Review Remit

NHS IMAS was commissioned by NHS North East Strategic Health Authority to carry out a review of the local emergency and urgent care system centred on Hartlepool. The aim was to assess current safety and efficacy, recent changes within the system and future proposals. The required deliverable was an expert report that will provide independent evidence to help inform the process that is considering the issue of the proposed closure of the Accident and Emergency Department (A&E) at the University Hospital of Hartlepool.

For the avoidance of doubt, the recommendations and opinions in this report are those of the NHS IMAS team, and have been offered to provide independent advice to the review panel that will meet in 2011. The panel will reach its own conclusions, based on its consideration of the available evidence, of which this report forms one part.

2. Background

The NHS IMAS visit followed a prolonged period of planning and extensive public consultation on the future configuration of hospital and community health services in the Stockton, Hartlepool, Sedgefield and Easington areas. An earlier report by the NHS Independent Reconfiguration Panel had suggested a consolidation of hospital services onto a single site located between Stockton and Hartlepool. The key drivers behind this recommendation, which still exist, were the sustainability of the quality and safety of hospital services that are currently stretched across two sites. Public funding for a proposed new hospital was agreed by the previous administration, but cancelled by the government following the general election. Since then, the North Tees and Hartlepool NHS Foundation Trust has been seeking alternative, non-public funding streams for the new hospital and considering transitional arrangements to ensure the on-going safety and quality of services, prior to the anticipated full reconfiguration when the new hospital opens. As part of these transitional arrangements, the Trust and its commissioners wish to close the accident and emergency department at the University Hospital of Hartlepool and instead provide services to patients with medical emergencies and minor injuries through a new model. It is this proposal that occasioned the SHA and local OSC to establish a process of which this report is a part.

3. The NHS IMAS Process

NHS IMAS visited the University Hospital of Hartlepool, the University Hospital of North Tees and a number of community health service facilities over 3rd and 4th of November 2010. The team conducted a series of meetings with managers and executive directors from the Trust; with clinicians including consultants, nurses and therapists; with local GPs; with representatives from the local authority; with the ambulance service; and with executive directors and managers from the PCT (see appendix 1 for visit timetable). A number of public documents were made available to the visiting team as background and data relating to non-elective care at the Trust was provided. The team visited the Hartlepool A&E, the EAU and other wards and departments at the University Hospital Hartlepool and community health service facilities, including the One Life Centre. This report was prepared to summarise our findings and recommendations.

The names and short biographies of the team members are below (appendix 2).

4. Views heard by NHS IMAS

4.1 The proposal to close Hartlepool A&E Department

Throughout both days of our visit, it was clear from everyone we met that there was a good understanding of and support for the 'Momentum' programme and its rationale. This extended throughout the Trust to local GPs, local authority colleagues, the ambulance service and members of community health care teams. Some local staff at University Hospital of Hartlepool were disappointed that the hospital would eventually close but understood the need for this. There was also a near universal understanding that the Trust intended to close the A&E department at Hartlepool *before* a new hospital was opened. This understanding was not new, and we were told by staff from all the organisations we talked to that the need to close Hartlepool A&E was implicit in the consultation. The widespread support amongst the staff we met for the closure of Hartlepool A&E was based on the view that at night, medical staffing was too thin and fell below acceptable standards.

4.2 Why is it not possible to increase night time medical staffing at Hartlepool?

The visiting team met a wide cross section of staff responsible for providing various aspects of urgent and emergency care. The commitment of the staff at Hartlepool to providing a very good service to local people was very evident, and there was a willingness to listen to ideas and to consider possible options. As noted above, there was widespread concern about the quality of service in the A&E department at night. The visiting team explored what practical steps had been taken to rectify the inadequate medical staffing at night. We were told that the posts had been advertised unsuccessfully on a number of occasions. We were told by clinical, managerial and executive staff that finance had not been an obstacle – rather it was that recruitment had not been possible due to unavailability of suitable candidates. Other options had also been looked at, such as sharing staff between the A&Es at Stockton and Hartlepool. This possibility had been rejected, as it would have compromised safety at the busier Stockton A&E department by spreading staff too thinly.

4.3 The proposed new model of care

Following the proposed closure of the A&E department, the intention is to accept selected emergency medical admissions directly to the EAU Ward (Emergency Assessment Unit) following GP referral or by ambulance following a 999 call. Patients with less serious injuries and illnesses would have the option of treatment at the One Life Centre in Hartlepool or of

going to the A&E department at Stockton. Consultants and managers told us that 24 hour staffing of this model by acute physicians and nurse practitioners would provide a much safer service. They had looked at similar models from elsewhere in the country to understand better how to make the model work well. Protocols for use by the ambulance service to help them determine the appropriate conditions to bring to the EAU were in development, although completion had been stalled by the decision to review the proposed closure of the A&E Department. We were told by a number of clinicians and managers from within the local health and social care system that there was a history of successful planning, implementation and monitoring of effective reconfiguration of services over the years. The visiting team discussed the proposed model in considerable detail and our findings are outlined below.

4.4 The One Life Centre

We were told that following the proposed closure of the A&E department, the One Life Centre in Hartlepool would provide services to patients with less serious illnesses and injuries, and these would work seamlessly with the Out-of-Hours primary care service. Different providers would be responsible for the various services that would be accommodated in the Centre, and they would be contractually obliged to collaborate together to provide a high quality service. Negotiations were underway to relocate the current Walk-in Centre (WIC) to the One Life Centre, although this has not been finalised at the time of our visit. The acute Trust would provide the 'minor' injuries service, which would replicate the previous 'minors' service at the A&E department. We were told that plain film x-ray will be available in the One Life Centre.

4.5 Urgent and emergency care provision in the Hartlepool area

4.5.1 During the two days of our visit, we were able to build a broad picture of how urgent and emergency care services were provided to the people of Hartlepool, broadly to assess the safety and efficacy of these services and to compare them with examples from other parts of the country. From discussions with local GPs, we heard that primary care had implemented a wide variety of good practice initiatives for same-day care of patients with urgent care needs. While there was not a written urgent care strategy for primary care, the main building blocks of a high quality service were in place and the GPs were able to describe these to us. The vertically integrated community care services were also able to describe an array of initiatives and provision that indicated a high level of investment and an intelligent use of resources. Overall, both primary and community health care services appeared to appreciate what 'good looks like' and their approach appeared to match some of the best examples in the country.

4.5.2 We learned that the local health community had a strategic forum to discuss and agree the provision of urgent and emergency care services across the 'patch' served by North Tees and Hartlepool NHS Foundation Trust. This is good practice. Social care was appropriately engaged, was seen as a valued partner by the local NHS and understood its pivotal role in supporting local people in the community to free hospital beds and reduce avoidable hospitalisation.

4.5.3 The Accident and Emergency Department at University Hospital of Hartlepool is typical of well run, smaller A&E departments in England. Patients with less serious problems book into reception and most then wait to be seen by a triage nurse. We were told that self-presenting patients with symptoms of potentially more serious conditions are sent directly for assessment from reception without needing to wait for triage. This practice is satisfactory. We were told that median times to treatment for 'minors' was about half an hour, and that generally patients were treated within an hour of arrival. Ambulance arrivals are assessed within 15 minutes of arrival and if admitted, are sent to the EAU, located on the 4th floor but

relatively close to the A&E department. GP 'expected' referrals go directly to the EAU unless they require resuscitation. The A&E department has middle grade medical cover from 08.00 to midnight daily. An emergency nurse practitioner service operates from 09.30 to 22.30, dealing with less serious injuries. Beyond midnight, a single junior doctor provides medical cover, supported by experienced nurses and non-resident consultants.

4.5.4 An 'Emergency Care Therapy Team' is available to support both the A&E department and the EAU at Hartlepool. This team helps avoid inappropriate admissions and supports early safe discharges. There are good links to the Rapid Response Team (RRT), which is an intermediate care team resourced to support patients in the community and prevent unnecessary hospitalisation. We were told about plans to provide IV therapy at home and to implement a 'virtual ward' model. These initiatives are progressive and where they have been implemented elsewhere in the country have been very successful. Overall, the therapy and intermediate care support to the hospital is well resourced, of high quality and ambitious in approach.

4.5.5 The EAU (Emergency Assessment Unit) at Hartlepool takes both GP 'expected' and medical referrals from the A&E department. The visiting team found a well organised ward with good medical and nursing support and a developing programme to deliver 'ambulatory emergency care' (AEC). Currently there is provision to manage low to medium risk patients with chest pain, potential pulmonary embolism and cellulitis. Ambulatory protocols have been produced and were shared with the visiting team. The time between a new patient arriving on the ward and being assessed by a senior doctor was variable depending on how busy the unit was. We were told that it was not uncommon for there to be a period of two hours between arrival and the start of assessment, although all patients have an early warning score recorded within 10 minutes of admission.

4.5.6 There is a level 3 intensive care unit at Hartlepool, which is able to artificially ventilate patients with multiple organ failure. The unit has the required 24-hour resident medical cover. There is also a well-resourced critical care outreach team. In discussions with the consultants who managed the ICU, we learned that their medium term aim was to provide a level 2 service (i.e. high dependency), with the ability to ventilate patients as necessary prior to their transfer to the level 3 unit at Stockton. The reason for the proposed change was that clinically, a level 2 unit was the appropriate level of provision given the nature of activity and demand, and continuing provision of level 3 care was both unnecessary and a strain on resources. In discussion with other consultants at the hospital, we learned that there were concerns about this proposed change of provision that at the time of our visit were unresolved. Our views on this matter are outlined below.

4.5.7 Following previous reconfigurations of services, major and complex surgical and trauma cases bypass Hartlepool and are managed at either Stockton or Middlesbrough. Patients requiring emergency surgery who self-present are transferred by ambulance, although there can sometimes be delays where the problem is not considered urgent. Where clinically appropriate, local patients are transferred back to Hartlepool to complete their recovery after surgery. Orthopaedic surgeons hold fracture clinics each afternoon at Hartlepool, although there is very little direct support to the A&E department. A staff surgeon provides general surgical cover during office hours to the A&E and wards. However, during the late evening and night, it can be very difficult to obtain a surgical opinion on patients at Hartlepool and we found no clear protocols covering contingencies. The default position appeared to be to request an ambulance transfer to Stockton, even where this was probably clinically

unnecessary. Resident surgical cover at Stockton is too thin to allow a doctor to cover both sites, and at the time of our visit, consultant cover was also inadequate, with just one surgeon being available for both sites. Plans to improve consultant cover have been progressed recently, but implementation will not take place until January 2011. This issue is covered in our recommendations below.

4.5.8 Overall, non-hospital based support for people with urgent care needs, long term conditions and those following discharge are good. The Trust's community directorate provides good quality admission avoidance and early supported discharge services, covering longer hours than is typical across England. There is very good provision of residential care. Social services told us that they worked with clients to ensure there was an appropriate awareness of alternatives to residential care so that patients had a choice. Our team visited the Hartsfield's Centre (Social Care Housing), which is a privately run (Joseph Rowntree Foundation) social housing complex in Hartlepool for 242 residents. The centre accommodates the Hartlepool district nursing service, rapid response team, falls team, discharge liaison, occupational therapy, physiotherapy and social care response teams and is a good example of how the NHS and private sector can work constructively together.

5. Our Findings and Recommendations

5.1 Is the A&E Department at the University Hospital of Hartlepool safe?

5.1.1 During our visit, we were told on many occasions that despite the acknowledged problems with medical staffing in the A&E department, there had not been any serious untoward incidents (SUIs) associated with these problems and that, through the hard work, dedication and expertise of the staff on the ground, the department was safe. We were told that the issue was essentially one of 'sustainability', of how long the present situation could remain safe through the willingness of staff to 'go the extra mile'.

5.1.2 The problem with this type of argument is that everything can appear to be safe until something bad happens. People then ask, 'Was the situation really safe?', and turn to the recommendations of the experts for guidance.

5.1.3 The medical staffing levels in the A&E department at night fall well short of the recommendations of the College of Emergency Medicine[10]. For A&E departments seeing 40,000 or more patients a year (such as at Hartlepool), the College says that:

> "*The minimum of eight [middle grade] doctors would be needed to provide 24-hour cover. This cover is* ***essential*** *[*their emphasis*] in a department of this size and throughput*".

Even for smaller A&E departments, the College recommends 24-hour middle grade cover in the interests of patient safety, despite acknowledging that this may not be economically justifiable.

5.1.4 The combined middle grade establishment of both A&E departments run by the Trust amounts to 15 whole time equivalents, with 10.3 in-post (4.7 vacancies). Given the inability of the Trust to recruit to its establishment, the likelihood to staffing two A&E departments round-the-clock to College recommended levels is remote. Retaining two A&E departments compromises safety at both. A single, consolidated unit would be much better able to provide safe and consistent cover 24-hours a day and to cope with the surges in activity that can occur throughout the year.

5.1.5 It is our view that the present medical staffing at the A&E department of the University Hospital of Hartlepool creates an unacceptable degree of risk. It is essential that patients arriving with urgent medical conditions are seen in a timely manner by an experienced doctor of at least middle grade level who is capable of assessing and stabilising their condition.

5.2 Our recommendations relating to the A&E department

5.2.1 In our view, the A&E department at Hartlepool should not operate in the absence of resident middle grade medical cover.

5.2.2 As a minimum, the A&E department should close to ambulances from 20.00 and not reopen until 08.00. A 20.00 closure is required to ensure that all patients requiring assessment and stabilisation have been dealt with and transferred to a bed by midnight, a process which can take up to four hours.

5.2.3 If a night time closure is decided upon, arrangements will need to be made to ensure that patients coming to the department 'out of hours' are redirected appropriately.

5.2.4 The Trust's current proposal to close the A&E department and accept GP referrals and differentiated ambulance arrivals direct to the EAU is a similar model to that we have seen working effectively in other parts of the country. It creates an alternative to the current model, can provide 24-hour medical staffing and potentially will enhance the safety of the main receiving A&E department at Stockton by concentrating resources there.

5.2.5 We believe that both alternatives are potentially workable prior to the opening of the new hospital and recommend that these options are considered.

5.3 The Proposed EAU Model

5.3.1 In principle, the proposed EAU model is a viable alternative to the type of 'majors' service currently provided at Hartlepool A&E. Clinicians on the EAU that we spoke with understood that taking patients direct from 999 ambulances would require some changes to their current approach, and we think that this is particularly true in terms of required response times.

5.3.2 The Royal College of Physicians UK Consensus Statement on Acute Medicine (November 2008) states that:

> *Patients should be assessed by a competent decision-maker within 30 minutes of in-hospital referral to an acute medical team from the emergency department or on arrival at an acute medical unit if directly referred……*[and]….*a treatment and investigation plan should be formulated and instigated within 60 minutes of arrival*

The EAU currently does not consistently meet this standard for A&E referred patients, and will need to meet the more stringent standard applying to patients arriving by ambulance in the new model.

5.3.3 During our visit, we considered whether the physical environment of the EAU was satisfactory to meet the needs of the proposed future model. The ward is located on the 4th floor of the hospital, although it is relatively close to the current A&E department. While it is not ideal for patients arriving by ambulance to have to travel to an assessment and treatment area by lift, there is at least one example in the country of a similar arrangement that we are

aware of and the ambulance service did not regard this as a problem when we spoke with them.

5.3.4 Apart from the lift issue, the entrance to the EAU is relatively narrow and is used for deliveries, visitor access, staff access etc. It can become congested. It is not ideal for ambulance arrivals to share an access point in this way, because of flow issues and the need to preserve patient's privacy and dignity.

5.3.5 The majority of the diagnostic services are located on the ground floor at Hartlepool, with the result that all patients arriving on the EAU who require diagnostics would need to be moved back down to the ground floor after initial assessment and then back up to the EAU.

5.3.6 We were told that some medical staff favoured the current location of the EAU, as moving it to the ground floor might confuse the public in terms of its function. We did not consider this argument to have merit. We were also told that one of the concerns was that moving the EAU to the ground floor would separate the medical staff at night from the main ward patients with the potential to reduce the responsiveness to 'deteriorating in-patients'. The distance involved is smaller than many other units we have reviewed. We would suggest that a robust 'track and trigger' system and a clear escalation process to respond to the potential 'deteriorating patient' is more the issue than the physical location.

5.4 Our recommendations relating to the EAU

5.4.1 The EAU must develop an appropriate array of internal professional standards, which mirror those of A&E departments and align with College guidance, to ensure that patients are assessed promptly when they arrive.

5.4.2 Performance against these standards should be measured to ensure compliance, and in particular that patients are assessed by a competent clinical decision maker within 30 minutes of arrival; that a treatment plan is instigated within 60 minutes; and that a consultant approved treatment plan, which includes an expected date of discharge, is signed off within 12 hours. This is the minimum recommendation from the Consensus statement and would meet the recommendations from NICE and NCEPOD. However, the Trust may wish to consider a tighter framework in view of the relatively isolated nature of the EAU.

5.4.3 The Trust should review the decision to retain the EAU on the 4th floor under the new model. While we accept that cost considerations may preclude a move, we believe that there would be significant advantages to patient care if the unit was on the ground floor in close proximity to the ambulance entrance and the diagnostic imaging department.

5.5 Intensive Care

5.5.1 There were anxieties amongst some consultants that without a level 3 Intensive Care Unit, acute medicine will be unsustainable on the Hartlepool site. The proposal from the ICU consultants to change provision to level 2 was therefore seen as potentially threatening acute medicine at Hartlepool.

5.5.2 The Royal College of Physicians[10] makes the following comments under the heading, 'Acute medical care in hospitals without an emergency department':

> *Some local hospitals within a local emergency care network do not have an emergency department. However, these hospitals will still need access to acute*

medical care, ideally coordinated via an AMU [acute medical unit]. For example, these hospitals could still deliver direct access to inpatient acute medical care for a local population according to agreed clinical pathways. Moreover, patients in these hospitals may develop a need for acute medical care if their clinical condition deteriorates in hospital. Such hospitals may or may not offer 24/7 acute medical admissions, depending on local need. Where such AMUs do exist they will need access to higher dependency care facilities (at least level 2 critical care) as part of a critical care network. This should be organised through agreed networks of care and protocols.

…..and recommends:

'… that AMUs develop an augmented care area (up to level 2 care) and staff with competencies to deliver this level of care. Safe transfer arrangements must be in place to ensure level 3 care when required. We recommend that large acute hospitals dealing with complex acute medicine must have onsite access to level 3 critical care (i.e. intensive care units with full ventilatory support).

5.5.3 From this guidance, it is clear that while Hartlepool requires a high dependency capability (level 2) to support acute medicine, a level 3 ICU with full ventilatory capability is unnecessary, although the ability to stabilise and transfer is essential. There must therefore be a clear and robust process to be able to escalate up to level 3 temporarily if necessary to stabilise in preparation for transfer.

5.6 Our recommendations relating to Intensive Care

5.6.1 The plans to receive acute medical patients direct to the EAU rely on the provision of a level 2 critical care service at Hartlepool and clear protocols for the stabilisation and transfer of patients who require level 3 critical care. Level 3 provision at Hartlepool is unnecessary.

5.6.2 It is important that senior medical staff at the Trust develop a consensus on what constitutes a safe clinical service. This should be based on College guidance and known good practice.

5.7 The One Life Centre

5.7.1 In our view the plans for the use of the One Life Centre require further work. The aim is clearly to have co-located minor injuries, minor illnesses and out of hours services in the Centre, although the current Walk-in Centre (WiC) has yet to agree to the proposed relocation. GPs from the emergent GP consortium indicated to us that they would want to revisit the way in which services were provided from the Centre when the consortium became 'live'. This aspiration needs to be factored into thinking.

5.7.2 Governance arrangements seemed to us to be a little unclear, and there appeared to be optimism rather than clear process in the way that the various services would work together. The Primary Care Foundation in its recent publication on GPs and A&Es stressed the need for integrated governance structures and good working relationships where urgent care services from different organisations work together. We feel that this advice should be applied to the working of the Centre.

5.8 Our recommendations – the One Life Centre

5.8.1 We recommend that a clear plan is agreed for what services will be provided from the One Life Centre, the aims of the services (individually and collectively) and their success criteria. The plan should be explicitly endorsed by leading GPs so that their commissioning consortium will inherit a plan that the local health community is signed up to.

5.8.2 We do not believe that it will be wise to have minor injuries, minor illnesses (WiC) and Out of Hours operating as separate services, with or without a contractual obligation to cooperate. We suggest that the PCT considers asking a lead organisation to hold the contract for the provision of services at the Centre and to sub-contract with its partners. This will help ensure that governance is seamless and that there is unity of purpose.

5.9 Surgical Support to University Hospital of Hartlepool

5.9.1 We were concerned at the lack of clarity concerning how to obtain a surgical opinion at Hartlepool, and particularly at night.

5.9.2 In the absence of appropriate guidance, middle grade doctors at Hartlepool have felt obliged on occasions to transfer their patients to Stockton at night in order to obtain a surgical opinion. This is poor practice and is a rare example of the Trust failing to address an important issue with its usual vigour and effectiveness.

5.9.3 We were told that there is a plan to have two consultant surgeons on-call at night from January, but we felt this was too far off and needed more thought.

5.10 Our Recommendations – Surgical Support

5.10.1 We recommend that the Trust develops a clear, written protocol for how to obtain a surgical opinion at Hartlepool as a matter of urgency. The lack of clarity puts doctors at Hartlepool into a difficult position, wastes resources and is bad for patients.

5.10.2 We recommend that the proposal to have two senior doctors on call for the Trust is brought forward.

5.11 Ambulance Services

5.11.1 The closure of the A&E department at Hartlepool and the opening of the One Life Centre to minor injuries will have significant, knock on effects on the ambulance service. Additional journeys will be required to and between the Trust's sites and without appropriate resourcing, this may affect overall ambulance response times.

5.11.2 At the time of our visit, there was a view in the Trust and PCT that protocols for ambulance transfers were in hand and that there were no major outstanding issues to be resolved. We were told that unresolved details were down to the need to suspend the closure of Hartlepool A&E department and halt the associated planning activities until the review process was complete.

5.11.3 Representatives from the North East Ambulance Service (NEAS) told us that they had not yet agreed protocols and were concerned that the cost implications of the proposed changes were not yet owned collectively by local health partners. Despite this, NEAS felt that relationships with the Trust and PCT were generally good and that the Trust was good at engaging the service in change processes.

5.12 Our recommendations – ambulance services

5.12.1 We do not believe that it is necessary to suspend planning until the issue of the proposed changes to A&E services is resolved. It is necessary to work through all potential scenarios to inform the debate and this can be without prejudice to the final outcome. Given that the eventual closure of Hartlepool A&E has already been agreed (when the new hospital opens), any reasonable observer would expect the Trust to be planning the detail of transitional arrangements. We would also add that given the Trust intended to close the A&E department in November, detailed plans should have been developed and agreed some time ago and ideally before the decision to hold a review was made. We therefore *recommend* that planning is recommenced.

5.12.2 Both the Trust and NEAS told us that they wanted, and understood the need for, 'simple rules' to govern which patients are conveyed to Hartlepool Hospital following any changes to A&E provision there. We endorse this view and *recommend* a meeting at the earliest opportunity to agree and sign off protocols.

5.12.3 It will be important that conveyance to the EAU by ambulance is based on clinical need and not bed availability on the ward. This principle requires agreement and the Trust will then need to manage its overall bed stock to ensure 24/7 access to the EAU.

5.12.4 We *recommend* that the PCT leads a discussion with NEAS to agree the cost implications of scenarios around changes to A&E provision at Hartlepool, and how additional costs will be met. It is important that overall ambulance response times are considered during the planning process.

5.12.5 We were told that where appropriate, Hartlepool residents admitted as emergencies to Stockton will have the option of 'repatriation' to Hartlepool Hospital. The Trust should decide if it needs to contract with NEAS PTS for transfers on the day of request, and will need to ensure that transfers and handovers are completed by early afternoon to ensure that delays to care plans do not take place. There is a risk that this proposed policy will disrupt care plans and increase length of stay if it is not expertly managed.

5.12.6 We were told that the One Life Centre would encourage and accept ambulance arrivals of appropriate patients with urgent care needs. In our experience, it is difficult to develop protocols for conveyance to WiCs/Urgent care centres that are workable for ambulance professionals, and this typically leads to a disappointing conveyance rate and/or onward transportation to A&E departments (wasting resources and incurring additional costs). While we would endorse a pilot project, we would *recommend* thorough evaluation after 6 months and a willingness to re-evaluate the One Life Centre as an ambulance destination if necessary.

5.13 Services for Children

5.13.1 Hartlepool hospital has a 'paediatric day assessment unit' catering for children with less serious conditions. Local paediatric emergencies are taken by 999 ambulances to Stockton, where there is a consultant led inpatient unit. This arrangement appears to work well, with occasional problems arising when parents inappropriately bring sick children to the A&E department at Hartlepool during the night. While we were told that none of these very sick children had had an adverse outcome, the children's doctors we spoke with felt the situations had been inherently unsafe.

5.13.3 The paediatric day assessment unit is soon to become fully nurse led, with telephone support from consultants and on-site medical support from clinic doctors. We felt that the plans appeared well thought through, with appropriate protocols and safety issues taken into account.

5.13.4 We were told that the One Life Centre was also expecting to see children from two years old up. This may need some thinking through, as the Centre does not appear to have a robust paediatric nursing strategy and there is also a risk of service duplication and public confusion.

5.14 Our recommendations – services for children

5.14.1 We would reiterate our concerns regarding Hartlepool's A&E department at night and note that a department with such poor medical cover is an entirely inappropriate destination for very poorly children.

5.14.2 We recommend that commissioners satisfy themselves that the locality requires children's' services provided by primary care, the One Life Centre and by the Trust. Where services for children are provided at the One Life Centre, we recommend that commissioners ensure that these are appropriately staffed to manage children.

6. Are there alternatives to the proposed new model of care?

6.1 The proposed new model consists of the closure of the A&E department at University Hospital of Hartlepool; provision for selected emergency medical admissions to the EAU in its current location at the hospital; and the transfer of the service for less serious injuries to the One Life Centre, where it will work in collaboration with the minor illness service and primary care out-of-hours service.

6.2 This report has focussed on the safety and efficacy of the current urgent and emergency care system, and of the proposals for change. We recognise that there may be other options for change that could be considered, each with its advantages and disadvantages. For completeness, some possible alternatives are listed below:

6.2.1 Preserve the status quo until a new hospital opens.
6.2.2 Close Hartlepool A&E to ambulance arrivals from 20.00 hrs to 08.00 hrs (with either a. A continued presence of the minor injuries stream run by ENPs 24/7; or b. A 'minors' stream run by ENPs, but closing at the same time as the A&E to ambulances.
6.2.3 Current proposal as outlined in 6.1 above.
6.2.4 Current proposal, but with the EAU on ground floor of the hospital.
6.2.5 EAU on ground floor with 'selected' ambulance arrivals and continued minors service as in 6.2.2 above.
6.2.6 Centralise all emergency admissions to the North Tees (Stockton) site with the closure of the A&E at Hartlepool.

6.3 It will be clear from this report that we do *not* consider the status quo to be a viable option and we strongly recommend against it. The other options are for health planners, local people, and their representatives to consider. The aim should be to build a safe, sustainable and affordable local urgent and emergency care system.

7. Conclusion

7.1 Hartlepool receives an excellent level of urgent and emergency care from its local health care providers. We found many examples of good practice during our visit and a very real focus on the provision of comprehensive and safe patient care.

7.2 The need to address what amounts to a risky night time A&E service is essential, and this cannot wait until a new hospital has been opened. It is far better to have a safe service a bit further away than a risky one on the doorstep. Surgical cover to Hartlepool must also be improved and the times for a competent clinical decision maker to assess patients arriving on the EAU reduced.

7.3 In our view, additional planning is needed to ensure the efficacy of services during the transition period while the system continues to explore the opportunities for a new hospital. Key issues that require resolution include:

- Building a consensus amongst the consultant community on the essential aspects of a safe medical service at Hartlepool
- the EAU must develop and work to internal professional standards based on College guidance
- protocols for ambulance conveyance need agreeing
- the role and operation of the One Life Centre needs further clarification.

All of these are 'fixable' and we have great confidence that by working together, the local health community will resolve all the issues we have raised.

Russell Emeny RGN
Dr Ian Sturgess FRCP
Mark Ellis RGN
NHS IMAS

November 2010

IMAS Report: Appendix 1

Day one visits
3 November 2010

Time	Meeting	Team One/Venue	Team Two/Venue
0900	Meet and greet with Alan Foster and Julie Gillon, Carole Langrick, David Emerton, Nick Roper	Board Room, North Tees	
0915	Alan Foster, Chief Executive/John Maddison, Director of Finance	Board Room, North Tees	
0945	Carole Langrick, Deputy Chief Executive/Director of Strategic Development	Board Room, North Tees	
1030	Julie Gillon, Director of Clinical Services and Compliance		

1100	Meet with Operational Managers and Senior Clinical Matrons: **Operational Managers** Sue Piggott, General Manager, Medicine Rowena Dean, General Manager, Orthopaedics Gill Carton, Associate Director, Emergency Care Julie Lane, Service Manager, Family Health (Gynae&Paeds) Lynn Kirby, Associate Director, Elective Pathways Sally Lagan, Associate Director, Service Developments and Projects Nicola Jones, Service Manager, General Surgery & Urology Chris Greaves, General Manager, Anaesthetics Rabina Tindale, Service Manager, A&E Barbara Carr, Associate Director, Nursing and Patient Safety	**Team 1** **Board Room, North Tees**	**Team 2** **Senior Clinical Nurses** Karen Oram, Matron, A&E, UHH Stuart Harper, Matron, A&E, UHNT Fiona McEvoy, Matron, Medicine, UHH Gail Fincken, Matron, Medicine, UHNT Pauline Townsend, Matron, Elderly Care Heather Duckers, Matron, Paediatrics **In the Seminar Room, 4th Floor, North Wing**. **11.30 am** Meet with Gill Carton, AD Elective Pathways and Sue Piggott, General Manager, Medicine and Elderly Care. **In the Seminar Room, 4th Floor, North Wing**

12 noon	***Travel to University Hospital of Hartlepool or Video Conferencing to UHH***	**Team 1** Travel to University Hospital of Hartlepool	**Team 2** **12 noon** Lunch and Meet with: Sue Piggott, GM, Medicine and Elderly Care Mel Cambage, Team Leader Rapid Response/Discharge Fiona Dinsdale, Patient Flow Manager Shirley Anderson, Locality Manager, Intermediate Care, UHH And Mental Health Representative **Discussion Room, 4th Floor, North Wing, North Tees**

1230 pm	Meet with Clinicians: Dr Basant Chaudhury, Clinical Director, General Medicine Dr Nick Roper, Consultant Physician Dr Sony Anthony, Consultant Cardiologist Dr Katie Elmer, Consultant Physician Dr Jay Vasani, Consultant Gastroenterologist Dr Kumar, Consultant Physician Dr Helen Skinner, Consultant Physician Dr Chris Ward, Consultant Physician Mr Chris Tulloch, Clinical Director, Orthopaedics Dr Jaget Jani, Clinical Director, Paediatrics Mr Pud Bhaskar, Clinical Director, General Urgery Mr Matt Tabaqchali, Associate Medical Director Dr Naranyan Suresh, Clinical Director, Anaesthetics	**Team 1** Board Room, University Hospital of Hartlepool and video conferencing to the University Hospital of North Tees lunch served during this period	**Team 2** **12.45 pm** Meet with Joanne Dobson, Systems Reform Manager, Tees PCT and Ali Wilson, Director of Health Systems and Estates Development, Tees PCT Venue: Discussion Room, 4th Floor, North Wing, North Tees
1330 pm	Meet with Community Directorate Representatives **(90 mins):** Linda Watson, Clinical Director, Community Services Julie Parkes, Therapy Services Manager Nick McDonaugh, Assistant Director of Specialist Services John Lovatt, Acting Assistant Director of Operations, Hartlepool Borough Council Sean McAnaneay, Assistant Director of Operations, Stockton Borough Council	**Team 1** Board Room, University Hospital of Hartlepool	**Team 2** **1315** EAU and tour Ambulatory Care, North Tees accompanied by: Julie Gillon, Director of Clinical Services Sue Piggott, GM Medicine and Dr Dawn Ashley, Consultant Physician
1400 pm	**Meet with PCT representatives (60 minutes)** Neil Nicholson, Acting Chief Executive Professor Peter Kelly, Director of Public Health Martin Phillips	**Team 2** Board Room, University Hospital of North Tees	

1500 pm	**BREAK**		**Team 2** ***option to travel to Hartlepool site to meet with IMAS Colleagues, however, video conferencing will be available*****.**
1530 pm	**Summary Time for IMAS Teams**		
1630 pm	Meet with GP representatives Dr Carl Parker (others to be confirmed)	Board Room, University Hospital of Hartlepool and afternoon tea	
1730	**CLOSE**		

Day two visits
4 November 2010

Time	Meeting	Team and Venue	Team and Venue
0900	Meet with Julie Gillon, Rabina Tindale and Gill Carton, Andrew Simson and Linda Watson at the entrance to A&E on the University Hospital of Hartlepool site.	Team One to remain at Hartlepool site to tour the patient pathway, whilst Team 2 will travel to Hartfields with Linda Watson.	
0915	Walk the Pathway Journey in Accident and Emergency and EAU (meet with Dr Jay Vasani, Consultant Physician and Fiona McEvoy, Senior Clinical Matron for Medicine and Elderly care at the University Hospital of Hartlepool)	**Team 1** Walking the Patient Pathway in A&E	**Team 2** Visit Hartfields with Linda Watson to walk through centre meeting with Multi Link, Rapid Response Team, Stroke Team, Social Care Staff, Discharge Team, Community Matrons
1100	Meet with Accident and Emergency Consultants: Andy Simpson, Clinical Director Kay Adeboye, Consultant in A&E Medicine Gill Davidson, Consultant in A&E Medicine Suresh Wadhwani, Consultant in A&E Medicine Alex Thomas, Consultant in A&E Medicine Ann Thistlethwaite, Consultant in A&E Medicine Dougal Southward, Consultant in A&E Medicine Raluca Ciornei, Consultant in A&E Medicine	**Team 1:** A&E Seminar Room, University Hospital of Hartlepool	**10.15 am** Travel to One Life Centre **10.30 am** Vist the One Life Centre at Hartlepool accompanied by Angela Hornsey, Manager of the OneLife Centre.
1230	Meet with Ambulance Representatives: Paul Liversidge, Director of Operations Elaine Bennington, Operational Performance & Commissioning Manager Dougie McDougall, Operations Manager (Tees A&E) Paul Fell, Head of Clinical Care and Patient Saffety	Board Room, University Hospital of Hartlepool Lunch wiill be served.	

1330 pm	**Visit to areas.**	**Team 1** Paediatrics with Heather Duckers, (Consultant Paediatrician tbc) and Julie Gillon	**Team 2** Stroke unit and Ward 9 with Sue Piggott/Basant Chaudhury/David Bruce
1430 pm	Summing up period with: Alan Foster, Chief Executive Carole Langrick, Deputy CE/Director of Strategic Development Julie Gillon, Director of Clinical Services and Compliance David Emerton, Medical Director Nick Roper, Associate Medical Director	Board Room, University Hospital of Hartlepool	
1500 pm	Depart for train to Newcastle		

IMAS **Report: Appendix 2**

The NHS IMAS Team

Dr Ian Sturgess BSc MB ChB FRCP is a Consultant Physician in General and Geriatric Medicine at East Kent Hospitals University NHS Foundation Trust. He combines his clinical work with his role as Associate Medical Director Patient Safety, having held a number of Clinical Director roles. He has been involved in improving emergency care flows since 2002 working with the Emergency Services Collaborative, the NHS Institute for Innovation and Improvement and is currently seconded part time as clinical lead of the Urgent and Emergency Care Intensive Support Team (ECIST).

Mr Russell Emeny BA (Hons), RGN, is the Director of the national Urgent and Emergency Care Intensive Support Team (ECIST). Trained as a registered nurse at St. Mary's Hospital, London, he has held a succession of clinical and managerial posts, including roles in large acute Trusts as Director of Operations and Director of Strategy, and in a PCT as Director of Commissioning.

Mr Mark Ellis RGN is a registered nurse with experience in Intensive Care, Cardiac and Accident and Emergency nursing. In 2005, he was appointed NHS Emergency Care Lead for Wales and more recently has been Director of Service Transformation in two UK Ambulance Services. Mark joined the Urgent and Emergency Care Intensive Support Team (ECIST) in May 2009.

NHS IMAS (NHS Interim Management and Support) and ECIST
NHS IMAS is an NHS organisation established to provide short and medium term support from the NHS to the NHS. It brings together experienced NHS managers and clinicians to provide consultancy and interim support to NHS Trusts and PCTs as a high quality alternative to employing external consultancies. **ECIST** is an arm of NHS IMAS that is funded by the NHS to support emergency and urgent care improvement programmes across the service in England.

Appendix 3

Documents received and reviewed by the Panel

No.	Document title:	Received from:
1.	IMAS report	NHS IMAS
2.	A&E staffing information	North Tees and Hartlepool NHS Foundation Trust
3.	Briefing from the School of Acute Specialties	Northern Deanery
4.	Briefing from the Foundation School	Northern Deanery
5.	2005 Sir Darzi 'Acute Service Review – Hartlepool & Teeside'	Momentum Project Office
6.	Momentum project – consultation summary document	Momentum Project Office
7.	Momentum project – full consultation document	Momentum Project Office
8.	Future Accident and Emergency Workload and Delivery, Project Scope – September 2009	Momentum Project Office
9.	A&E / MIU Value Impact Assessment – June 2010	Momentum Project Office
10.	Hartlepool Joint Needs Assessment – October 2010, summary of commissioning priorities for Hartlepool	Downloaded from NHS Tees Public Helath website
11.	Independent Reconfiguration Panel report 'Advice on Proposals for Changes to Maternity and Paediatric Services in North Tees And Hartlepool' – December 2006	North Tees and Hartlepool NHS Foundation Trust
12.	A&E / MIU Implementation Timeline Plan, August to November 2010	North Tees and Hartlepool NHS Foundation Trust
13.	A&E reconfiguration (23:00-08:00)	North Tees and Hartlepool NHS Foundation Trust
14.	A&E / MUI / OOHs Implementation Plan, communications and engagement document	North Tees and Hartlepool NHS Foundation Trust
15.	Information about current A&E (facilities, size, staffing etc) at Stockton	North Tees and Hartlepool NHS Foundation Trust
16.	A&E Attendance Review	North Tees and Hartlepool NHS Foundation Trust
17.	Equipment MIU	North Tees and Hartlepool NHS Foundation Trust
18.	Current capacity figures; arrivals accepted and not accepted at UHH	North Tees and Hartlepool NHS Foundation Trust
19.	UHH attenders by diagnosis November and December 2010	North Tees and Hartlepool NHS Foundation Trust
20.	Impact analysis of North Tees site if MIU model delivered at UHH or One Life Centre (radiology)	North Tees and Hartlepool NHS Foundation Trust
21.	Map showing category A incidents within the Tees area for the six month period July 2010 to December 2010, 6.5 minutes response isochrones based by stations and stand by points	North East Ambulance Service NHS Trust

22.	Map showing category B incidents wthin the Tees area for the six months period July 2010 to December 2010, 17.5 minutes response isochrones based by stations and stand by points	North East Ambulance Service NHS Trust
23.	Telemedicine: briefing document for trust executive team 21 September 2010	North Tees and Hartlepool NHS Foundation Trust
24.	Telemedicine: presentation to trust executive team delivered on 21 September 2010	North Tees and Hartlepool NHS Foundation Trust
25.	Telehealth Care Briefing – 7 September 2010	North Tees and Hartlepool NHS Foundation Trust
26.	Operational Guidance for Emergency Care Pathways – post accident and emergency re-configuration at University Hospital of Hartlepool – November 2010	North Tees and Hartlepool NHS Foundation Trust
27.	Standard Operating Procedure for the rapid assessment of major patients in accident and emergency	North Tees and Hartlepool NHS Foundation Trust
28.	Protocol for obtaining surgical opinon at UHH	North Tees and Hartlepool NHS Foundation Trust
29.	Management of acute upper GI bleeding	North Tees and Hartlepool NHS Foundation Trust
30.	Patient pathways orthopaedics	North Tees and Hartlepool NHS Foundation Trust
31.	Ambulance treatment of cellulitis	North Tees and Hartlepool NHS Foundation Trust
32.	Outpatient DVT proforma	North Tees and Hartlepool NHS Foundation Trust
33.	Outpatient management of PE proforma	North Tees and Hartlepool NHS Foundation Trust
34.	Report of complaints received relating to the A&E department 1 April 2010 – 31 December 2010	North Tees and Hartlepool NHS Foundation Trust
35.	Statements from the trust and Northern Deanery on their role in undergraduate teaching, and their expectations for the future	North Tees and Hartlepool NHS Foundation Trust and Northern Deanery Postgraduate Dean
36.	Secrutary of states 4 tests for service reconfiguration	NHS North East
37.	Hartlepool LINk Enter and View visit report to A&E services at Hartlepool on 17 January 2011	Hartlepool LINk
38.	Hartlepool LINk Annual Report	Hartlepool LINk
39.	Hartlepool LIKk Publication	Hartlepool LINk
40.	One Life Centre Operational Policy	North Tees and Hartlepool NHS Foundation Trust
41.	MIU Operational Policy	North Tees and Hartlepool NHS Foundation Trust
42.	Project Initiation Document – A&E, Minor Injuries, OOH Provision Project (Hartlepool)	North Tees and Hartlepool NHS Foundation Trust

43.	Momentum A&E/MIU Project Group email trail (July – August 2010)	North Tees and Hartlepool NHS Foundation Trust
44.	Acute Service Review – clinical practice circular December 2006	North Tees and Hartlepool NHS Foundation Trust
45.	ICT Project Initiation document	North Tees and Hartlepool NHS Foundation Trust
46.	Triage Operational Policy	North Tees and Hartlepool NHS Foundation Trust
47.	Triage training pack	North Tees and Hartlepool NHS Foundation Trust
48.	Figures on the numbers of referrals to University of Hartlepool Hospital A&E from walk in centres and GP's out of hours services, by age group and patients	North Tees and Hartlepool NHS Foundation Trust
49.	Figures on numbers of referrals to University of North Tees Hosptial A&E from walk in centres and GP's out of hours services, by age group and patients	North Tees and Hartlepool NHS Foundation Trust
50.	Figures to show number of A&E attendance activity for University of Hartlepool Hospital between June and December 2010, by age group of patients	North Tees and Hartlepool NHS Foundation Trust
51.	Figures to show number of A&E attendance activity for University of North Tees Hospital between June and December 2010, by age group of patients	North Tees and Hartlepool NHS Foundation Trust
52.	Summary document outlining the Trusts plans / work-streams for the momentum pathways	North Tees and Hartlepool NHS Foundation Trust
53.	Strategic Outline Case: Momentum: Pathways to Healthcare, Community Facilities Development	NHS Tees
54.	North Tees and Hartlepool NHS Foundation Trust Validation Visit Report for: urgent and emergency care; diabetes services; stroke services; respiratory services	NHS Tees
55.	A&E / MIU financial options model – June 2010	North Tees and Hartlepool NHS Foundation Trust

Appendix 4

Externally led review of A&E services
University Hospital of Hartlepool

Review dates: **26 and 27 January 2011**

- **Final - REVIEW PROGRAMME**

Day 1 – 26 January 2011 – One Life Centre, Hartlepool

08.45 – 09.30 (45min) **Private Session A**	Review Panel pre-meeting
09.30 – 10.00 (30min) **Session 1**	Review Panel meet with Trust Senior Team to provide overview of the two days and confirm process
10.00 – 10.45 (45min) **Session 2**	Review Panel meet with representatives from IMAS
10.45 – 11.00	15 minute comfort break
11.00 – 12.15 (1hr 15min) **Session 3**	Review Panel walk round and meet team at One Life Centre
12.15 – 13.30 (1hr 15min) **Private Session B**	Evidence review & panel discussion (Working lunch – to be served at 12.30)
13.30 – 14.15 (45min) **Session 4**	Review panel meet with representatives from PCT
14.15 – 15.15 **Private Session C**	Evidence review & panel discussion (15 minute comfort break)
15.15 – 16.15 (1hr) **Session 5**	Review panel meet with representative from the public groups (TBC)
16.15 – 16.30	15 minute comfort break
16.30 – 17.15 (45min) **Session 6**	Review panel meet with trust senior team
17.15 – 18.00 (45min) **Private Session D**	Review Panel final discussion to reflect on day, agreement of emerging themes, agreed any additional evidence to be requested from trust and questions for sessions on following day

Close by 18:00

Day 2 – 27 January 21011 – University of Hartlepool Hospital, Education Centre

08.30 – 09.30 (1hr) **Private Session A**	Review Panel meeting – review previous day and consider any additional evidence requested	
9.30 – 11.00 (1hr 30min) **Session 1**	Review panel to visit and walk round A&E and medical assessment unit	
11.00 – 11.30 (30min) **Private Session B**	Review panel reconvene – debrief from visit to A&E and medical assessment unit	
11.30 – 12.15 (45min) **Panel will split in two for this session** **Session 2**	Team A Review panel members meet with selection of doctors from all training and non-training grades (SAS) doctors	Team B Review panel members meet with Ambulance Service representatives
12.15 – 13.45 (1hr 30min) **Private Session C**	Evidence review & panel discussion (Working lunch – to be served at 13.00)	
13.45 – 14.30 (45min) **Session 3**	Review Panel meet with A&E / medical admissions nurses	
14.30 – 15.00	30 minute comfort break	
15.00 – 15.45 (45min) **Panel will split in two for this session** **Session 4**	Team A Review panel meet with consultants from A&E and medical admissions	Team B Review Panel meet with representatives from consultant teams who are involved in A&E services
15.45 – 16.00	15 minute comfort break	
16.00 – 16.45 (45min) **Session 5**	Review panel meet with colleagues representing the GP commissioner	
16.45 – 17.45 (1hr) **Private Session D**	Review panel final discussion and agreement of findings/recommendations	
17.30 – 18.00 (30min) **Session 6**	Initial feedback session - the review panel will meet with representation from the PCT, GP commissioners and senior trust colleagues to outlining the panel's findings.	

Refreshments will be served as appropriate during the 2 days

The panel may request additional evidence during the visit from the trust

Appendix 5

Panel members biographical details

Professor Stephen Singleton (Panel Chair)

Stephen is Regional Director of Public Health, Medical Director and Chief Knowledge Officer of the North East Strategic Health Authority.

From a background as a rural GP and Director of Public Health in Northumberland he has been Medical Director of NHS North East since its inception, previously being in the post for the former Northumberland, Tyne and Wear SHA. Stephen has a long term interest in knowledge management and until very recently was Vice Chair of the NHS Evidence Advisory Board (NICE). For NHS North East he leads on strategy, performance, leadership development and public health. As a senior civil servant with the Department of Health he also has a formal liaison role with the Department of Work and Pensions.

Stephen is a Visiting Professor of Applied Epidemiology in the Institute of Health and Society at Newcastle University and has research interests in quality, safety, medical education and informatics.

Stephen is Chair of the Trustees of the Children's Foundation.

Dr Ed Glucksman

Ed is a Consultant in Emergency Medicine and has worked in this capacity at King's College Hospital NHS Foundation Trust, London since 1981.

Ed was Clinical Director for Accident & Emergency Services at King's College Hospital from 1992-2003 and since then has been the Clinical Director for the Medical Division which includes Emergency Medicine. He was Registrar, and then Vice President of the College of Emergency Medicine (1997-2010) and is a College UK and overseas examiner.

Ed is a GMC Associate involved in standard setting for the PLAB examination and is a team leader for assessments under the GMC's performance procedures.

Ed is a past President of the Emergency Medicine Section of the Royal Society of Medicine and continues to serve on the Section's Council.

Councillor Stephen Akers-Belcher

Stephen is the current Chair of the Health Scrutiny Forum at Hartlepool Borough Council and has represented the Rift House Ward, Hartlepool since 2004. Stephen has an employment background in elderly care and is currently working in the mental health sector.

Stephen's main ambition on entering Council was to be a community councillor, this has shaped Stephen's tenure as an Elected Member and has lead to him helping to set up The Rifty project, which is a community based youth group catering for around 60 young people.

Councillor Sheila Griffin
Sheila is the current Vice Chair of the Health Scrutiny Forum at Hartlepool Borough Council and has represented the Brus Ward, Hartlepool since 1991. Sheila is Secretary of the West View Friendship Group, an active member of Churches Together, Director of West View Advice and Resource Centre which was set up 25 years ago by the Christian Council, has been Director of West View Project for the last 30 years which provides activities for young people. Sheila is also a mother to two sons, grandmother of six, great-grandmother of three and a member of the Hartlepool Labour Party.

Ms Sandra Collinson
Sandra is a Nurse Consultant in Emergency Care at City Hospitals Sunderland and has been in post since 2000. She works in main A/E and the nurse led walk in centre where 800000 patients a year are seen.

Sandra currently leads a team of 14 ENP's and runs a nurse led area within A/E. She is also the lead for nursing on falls and radiological group directions in the Trust, as well as delivering a wide range of education courses- ALERT, IMPACT, Trauma and clinical skills for nurses. Sandra is about to start teaching part time on a nurse practitioner degree course at Northumbria University.

Sandra has worked in A/E since 1978 and worked in four A & E departments across the North East.

Professor Tim Blackman
Tim is Professor of Sociology and Social Policy in the School of Applied Social Sciences at Durham University and Director of the University's Wolfson Research Institute, a cross-faculty research institute bringing together almost 200 academics working on a wide range of health and wellbeing topics.

Tim is also Dean for Queen's Campus in Stockton-on-Tees, where Durham's medical and biomedical programmes are based along with human sciences, psychology, finance, management and marketing, and where the University hosts the North East Public Health Observatory and the Northern Deanery's Tees Valley Vocational Training Scheme.

Tim's early academic interests were in housing, urban planning, health improvement and community action, but now focus on comparative policy research and systems thinking, with recent projects funded by the National Institute for Health Research on Spearhead Primary Care Trusts and the Economic and Social Research Council on approaches to tackling health inequalities across the countries of the UK.

Tim also has interests in methodological innovation, including using virtual environments and case-based methods, especially Qualitative Comparative Analysis, a technique for exploring the effects of causal combinations.

Tim was elected to the Academy of Social Sciences in 2004 and is a Board member of the North East Health Innovation and Education Cluster, the Institute for Local Governance and the County Durham Foundation.

Dr Colin Doig

Colin is a Consultant Cardiologist and Physician with Northumbria Healthcare, based at North Tyneside General Hospital since 1995.

Colin is Programme Director for General (Internal) Medicine for the Northern region, having previously also been Programme Director of the Acute Medicine training programme. Colin sits on the national Specialty Advisory Board for General (Internal) Medicine. At Trust level he is Business Unit Director for Clinical Support Services responsible for laboratory disciplines, radiology, cancer and pharmacy services.

Colin is also Senior Clinical Tutor supervising the Foundation Programme at Northumbria. He has extensive experience of change management in diverse clinical and managerial arenas.

Mr Derek Cruickshank

Derek is a Consultant Gynaecological Oncologist having been appointed as Consultant in 1993 (The James Cook University Hospital, Middlesbrough). He led the development of a "Centralised Network Gynaecological Cancer Service" for the population of Teesside, North Yorkshire and County Durham (1.05million). This was strategically supported by the Calman-Hine Report and the Gynaecological Cancer National Improving Outcomes Guidance. He is actively involved in the recruitment of NCRN Gynaecological Cancer Trials as the local Principal Investigator for several of these including UKCTOCS (ovarian cancer screening RCT). He is also on the UKFOCSS Trial Steering Committee. As Colposcopy Lead he introduced "direct referral from cytology to colposcopy" which is now the national standard of care. He is co-chairman of the Regional Colposcopy Professional Advisory Group (quality assurance).

Derek was appointed Clinical Director for gynaecology in 2004 and progressed to the appointment of Chief of Service for the Women & Children's Division in the Trust in April 2009 managing 720 staff with a service income of £54million. In 2009 he was appointed as gynaecological oncology surgeon on NICE Guideline Development Group for "recognition and initial management of ovarian cancer". He also acts as an External Clinical Advisor to the Parliamentary Health Service Ombudsman since 2008.

Derek is the Principal Trainer for Subspecialty Training in Gynaecological Oncology at South Tees since 2005. He was appointed Head of School for Obstetric & Gynaecology training in the Northern Deanery in 2008 with a pool of 120 trainees. In this regard he has a particular interest in the relationship between training and workforce planning.

Dr Paul Pagni

Paul is a GP partner and has been in Hartlepool for the past 23 years. Paul is an active member of the local PBC committee and has been voted on the commissioning executive committee.

Appendix 6

Why is safety an issue at Hartlepool A&E?

The safety of any NHS service is always relative (meaning that it is very difficult for a service to be 100% safe and circumstances will dictate how close to 100% it is possible to be) and is judged by a number of features, including the ability to meet nationally or internationally agreed standards in areas like:

- The availability and quality of staff
- The availability and quality of equipment and other necessary drugs, treatment modalities
- The availability and quality of supporting and related services

Evidence from members of the public often suggests surprise that safety may be an issue, based probably on the "taken for granted" assumption that all NHS services will be safe. This may be tempered by the advent of more transparent public data about outcomes (for example the "Dr Foster League Tables" widely published in national and local media) and because of high profile cases of major safety and quality failures (from the Bristol baby heart surgery scandal to the Mid-staffs Hospital elderly care excess mortality/poor care outrage).

The relevant issues on ability to meet nationally or internationally agreed standards for Hartlepool are:

1. The availability and quality of staff:

    a. The critical issue comes from the College of Emergency Medicine ('The Way Ahead 2008 -2012' - page 12) recommendation that there should be:

    The presence of a doctor ST4 or above (A doctor in 4th year of post-graduate medical training in the speciality of Emergency Medicine or above) trained and experienced in Emergency medicine 24 hours a day
    This is not achieved and not achievable by Hartlepool

    b. The College of Emergency Medicine also says(p39):

    By 2012, supervision of CST trainees by middle grade doctors or consultants should be available indirectly 100% of the time (i.e. present in the department), and directly 30% of the time, during any service provision for any department throughout core training. ***Foundation year and core trainees should no longer be expected to work in an ED unsupervised overnight****. The presence or availability of more senior trainees in other specialties is not a substitute for appropriate supervision of EM trainees by EM specialists.*

This standard is not met in Hartlepool and will not be met in 2012

c. The Emergency Care Directorate of North Tees and Hartlepool has an establishment of 15 “middle grade” doctors- two ST3’s, staff grades and ST4-ST6 doctors. However, they have never been able to recruit to this establishment and there have never been sufficient doctors to staff rotas 24 hours a day in both the departments. There are 12 doctors in post at present. A 24 hour rota at North Tees is maintained and there is a middle grade present at Hartlepool 8am- 12 MN. This is only achieved by using locum doctors who are difficult to find.

d. The “junior doctor” establishment is : 6 Foundation doctors (just qualified doctors in their first two years after university doing a rotation of experience including A&E in their second year), 2 or 3 doctors in their first year of training in Emergency Medicine, 3 or 4 GP trainees and 4 “trust grades” (doctors not in training but with no specialist qualifications either). There are 2 or 3 gaps at present. The ability of these doctors varies and many have not done EM before they start work at Hartlepool.

2. The availability and quality of equipment and other necessary drugs, treatment modalities – this is not a major issue at Hartlepool although the college of medicine does recommend the availability of 24 hour CT scanning. This service is not available in Hartlepool but there is an on call radiographer and radiologist

3. The availability and quality of supporting and related services:

a. The only resident specialities at Hartlepool at night are :

- Medicine – resident specialist trainee or staff grade (staff grade is a generic term for non-consultant but experienced doctor who is not in a training post)
- Intensive Care Unit - resident staff grade
- there is a radiographer and laboratory scientist on call.

b. The college of Emergency Medicine further says (p15)

Where key support services such as Orthopaedics, General Surgery or Paediatrics are not on site, then there is a greater need for more senior Emergency physician to assess, stabilise and treat patients prior to discharge or transfer

Trauma, surgical and paediatric services are all based in Stockton

Appendix 7

Hartlepool LINk – Summary

Introduction:
Hartlepool LINk is a network of local people and organisations, funded by Government and supported by Hartlepool Voluntary Development Agency (the independent host organisation) to promote and support the involvement of people in commissioning, provision and scrutiny of local health and social care services. Every LINk in the country has the same powers and responsibilities but it is the individual LINk that decides what will work best in their area.

The role of Hartlepool LINk is to:

- Give everyone the opportunity to say what they think about their local health and social care services in terms of what is working well and what is not so good.
- Give people an opportunity to monitor and review how services are both planned and delivered.
- Provide feedback on what people have said about services, so that improvements can be made.

Hartlepool LINk Mission Statement:
"Hartlepool LINk has been established in a way that is inclusive and enables involvement from all areas of the local community. We wish to involve those who are seldom heard."

The Way Forward:
Hartlepool LINk has a range of methods available to enable them to say how local services could improve:

- Make reports and recommendations to commissioners and receive a reply within a set period of time.
- Ask commissioners for imformation and receive a reply within a set period of time.
- Enter certain Health and Social Care premises to observe the nature and quality of services.
- Refer issues to Overview and Scrutiny committees and receive a response.

Work with Commissioners:
Hartlepool LINk has been created through the introduction of legislation (Local Government and Public Involvement in Health Act 2007). It has powers to hold Health and Social Care service providers to account. The same legislation puts a greater obligation on providers and commissioners to consult with the public about services. It is envisaged that the LINk will be looked upon as one of the main ways of ensuring people are involved in making decisions about services. Hartlepool LINk will provide commissioners with a first point of contact for involvement and engagement. The LINk will be a pool of local knowledge, service users and expertise, which will assist commissioners assess the needs of local populations. Involving

the public through consultation with Hartlepool LINk will help commissioners take decisions that best reflect the public's need.

Enter and View:
To enable Hartlepool LINk to gather information they need about services, there will be times when it will be appropriate for them to see and hear, for themselves, how services are provided. The Government has introduced duties on certain commissioners and Health & Social Care services to allow authorised representatives of Hartlepool LINk to enter premises that providers own or control, to observe the nature and quality of services.

Participation:
Hartlepool LINk is made up of participants who are individuals, groups and organisations all of which have an interest in local Health and Social Care services. All participants are volunteers. Hartlepool LINk has been established in a way that is inclusive and enables involvement from all areas of the local community. We wish to involve those who are seldom heard.

More information can be found by visiting the Hartlepool LINk website -
www.hartlepoollink.co.uk/link.html

Hartlepool LINk
the community contribution in shaping health and social care services

Appendix 8

Transportation - Information provided by Hartlepool Borough Council

In order to produce a strategy for managing the 2011/12 Budget Deficit, Hartlepool Borough Council's Cabinet proposed a series of cuts that were agreed by Full Council at their meeting of 10 February 2011. Amongst the cuts that were agreed were:-

Dial-a-Ride:
Discontinuation of this service would save the Council £209,000 per year. A proposal to make the service self-financing would see costs increase from £2.50 to £10.00 per journey.

Cllr James, Chair of Scrutiny Co-ordinating Committee said:-

"Clearly, Cabinet has taken into account the high cost of running the service and the fact that the current fleet of vehicles needs replacing. The service currently costs the Council £209,000 a year to run but a further £200,000 would need to be spent next year to replace the five-vehicle fleet…Members of the Scrutiny Coordinating Committee did comment, however, that the withdrawal of the service could create an opportunity for the taxi trade to step in and provide a similar service to current Dial-a-Ride users"

H1 Bus:
The H1 (or Hospital Bus) began in December 2007 and was initially jointly funded by North Tees and Hartlepool NHS Trust and Hartlepool Primary Care Trust (PCT). It was introduced after some services were moved to North Tees, but has become solely funded by Hartlepool Council at a cost of £85,000 per year. On average around 200 people use the service every week and Hartlepool Council is currently having to subsidise each journey to the tune of £9 (see overleaf)

Cllr James, Chair of Scrutiny Co-ordinating Committee said:-

"We reluctantly recommend the withdrawal of the hospital bus service. Given the scale of Government cuts imposed on the Council, it was felt that it was not possible to support its retention given the low usage and high cost to the Council. There's also evidence that people are using the buses for purposes other than to visit hospital or patients."

Supported Buses:
Removal of subsidy given to bus operators to provide financial backing to 'non-viable' services, this would save the Council £287,000 per year, but may lead to bus operators in future removing 'non-viable' services.

Service Number *(Operator)*	**Route** *(Purpose of Service)*	**Period and Frequency**	**Cost to HBC £ per annum** *(average cost per passenger journey)*	**Average Pax wholly, or one trip end, in H'pool Borough** per bus per hour	per week	**Notes**	**Practical Public Transport Alternatives**
'H1' *(Compass Royston)*	Hartlepool Hospital - North Tees Hospital via Town Centre & Catcote Road *(provides unique direct links between Hartlepool and North Tees Hospital, for outpatients appointments & visiting)*	Mon - Sun, (see notes for frequency).	85,742 *(£8.94)*	3.0 *(1 bus)*	188 *Compass: June '10*	journeys depart from Hartlepool Hospital at: 0900, 1030, 1245, 1415, 1645 & 1815; journeys depart from North Tees Hospital at: 0945, 1115, 1330, 1600, 1730 & 2010. Also operates on Sundays (no Bank Holiday service).	None for the Hartlepool Hospital - Raby Road (- North Tees Hospital) section of route. For the Town Centre - Newton Bewley (- North Tees Hospital) section of route the Stagecoach '36' (change at Stockton High Street for North Tees Hospital; 14 buses per hour Mon - Sat daytime, 4 buses per hour evenings & Sundays) offers an alternative.

Appendix 9

Summary of Move of GP Commissioning

The New Vision

The white paper, Equity and Excellence: Liberating the NHS was published in July 2010. It puts the patient at the heart of everything the NHS does, focuses on achieving continuously improving outcomes that are the best in the world, chiefly through empowerment of GPs in the commissioning process. GPs will deliver results based on the needs of the patient.

GP Consortia

GPs will lead the commissioning process through the formation of GP Consortia, and every GP practice will be required to be part of a consortium by 2012. Consortia will continue to provide high quality care, whilst bringing the decision making process closer to patients and public. GP Consortia will have the freedom to use resources in ways that achieve the best and most cost-efficient outcomes for patients. GP consortia will have a duty to promote equality and work in partnership with local authorities.

The Primary Care Trusts (PCTs) will be abolished in 2013, when GP consortia are fully operational. Consortia will be supported through the formation of NHS commissioning board (NHSCB), in developing commissioning guidelines, model contracts and tariffs. Consortia will be held to account by the NHSCB for the outcomes they achieve.

Each consortium will have the opportunity to either employ staff or secure services from external organisations, including local authorities, voluntary organisations and independent sector providers

Timescales for consortia

2010/11

- GP consortia begin to come together in shadow form April 2011
- A comprehensive system of shadow GP consortia in place.
- NHS Commissioning Board to be established in shadow form

April 2012

- SHAs abolished.
- Formal establishment of GP consortia
- NHS Commissioning Board to be established as an independent statutory body.

Autumn 2012

- NHS Commissioning Board makes allocations for 2013/14 to GP consortia

April 2013

- PCTs are abolished

- GP consortia to be fully operational

Pathfinder programme

The pathfinder programme has been established nationally to support consortia that are keen to make fast progress under existing arrangements. The pathfinder consortia will test the new commissioning arrangements at an early stage before GP consortia take on statutory responsibilities from April 2013. The programme will create learning networks, ensure that experience and best practice are spread, and will involve front line clinicians in delivering the QIPP agenda.

Three pathfinder consortia in the north east started in January 2011, covering a population of 36%; these are:

- County Durham and Darlington
- Langbaurgh
- Newcastle Bridges

The following two pathfinder consortia started in February 2011 bringing the population coverage in the north east to 57%; these are:

- Northumberland
- GatNet (Gateshead)

Stakeholder engagement

Stakeholder engagement work in the north east is taking place at three levels:

1. North east engagement events: a quarterly programme of events facilitated by the NHS Alliance and National Association of Primary Care.

2. Pathfinder workshop events: a monthly programme of events that targets specific topics

3. Each PCT cluster has a programme of local engagement events scheduled, to complement the north east wide work.

Over the coming 12 months, the SHA will be coordinating a comprehensive programme of engagement – spanning not only GP pathfinder commissioners but also local authorities and health care providers from the public, private and third sector. The programme is increasingly being developed and delivered by the GPs themselves. On 29 March 2011 a pathfinder event will focus on the structure and duties of Health and Wellbeing Boards and how GP consortia and local authorities will work together to understand their joint priorities and achieve success.

Appendix 10

Numbers modelling of patients currently using A&E in Hartlepool

1. A&E activity June to December 2010 comparison between University Hospital of North Tees (UHNT) and University Hospital of Hartlepool

	Attendance		Admissions	
Month (2010)	**UHNT**	**UHH**	**UHNT**	**UHH**
June	5173	3543	997	629
July	5353	3713	939	660
August	5010	3199	1002	603
September	4854	3269	919	557
October	4834	3287	1023	737
November	4519	2903	1028	594
December	4704	2999	1171	609

2. Figures to show the numbers of A&E attendance, split by site, by age group of patients.

University Hospital of Hartlepool

Attendance by age group / by referrer

Referral Source Description	Age Group	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Grand Total
Other	0 – 16	807	979	870	808	578	757	689	679	585	6752
	17 – 34	961	967	957	1011	911	878	892	745	741	8063
	35 -54	679	691	691	773	682	678	617	572	616	5999
	55 – 74	383	394	372	471	426	379	366	332	390	3513
	75 +	221	260	254	233	206	189	253	222	240	2078
Other Total		3051	3291	3144	3296	2803	2881	2817	2550	2572	26405
Deputising Service	17 – 34	1									1
	55 – 74		1								1
Deputising Service Total		1	1								2
Emergency Services	0 – 16	6	9	4	6	6	5	2	5		43
	17 – 34	77	71	69	71	84	67	83	70	76	668
	35 – 54	71	85	72	65	65	85	96	64	83	686

	55 – 74	65	73	69	88	65	46	67	70	83	626
	75 +	72	101	88	94	88	88	118	57	101	807
Emergency Services Total		291	339	302	324	308	291	366	266	343	2830
GP	0 – 16	6	2	2	3	3	4	5	1	3	29
	17 – 34	8	7	5	4	7	8	7	4	5	55
	35 – 54	9	12	12	3	3	7	3	5	9	63
	55 – 74	7	5	2	10	1	6	7	7	7	52
	75 +	4		4	2	7	7	3	7	4	38
GP Total		34	26	25	22	21	32	25	24	28	237
NHS Direct	0 -16	8	3	4	1	2	4	6	6	3	37
	17 – 34	6	3	7	7	1	7	6	9	3	49
	35 – 54	6	2	2	4	1	8	4	4	2	33
	55 – 74	4	3	2	1	1	1	1	1	2	16
	75 +				1						1
NHS Direct Total		24	11	15	14	5	20	17	20	10	136
Primecare	0 – 16		3	2		2	1	4	1	2	15
	17 – 34	2	5	3	1	5	0	3	1	1	21
	35 – 54	4	2	1	2	2	0	3	0	1	15
	55 – 74	1	4	2	2	0	0	3	4	0	16
	75 +	2	1	1	1	0	0	0	0	2	7
Primecare Total		9	15	9	6	9	1	13	6	6	74
Urgent Care	0 – 16	10	4	6	6	6	6	5	2	4	49
	17 – 34	10	8	12	7	7	7	11	12	10	84
	35 – 54	7	6	7	6	7	7	9	3	4	56
	55 – 74	3	6	2	4	6	3	2	4	8	38
	75 +	1	0	3	0	2	0	0	4	0	10
Urgent Care Total		31	24	30	23	28	23	27	25	26	237
Walk in Centre	0 – 16	0	0	3	3	4	8	5	4	3	30
	17 – 34	0	0	5	8	7	4	9	3	4	40
	35 – 54	0	0	4	9	5	7	5	4	4	38
	55 – 74	0	0	5	5	5	1	3	0	2	21
	75 +	0	0	1	3	4	1	0	1	1	11
Walk In Centre total		0	0	18	28	25	21	22	12	14	140
TOTAL		3441	3707	3543	3713	3199	3629	3287	2903	2999	30061

Attendance by arrival mode of transport

Arrival Mode	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Grand Total
Ambulance	551	615	560	613	597	544	642	587	631	5340
Bicycle	5	2	8	5	5	4	5	4	1	39
Car	2395	2640	2452	2579	2188	2294	2126	1962	1949	20585

Employers Transport	2	8	5	8	3	8	3	3	4	44
Motorbike / Scooter	2	1	4	1	3	1	1	1	0	14
Other	17	11	14	8	7	11	13	9	11	101
Police	27	18	34	26	36	22	47	27	41	278
Public Transport	57	58	75	54	43	34	51	40	33	445
Taxi	225	210	215	236	162	196	238	170	229	1881
Unknown	5	2	0	3	3	6	5	3	1	28
Walked	155	142	176	180	152	149	156	97	99	1306
Grand Total	3441	3707	3543	3713	3199	3269	3287	2903	2999	30061

Attendance by Age Group

Age Group	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Grand Total
0 – 16	837	1000	891	827	601	785	716	698	600	6955
17 – 34	1065	1061	1058	1109	1022	971	1011	844	840	8981
35 – 54	776	798	789	862	765	792	737	652	719	6890
55 – 74	463	486	454	581	501	436	449	418	492	4283
75 +	300	362	351	334	307	285	374	291	348	2952
Grand Total	3441	3707	3543	3713	3199	3269	3287	2903	2999	30061

3. Figures on the numbers of referrals to Hartlepool A&E and Stockton A&E from walk in centres and GP's out of hours services, by age group and patients.

University Hospital of Hartlepool

Attendance by age group / by referrer

Referral Source Description	Age Group	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Grand Total
Deputising Service	17 – 34	1									1
	55 – 74		1								1
Deputising Service Total		1	1								2
Emergency Services	0 – 16	6	9	4	5	6	5	2	5	0	42
	17 – 34	76	70	69	70	81	66	82	70	75	659
	35 – 54	70	84	69	64	61	84	93	64	82	671
	55 – 74	64	72	65	85	64	46	67	67	81	611
	75 +	71	101	86	93	87	88	118	57	97	798
Emergency services total		287	336	293	317	299	289	362	263	335	2781
GP	0- 16	5	2	2	3	3	3	5	1	3	27
	17 – 34	8	6	5	4	7	6	6	4	4	50
	35 – 54	8	12	11	3	3	7	3	5	9	61
	55- 74	6	5	2	10	1	5	7	7	7	50
	75 +	4		4	2	6	7	3	7	4	37
GP Total		31	25	24	22	20	28	24	24	27	225
NHS Direct	0 – 16	8	3	4	1	2	4	6	6	3	37

	17 – 34	6	3	7	6	1	7	6	9	3	48
	35 – 54	6	2	2	4	1	8	4	4	2	33
	55 – 74	4	3	2	1	1	1	1	1	2	16
	75 +				1						1
NHS Direct Total		24	11	15	13	5	20	17	20	10	135
Primecare	0 – 16		3	2		2	1	4	1	2	15
	17 – 34	2	5	3		5		3	1	1	20
	35 – 54	4	2	1	1	2		3		1	14
	55 – 74	1	3	2	2			3	4		15
	75 +	2	1	1						2	6
Primecare Total		9	14	9	3	9	1	13	6	6	70
Urgent Care Centre	0 – 16	10	4	6	6	6	6	5	2	4	49
	17 – 34	10	8	12	7	7	7	11	12	10	84
	35 – 54	7	6	7	6	7	7	8	3	4	55
	55 – 74	3	5	1	4	6	3	2	4	8	36
	75 +	1		3		2			4		10
Urgent Care Centre Total		31	23	29	23	28	23	26	25	26	234
Walk in centre	0 – 16			3	3	4	8	5	4	3	30
	17 – 34			5	7	7	4	9	3	4	39
	35 – 54			4	9	5	6	5	4	4	37
	55 – 74			5	4	5	1	3		2	20
	75 +			1	3	4	1		1	1	11
Walk In Centre total				18	26	25	20	22	12	14	137
Grand Total		383	410	388	404	386	381	464	350	418	3584

Attendance by arrival mode of transport

Arrival Mode	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Grand Total
Ambulance	551	615	560	613	597	544	642	587	631	5340
Bicycle	5	2	8	5	5	4	5	4	1	39
Car	2395	2640	2452	2579	2188	2294	2126	1962	1949	20585
Employers Transport	2	8	5	8	3	8	3	3	4	44
Motorbike / scooter	2	1	4	1	3	1	1	1		14
Other	17	11	14	8	7	11	13	9	11	101
Police	27	18	34	26	36	22	47	27	41	278
Public Transport	57	58	75	54	43	34	51	40	33	445
Taxi	225	210	215	236	162	196	238	170	229	1881
Unknown	5	2		3	3	6	5	3	1	28
Walked	155	142	176	180	152	149	156	97	99	1306
Grand Total	3441	3707	3543	3713	3199	3269	3287	2903	2999	30061

Attendance by age group

Age Group	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Grand Total
0 – 16	837	1000	891	827	601	785	716	698	600	6955
17 – 34	1065	1061	1058	1109	1022	971	1011	844	840	8981
35 – 54	776	798	789	862	765	792	737	652	719	6890
55 – 74	463	486	454	581	504	436	449	418	492	4283
75 +	300	362	351	334	307	285	374	291	348	2952
Grand Total	3441	3707	3543	3713	3199	3269	3287	2903	299	30061

HEALTH SCRUTINY FORUM

29 March 2011

Report of: Scrutiny Support Officer

Subject: SCRUTINY INVESTIGATION CONNECTED CARE –- ADDITIONAL EVIDENCE FROM HARTLEPOOL CARERS

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1. PURPOSE OF THE REPORT

1.1 To consider additional written evidence collated from Hartlepool Carers in relation to the ongoing inquiry into Connected Care.

2. BACKGROUND INFORMATION

2.1 Members will recall that at the meeting of this Forum on 1 March 2011 the Centre Manager at Hartlepool Carers provided verbal evidence in relation to the work undertaken by Hartlepool Carers and their involvement with the Connected Care Programme.

2.2 Consequently following the meeting of 1 March 2011 additional written evidence was received relating to the Low Level Support Service provided by Hartlepool Carers as detailed below:-

"Hartlepool Carers Low Level support Service was introduced in December 2006, to help support local residents in the NDC area. This service sits alongside Hartlepool Carers volunteer service for Carers, which was established in 1998.

Both of these services compliment each other, the Carers Volunteer Service is only available to residents of Hartlepool and the surrounding villages if they are an unpaid Carer and the Low Level Support Project helps to support some of the more vulnerable, disabled, frail, lonely and isolated citizens.

The volunteer services that we offer include (but are not limited to):-

- *Emotional support e.g Befriending, Sitting Service and visiting services*
- *Shopping or collecting shopping as necessary*
- *Chaperone to any medical appointments, hospital visits etc.*
- *Dog walking & sitting service*
- *Small DIY jobs & Gardening services*
- *Driving services*
- *Social groups support services & holidays*

All of our services are arranged and mutually agreed with each client and volunteer with the aim of helping to promote and retain independence, choice, control and dignity. We currently have over 115 active volunteers offering a huge variety of services on a weekly basis."

3. RECOMMENDATION

3.1 That Members of the Forum note the content of this report and the written evidence detailed under paragraph 2.2

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:-

(i) Minutes of the Health Scrutiny Forum of 1 March 2011.

HEALTH SCRUTINY FORUM

29 March 2011

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Support Officer

Subject: SCRUTINY INVESTIGATION INTO CONNECTED CARE – FEEDBACK FROM FOCUS GROUP

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1. PURPOSE OF REPORT

1.1 To facilitate a discussion amongst Members of this Forum in relation to the Focus Group held on Connected Care.

2. BACKGROUND INFORMATION

2.1 As part of the evidence gathering process for the undertaking of the investigation into Connected Care, the following focus group was recently attended by Members of the Health Scrutiny Forum:-

(a) Focus Group into Connected Care held on 28 February 2011;

2.2 In line with good practice, Members of this Forum who were in attendance are requested to share / discuss their findings at today's meeting.

3. RECOMMENDATIONS

3.1 That Members of the Forum discuss their findings from the Focus Group as outlined in paragraph 2.1 of this report.

Contact:- James Walsh – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
Tel: 01429 523 647
Email: james.walsh@hartlepool.gov.uk

BACKGROUND PAPERS

There were no background papers referred to in the preparation of this report.

HEALTH SCRUTINY FORUM FOCUS GROUP – CONNECTED CARE

28 February 2011

Notes

Present:

Councillors: Stephen Akers-Belcher (Chair of Health Scrutiny Forum), Marjorie James (Ward Councillor for Owton Manor), Christopher Akers-Belcher (Hartlepool LINk Co-ordinator)

Officers: James Walsh, Scrutiny Support Officer

Investigation into Connected Care

The focus group was held at Manor Resident Association, to which local people who had experience of the Connected Care model were present along with a couple of the Navigators. Details of evidence gathered is detailed below, but anonymised:-

- Case Study One: This person had been suffering financial difficulties and through a Benefits Advice Worker was put in touch with a Connected Care Navigator. Up to that point, they felt like there was no 'personal' feedback from the statutory and non-statutory bodies that they were trying to access for help. The Navigator helped to arrange phone calls, letters and meetings to get everything back on track and gave the individual "hope", something they hadn't been experiencing before.

  It was the flexible approach by the Navigator that allowed for different people with different circumstances to receive a personalised service which met their needs. It was revealed that the individual had been tenant of the year previously, but the lack of awareness of the Connected Care programme by the housing provider (they had directed the individual to Citizens Advice Bureau, which was seen as impersonal in nature) meant that within 6 months of the award, the individual was being portrayed as a poor tenant. The work of the Navigator lead the person to make a heartfelt statement that the Navigator had "done so much for me, really grateful".

- Case Study Two: The Connected Care Navigator had ensured that this individual had remained in a tenancy after the passing of their spouse. Originally the 'Benefits Office' had said they were at the risk of being evicted, but the Navigator had arranged meetings and supported the individual in having the tenancy transferred into their name.

  The individual made an observation about the impersonal nature of the 'booths' at the Civic Centre when advice was sought, whereas within the Connected Care programme, individuals could discuss their problems in private confidential settings. Some of the quotes from this individual in

terms of the Navigators were:-

"Think of people, not of themselves"
"Make you feel wanted"
"Greatest people on this world"
"Worth millions"

- Case Study Three: This individual had been in jail and became estranged from their child. In moving back to the area to try and be with their child, they were struggling to find out where to go. Through the support of Connected Care, this individual had started out as a volunteer with Manor Residents, had moved into a flat and were currently working towards moving into a house. They were also gaining qualifications and said that they had now come too far to lapse back into drug usage that had originally been the catalyst to their jail sentence.

  The non-judgemental approach of the Navigator, by seeing the individual as having a past, but recognising that it was in the past, had enabled the individual to feel a sense of worth. As the individual stated "I would be lost without them", the Connected Care Navigators were there as someone to talk to "talking to you, not at you" and to help find solutions to their problems. The biggest change was that the local community, who had initially isolated the individual, saw them now as a valued member of their community.

- Case Study Four: Again this individual had been in trouble with the law and lost their children as result. The circle that they were in was that they couldn't have their children back without a house, but without children they couldn't get a house. The individual had originally accessed a Hairdressing course through the Helping Hands scheme and subsequently through the Connected Care programme they had secured a house and got their children back.

Overall each individual involved with the Connected Care programme agreed that they wanted to see the scheme expanded, for it to be strengthened and also safeguarded for the future.

In conclusion, the Chair thanked all attendees for their input to the investigation.

HEALTH SCRUTINY FORUM

29 March 2011

Report of: Scrutiny Support Officer

Subject: DRAFT FINAL REPORT – CONNECTED CARE

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1. PURPOSE OF REPORT

1.1 To inform Members of the Health Scrutiny Forum that presented at today's meeting will be the Draft Final Report into 'Connected Care'.

2. BACKGROUND INFORMATION

2.1 In accordance with the Authority's Access to Information Rules, it has not been possible to include the Draft Final Report within the statutory requirements for the despatch of the agenda and papers for this meeting. Although, arrangements have been made for the Draft Final Report into 'Connected Care' to be circulated under separate cover and in advance of this meeting.

3. RECOMMENDATION

3.1 Members are requested to note the content of this report and agree the Draft Final Report into 'Connected Care'; to be circulated under separate cover in advance of this 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

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

HEALTH SCRUTINY FORUM

29 March 2011

Report of: **Health Scrutiny Forum**

Subject: **DRAFT FINAL REPORT – CONNECTED CARE**

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1. PURPOSE OF REPORT

1.1 To present the findings of the Health Services Scrutiny Forum following its investigation into 'Connected Care'.

2. SETTING THE SCENE

2.1 At the meeting of the Health Scrutiny Forum on 22 June 2010, Members determined their work programme for the 2009/10 Municipal Year. The topic of 'Connected Care' was selected as a scrutiny topic for consideration during the current Municipal Year.

2.2 Connected Care was developed by Turning Point, 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. In essence Connected Care is 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."[1]

2.3 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 link Connected Care to locality based commissioning.

2.4 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."[2]

[1] Turning Point, 2009
[2] Health Scrutiny Forum, 2009

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

2.5 In February 2010, the 200+ page 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.

2.6 Connected Care is currently being delivered in the Owton Ward of Hartlepool by 'Who Cares (NE)', which is a Social Enterprise model of delivery operated by residents and local community organisations. There are 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."[3]

3. OVERALL AIM OF THE SCRUTINY INVESTIGATION

3.1 The overall aim of the Scrutiny investigation was to explore and evaluate the impact of Connected Care in Hartlepool.

4. TERMS OF REFERENCE FOR THE SCRUTINY INVESTIGATION

4.1 The Terms of Reference for the Scrutiny investigation were as outlined below:-

(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 learnt from the Durham University evaluation and how these and other lesson 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; and

(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

[3] Director of Child & Adult Services, 2010

(ii) If / how the service could be provided at a reduced financial cost (within the resources available in the current economic climate).

5. MEMBERSHIP OF THE REGENERATION AND PLANNING SERVICES SCRUTINY FORUM

5.1 The membership of the Scrutiny Forum was as detailed below:-

Councillors S Akers-Belcher, Barker, Cook, Fleet, Griffin, A Lilley, G Lilley, McKenna and Simmons

Resident Representatives: Mary Green, Norma Morrish and Linda Shields.

6. METHODS OF INVESTIGATION

6.1 Members of the Health Scrutiny Forum met formally from 23 November 2010 to 29 March 2011 to discuss and receive evidence relating to this investigation. A detailed record of the issues raised during these meetings is available from the Council's Democratic Services.

6.2 A brief summary of the methods of investigation are outlined below:-

(a) Detailed presentations from staff involved in the Connected Care Programme, supported by written and verbal evidence;

(b) Verbal and written evidence from Housing Hartlepool, Accent Foundation, IntraHealth, Hartlepool Carers and Owton Fens Community Association (OFCA);

(c) Verbal evidence from local people involved in the Connected Care programme; and

(d) Focus Group meeting with local people and the Navigators from the Connected Care programme.

FINDINGS

7. THE DEVELOPMENT AND CURRENT DELIVERY MODEL OF CONNECTED CARE

7.1 In order to understand how Connected Care had developed in Hartlepool, Members of the Health Scrutiny Forum gathered the following evidence:-

The development of Connected Care

7.2 At their meeting of 1 February 2011, Members heard from the Chair of the Connected Care Steering Group that Connected Care had developed out of the concerns raised by Ward Councillors in the Owton Manor Ward; which was one of the most deprived wards in Hartlepool. Ward Councillors were particularly concerned about the disparate way that funding in the Owton Ward was being distributed and the fact that overall outcomes for residents were not improving in line with the financial expenditure.

7.3 Members at their meeting of 23 November 2010 gathered evidence that Connected Care as a programme had been developed by the social care organisation Turning Point. In 2006, Hartlepool and specifically the Owton Ward had been chosen as one of the first pilots in the country for Connected Care, with the aim of integrating social and health care strategies for social inclusion.

7.4 The Connected Care Manager informed the Forum at their meeting of 1 February 2011 that the original key aims of the Connected Care Service were to:-

(i) Provide holistic rather than fragmented response;

(ii) Ensure that services were simple to access and use and employed a "one stop" ethos;

(iii) Ensure that services are centred around the individuals perception of their problems and what outcomes would make a positive difference;

(iv) Ensure that Connected Care is concerned with building community capacity by putting the community in control of the services they need;

(v) Ensure the co-production and co-delivery of services and share skills and expertise from across the community; and

(vi) Design and deliver flexible services that employ a local work force that are willing to do things differently.

The current delivery model of Connected Care

7.5 The Members of the Forum were particularly pleased to learn; at their meeting of 1 February 2011; that the provision to residents of the Owton Manor Ward via the Connected Care Programme was one of a 'holistic' one-stop shop. There was a continual commitment to consultation with local groups and partners to ensure that services were meeting the needs of the local populous, as well as ensuring that there was constant innovation to delivery. The main aim of the Connected Care Programme was to facilitate access to services for those residents of Owton Manor in need of that level

of support, via one venue rather than having to deal with a multitude of people at a wide range of venues.

7.6 In order to achieve the delivery model as highlighted in paragraph 7.5, the Members of the Health Scrutiny Forum considered the Service Navigation scheme which had benefitted 1,392 people between 2009-2010. The Service Navigation Scheme was delivered by Navigators whose role it was to identify and engage with those individuals in greatest need of support and in doing so:-

(i) Supporting people to change their lifestyle by working in partnership with other service providers;

(ii) Helping, guiding and supporting them to find the right services in the community to address their needs;

(iii) Ensuring access to relevant knowledge, information and support in order to enable informed choices concerning access to health and social care services; and

(iv) Working with other local services and providers to influence and improve the delivery of services.

7.7 With the Navigators being one of the key facets to the successful delivery of Connected Care in Hartlepool, Members also recognised that there were a number of other projects that Connected Care worked with, which ensured that the residents of Owton Manor could utilise the most appropriate support provision to meet their individual needs. Some of the projects accessed by residents involved in the Connected Care Programme are as follows:-

(i) Handyman Service
This project offers a simple handyman service to elderly or infirm residents, providing simple tasks such as light bulb changing, path clearance in snowy conditions, decorating and garden maintenance.

(ii) Families Accessing Support Team (FAST)
The FAST project provides a multi-agency voluntary sector response to reduce incidents of crime and disorder through a combination of case workers, family befriend support worker and training and employment officer.

(iii) Nurturing Young Peoples Development Project (NYPD)
The NYPD Project provides young people with a drop-in centre that provides advice and guidance designed to motivate and encourage young people to not only become ambassadors and peer mentors, but to realise the opportunities that are available to them through project, training and educational programmes.

(iv) Supported Access to Independent Living (SAILS)
Essentially a 'good neighbour' scheme, SAILS is geared towards individuals whose needs require an intensive level of support, this can be through assistance with shopping, tidying the garden, home visits, ensuring the individual can gain access to social activities and home visits for Benefit advice.

(v) Supported Accommodation for Young People
This programme was funded by the Northern Rock Foundation and brought together providers such as Hartlepool Borough Council, the Accent Foundation and Housing Hartlepool to deliver supported accommodation for young people; including the provision of 24 hour support, a crash pad and support to move on accommodation.

8. THE IMPACT OF CONNECTED CARE ON THE COMMUNITY

8.1 The Members of the Health Scrutiny Forum were particularly interested in hearing from a number of sources, about the impact that Connected Care had made on residents of the Owton Manor Ward of Hartlepool. In order to understand this impact, Members considered evidence as detailed below:-

Evidence from IntraHealth

8.2 When the Health Scrutiny Forum met on 1 March 2011, the Patient and Liaison Officer from IntraHealth was in attendance and provided Members with a very detailed presentation relating to the involvement of IntraHealth with the Connected Care Programme. Members were informed that one of the key focuses of IntraHealth was to help their patients and support their local community, something they felt Connected Care could help them achieve.

8.3 The Patient and Liaison Officer explained to Members how IntraHealth was involved in Connected Care, as well as the Patient and Liaison Officer being a member of the Connected Care Steering Group, IntraHealth's involvement with Connected Care is detailed below:-

(i) Working with Connected Care Navigators;

(ii) Ensuring that the Navigators are an active member of IntraHealth's Patient Participation Group;

(iii) By having Navigator drop-in sessions held 1.5 hours weekly at Wynyard Road Medical Centre; and

(iv) Joint participation in community events.

8.4 Members were already au fait with SAILS (see paragraph 7.7(vi)) and the Patient and Liaison Officer explained that IntraHealth had been involved with SAILS through their Wynyard Road Medical Centre. IntraHealth were able to

offer support to 20 people accessing the SAILS scheme and the Forum was pleased to note that this had lead to some very positive local publicity (see Appendix A).

8.5 Through the partnership working of IntraHealth with the Connected Care programme and specifically through the SAILS scheme, the Patient and Liaison Officer at IntraHealth felt that the following benefits had been achieved for the community:-

(i) Reduction in emergency hospital admissions;

(ii) Service excellence;

(iii) Holistic Care – Health & Social;

(iv) Efficiency; based on:-

a. Medical response not always being required;
b. Navigators being part of the skill mix that now can be offered; and
c. Patients wanting and now expecting a responsive service.

It was acknowledged that some of the above benefits were difficult to quantify and that work with the London School of Economics and Political Science (LSE) into defining the 'cost' benefits of Connected Care, would be vital in proving the worth of the scheme.

Evidence from Accent Foundation

8.6 When the Health Scrutiny Forum met on 1 March 2011, the Area Manager (North East) from the Accent Foundation was in attendance. The Area Manager informed Members that the Accent Foundation was a housing provider with currently 100 properties in Hartlepool. Members were interested to learn that the Accent Foundation had only just started working with the Connected Care programme.

8.7 The Area Manager from the Accent Foundation informed the Health Scrutiny Forum that the Connected Care programme had enabled them to work to support young people in ensuring that they could achieve and sustain tenancy arrangements, whilst helping to support those tenants who had debt problems.

8.8 The Forum was delighted to learn that the work of the Accent Foundation with Connected Care had lead to increased partnership working with organisations such as IntraHealth and Housing Hartlepool. This meant that through the Glamis Walk Supported Living Project, 7/8 units owned by the Accent Foundation were being utilised for supported housing schemes and the combined efforts of IntraHealth and Housing Hartlepool were ensuring that tenants were kept on the 'right track', therefore, leading to sustainable tenancies.

Evidence from Housing Hartlepool

8.9 During the meeting of the Health Scrutiny Forum of 1 March 2011 the Housing Manager (Neighbourhoods) from Housing Hartlepool was present and provided Members with a detailed overview of the involvement of Housing Hartlepool with Connected Care.

8.10 The Housing Manager detailed to Members the different programmes that Housing Hartlepool were involved in through Connected Care. The Health Scrutiny Forum had already heard details of the Handyman Scheme (see paragraph 7.7(i)), but were interested to learn that through the funding of the scheme by Housing Hartlepool, 430 tenants had benefitted from the services provided by the Handyman Scheme and during the bad winter weather of 2010/11, the service had been invaluable to residents in clearing paths to and from their residencies.

8.11 Members of the Health Scrutiny Forum were pleased to hear that Housing Hartlepool were working very closely with the Connected Care Navigators to sustain tenancies. Navigators were also helping Housing Hartlepool tenants through attendance at court hearings and ensuring that the tenant was accessing their full benefit entitlement. It was through this partnership working that the Housing Manager; was pleased to announce; had lead to a reduction in eviction rates for those Housing Hartlepool tenants who were part of the Connected Care scheme.

Evidence from Hartlepool Carers

8.12 The Centre Manager from Hartlepool Carers was present when the Health Scrutiny Forum met on 1 March 2011. Forum Members were informed that Hartlepool Carers had utilised the Connected Care programme to help support some of the clients that Hartlepool Carers worked with.

8.13 It was, however, recognised by Members that Hartlepool Carers themselves offered a Low Level Support Service; operated by 115 volunteers; to support residents in New Deal for Communities (NDC) areas. The Low Level Support Service aimed to offer:-

(a) Emotional support e.g. Befriending, Sitting Service and visiting services;

(b) Shopping or collecting shopping as necessary;

(c) Chaperone to any medical appointments, hospital visits etc;

(e) Dog walking & sitting service;

(f) Small DIY jobs & Gardening services;

(g) Driving services; and

(h) Social groups support services & holidays

Evidence from Local People Accessing Connected Care

8.14 Through verbal evidence provided at the meeting of the Health Scrutiny Forum held on 1 February 2011, written testimonials of people benefiting from the Connected Care service presented to Members at their meeting on 1 March 2011 and by gathering the views of local people at a Focus Group held on 28 February 2011, Members of the Health Scrutiny Forum reinforced the view that Connected Care was ensuring that people in Owton Manor were becoming more empowered and better able to make positive choices.

8.15 A summary of the views of local people who have been involved with the Connected Care programme in Hartlepool as received by Members of the Health Scrutiny Forum throughout their investigation are detailed in the following individual case studies:-

Case Study 1: Had suffered from financial difficulties and through a Benefits Advice Worker was put in touch with a Connected Care Navigator. Up to that point, they felt like there was no 'personal' feedback from the statutory and non-statutory bodies that they were trying to access for help. The Navigator helped to arrange phone calls, letters and meetings to get everything back on track and gave the individual "hope", something they hadn't been experiencing before.

It was the flexible approach by the Navigator that allowed for different people with different circumstances to receive a personalised service which met their needs. It was revealed that the individual had been tenant of the year previously, but the lack of awareness of the Connected Care programme; by the housing provider (they had directed the individual to Citizens Advice Bureau, which was seen as impersonal in nature); meant that within 6 months of the award the individual was being portrayed as a poor tenant. The work of the Navigator lead the person to make a heartfelt statement that the Navigator had "done so much for me, really grateful".

Case Study 2: The Connected Care Navigator had ensured that this individual had remained in a tenancy after the passing of their spouse. Originally the 'Benefits Office' had said they were at the risk of being evicted, but the Navigator had arranged meetings and supported the individual in having the tenancy transferred into their name.

The individual made an observation about the impersonal nature of the 'booths' at the Civic Centre when advice was sought, whereas within the Connected Care service individuals could discuss their problems in private confidential settings. Some of the quotes from the individual in terms of the Navigators were: "Think of people, not of themselves"; "Make you feel wanted"; "Greatest people on this world"; and "Worth millions".

Case Study 3: Had been in jail and become estranged from their child. In moving back to the area to try and be with their child, they were struggling to find out where to go. Through the support of Connected Care, this individual had started out as a volunteer with Manor Residents, had moved into a flat and were currently working towards moving into a house. They were also gaining qualifications and said that they had now come too far to lapse back into drug usage that had originally been the catalyst to their jail sentence.

The non-judgemental approach of the Navigator, by seeing the individual as having a past, but recognising that it was in the past, had enabled the individual to feel a sense of worth. As the individual stated "I would be lost without them", the Connected Care Navigators were there as someone to talk to "talking to you, not at you" and to help find solutions to their problems. The biggest change was that the local community, who had initially isolated the individual, saw them now as a valued member of their community.

Case Study 4: Had had been in trouble with the law and lost their children as result. The circle that they were in was that they couldn't have their children back without a house, but without their children they couldn't get a house. Initially accessing a Hairdressing course through the Helping Hands scheme, they had been one of the first tranche of people to benefit from the Connected Care service, leading to them securing a house and being reunited with their children.

Evidence from Owton Fens Community Association (OFCA)

8.16 Representatives from OFCA provided Members with evidence of the impact that Connected Care had made on the Owton Manor community, when they met on 1 March 2011. The representative from OFCA commented that the Connected Care model had made a huge difference to the lives of residents in the Owton Manor area of the Town. Emphasis was placed on the current work being under taken by Connected Care, Turning Point and the LSE to prove the financial worth of Connected Care to all organisations, whether they be housing providers, the Local Authority or the NHS.

9. LESSONS LEARNT FROM THE DURHAM UNIVERSITY EVALUATION OF CONENCTED CARE

9.1 When Members of the Health Scrutiny Forum met on 1 February 2010, the Chair of the Connected Care Steering Group was present to talk to the Forum about the lessons learnt from the evaluation into Connected Care undertaken by Durham University. It was recognised by Forum Members that due to the publication of the report back in February 2010 a number of the recommendations were already being actioned.

9.2 The Chair of the Connected Care Steering Group drew Member's attention to the importance that the evaluation placed on the Navigators being independent of the services provided. This meant that as the Navigators didn't have any vested interests, then they didn't have to defend

organisations when things went wrong. The report then went on to highlight a number of lessons that could be learnt by other Connected Care programmes as detailed below:-

(a) A Service Co-ordinator that oversees the services can play a transformational role in acting as 'maker of the services, in setting up the services and embedding Connected Care with other services locally;

(b) Commissioners overseeing Connected Care need to work continuously to sustain partnerships between statutory services and communities. Connected Care needs to be a significant priority for commissioners to mitigate the tension between pursuing nationally determined targets and long term partnership goals;

(c) Leadership is critical as implementation involves transformation of a service system rather than the simple provision of additional services;

(d) For Connected Care to be embraced within wider services, partner organisations need to train their own staff to understand new roles and relationships. Staff need to be enabled to work across service boundaries and develop collaborative relationships and mechanisms including spheres of information sharing and confidentiality;

(e) It is important to reach agreement on vision and outcomes early in order to focus energies on service change and to secure relationships with the full range of services across health, housing and social care to implement change;

(f) Community members as part of the service solution bring local 'know-how', an understanding of their local area and a greater commitment to sustain contact with users of the service until all issues are resolved. Service users in the community who were interviewed valued the service as 'someone on their side' and perceived it as less impersonal than, and independent of, local statutory services;

(g) Dynamic forms of user engagement need to be sustained in order to continuously inform service delivery;

(h) Connected Care service design is based, in principle, on shifting power from commissioners to the community. Community organisations can play a critical role in securing greater accountability at a local level. In communities, where there is little history of engagement, the need for continued investment in capacity building is critical. It is also important to understand levels of prior community engagement to highlight any capacity building that is needed locally; and

(i) Wider community involvement is not an easy objective to achieve. There is a need to establish processes that develop and sustain

community engagement in the planning, management and delivery of a Connected Care service.

10. THE IMPACT OF CURRENT AND FUTURE BUDGET PRESSURES ON CONNECTED CARE

10.1 The Connected Care Manager was present at the Health Scrutiny Forum meeting of 1 February 2011, where Members were informed of the budgetary pressures on the continuation of the Connected Care programme. Like many publically funded programmes, Connected Care was likely to feel pressured by the general reduction in public spending by the current Government through the removal of Working Neighbourhoods Fund (WNF) and the Comprehensive Spending Review (CSR).

10.2 Members were aware of the impact of the withdrawal of WNF and the challenges faced by the Local Authority (amongst others) by the CSR announcement. However, the Connected Care Manager informed Members that detailed discussions were being undertaken by Connected Care, Turning Point and the LSE in order to quantify the impact of Connected Care to the community. There was some initial evidence that the overall cost of an eviction for Housing Hartlepool was £6,000, therefore, if Connected Care could be proven to have stopped an eviction, then that was how much the service was worth to Housing Hartlepool. Similarly clearing old people's paths during snowy weather, may save the local NHS money in hospital admissions due to slips and falls. The Connected Care Manager emphasised that this did not mean that for example they would go to Housing Hartlepool asking for £6,000, but that it would enable a more open discussion in terms of the value of funding Connected Care.

10.3 With the positive evaluation of Connected Care in Hartlepool, as undertaken by Durham University (see Section 9), the Connected Care Manager highlighted that although Connected Care was not a cost free service, it did demonstrate an example of the Government's policy direction of the 'Big Society' and Members were delighted to learn that Andrew Lansley; Secretary of State for Health; had recently visited the Connected Care programme in Hartlepool and been impressed by the service provided and achievements made.

11. HOW CONNECTED CARE MIGHT BE DELIVERED IN THE FUTURE

11.1 Members of the Health Scrutiny Forum had already made their intentions clear in terms of future delivery of Connected Care back in April 2009 (see paragraph 2.4). This desire to see a 'roll-out' of the Connected Care model to other areas of the Town had yet to be realised, but Members were informed by the Connected Care Manager at their meeting of 1 February 2011 that 'Who Cares North East Limited' had been set up as social enterprise organisation. The evaluation by Durham University highlighted the development of the Social Enterprise as:-

"Its aims were to extend its service navigation, low level support, Handyman and benefits and welfare advice services across the south of Hartlepool, beyond the boundaries of the Owton estate."[4]

11.2 Although the social enterprise would allow greater benefits for the people of Owton Manor, so it was also seen as a vehicle that may allow for the 'roll-out' of Connected Care to other areas of the Town which may benefit from this service. Forum Members, however, recognised that other providers were providing support to other communities in the Town and that these needed to be taken into account when factoring in any full scale roll-out of Connected Care delivery. The recognition of individual communities having different needs was an element of the evaluation by Durham University, which stated:-

"One of the prime features of the service that enhances its potential to provide appropriate service is its localism and the opportunity for Connected Care to be based on a deep understanding of the distinctive problems facing that local community."[4]

11.3 When Connected Care partner organisations had been present at the Health Scrutiny Forum meeting of 1 March 2011, there was considerable support for a roll-out of Connected Care across Hartlepool. The Housing Manager from Housing Hartlepool commented that it could only benefit the organisation, with Housing Hartlepool likely to be the main housing provider in areas targeted, whilst the Patient and Liaison Officer from IntraHealth spoke of the impact the scheme could make in other areas of the Town where IntraHealth were already delivering services.

12. CONCLUSIONS

12.1 The Health Scrutiny Forum concluded:-

(a) That Connected Care service have made an major impact on the lives of the people of Owton Manor, ensuring that they are more empowered members of their local community;

(b) That the proactive impact of Connected Care in terms of benefitting other statutory and non-statutory services was difficult to quantify, but that efforts were being made through the work being undertaken by the LSE, to address that issue;

(c) That support existed within organisations currently involved in Connected Care to see the service rolled out across the Town;

(d) That care needed to be taken to ensure that any roll-out of Connected Care did not duplicate efforts already on-going within communities;

[4] Callaghan et al., 2009

(e) That organisations involved with Connected Care needed to ensure that they continued to promote the role of Connected Care to all staff and service users; and

(f) That a 'one-size-fits-all' delivery model for Connected Care would not work and expansion of the scheme must take into the account the needs of the community to ensure the delivery of a bespoke service.

13. RECOMMENDATIONS

13.1 The Health Scrutiny Forum has taken evidence from a wide range of sources to assist in the formulation of a balanced range of recommendations. The Forum's key recommendations to the Cabinet are as outlined below:-

(a) That a strategy is devised to identify those communities within Hartlepool who may benefit from the delivery of the Connected Care model;

(b) That once recommendation (a) is completed, Connected Care is rolled-out to other communities in Hartlepool:-

(i) Ensuring that the necessary governance structure is in place;

(ii) Delivering a bespoke service for residents, that incorporates current service providers and does not duplicate the work of those providers already delivering relevant services in that community; and

(iii) That a feasibility study is carried out into support for the Connected Care roll-out through the transfer of staff and / or resources.

(c) That following the completion of the work being undertaken by the LSE:-

(i) That the findings are shared with the Health Scrutiny Forum; and

(ii) That where evidence demonstrates the financial benefits of Connected Care, those organisations benefitting from early intervention by Connected Care, are invited to support or further support the Connected Care programme through resource allocation.

ACKNOWLEDGEMENTS

The Forum is grateful to all those who have presented evidence during the course of our investigation. We would like to place on record our appreciation, in particular of the willingness and co-operation we have received from those named overleaf:-

Hartlepool Borough Council:

Geraldine Martin – Head of Service, Adult Social Care

Jill Harrison – Assistant Director, Adult Social Care

Councillor Ray Wells

Councillor Kevin Cranney – OFCA

Councillor Marjorie James – OFCA

Councillor Christopher Akers-Belcher – LINk Co-ordinator, Hartlepool LINk

Councillor Stephen Thomas – LINk Development Officer, Hartlepool LINk

External Representatives:

Ray Harriman – Connected Care Manager

Angie Wilcox – Manager, Manor Residents Association

Professor Gerald Wistow – Chair of the Connected Care Steering Group

Helen Ivison – Housing Manager (Neighbourhoods), Housing Hartlepool

Elizabeth Carroll – Patient and Liaison Officer, Intrahealth

Tracy Jefferies – Centre Manager, Hartlepool Carers

Wanda Graham – Area Manager (North East), Accent Foundation

Those individuals involved in the Connected Care Programme who provided evidence at the Forum Meetings and the Focus Group held on 28 February 2011.

COUNCILLOR STEPHEN AKERS-BELCHER
CHAIR OF THE HEALTH SCRUTINY FORUM

March 2011

Contact Officer: James Walsh – Scrutiny Support Officer
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BACKGROUND PAPERS

The following background papers were consulted or referred to in the preparation of this report:-

(a) Report of the Scrutiny Support Officer entitled 'Scrutiny Investigation into Connected Care – Scoping Report' presented at the meeting of the Health Scrutiny Forum of 23 November 2010

(b) Turning Point (2009) *Connected Care*, Available from http:www.turning-point.co.uk/commissionerszone/centreofexcellence/Pages/ConnectedCare.aspx (Accessed 27 September 2010)

(c) Final Report of the Health Scrutiny Forum entitled 'Reaching Families in Need' presented at the meeting of Cabinet of 17 August 2009

(d) Callaghan, G., Quinn, J. (2010) *Evaluation of Connected Care in Hartlepool*, Durham University

(e) Report by the Director of Child and Adult Services entitled 'Progress Report – Connected Care' presented to Cabinet of 8 February 2010

(f) Report of the Scrutiny Support Officer entitled 'Scrutiny Investigation into Connected Care – Setting the Scene – Covering Report' presented at the meeting of the Health Scrutiny Forum of 1 February 2011

(g) Presentation by the Connected Care Manager entitled 'Health Scrutiny – Connected Care: Connected Services – Connecting People' delivered to the Health Scrutiny Forum meeting of 1 February 2011

(h) Report of the Connected Care Manager entitled 'Supported Accommodation Service for Young People Aged 18-24' presented to the Health Scrutiny Forum meeting of 1 February 2011

(i) CD / Booklet of the Connected Care service entitled 'Partnership Working in Owton' presented to the Health Scrutiny Forum meeting of 1 February 2011

(j) Report of the Scrutiny Support Officer entitled 'Scrutiny Investigation into Connected Care – Partner Organisations – Covering Report' presented to the Health Scrutiny Forum meeting of 1 March 2011

(k) Presented by the Patient and Community Liaison Officer entitled 'IntraHealth and Connected Care' delivered to the Health Scrutiny Forum meeting of 1 March 2011

(l) Testimonies from Connected Care service users presented to the Health Scrutiny Forum meeting of 1 March 2011

(m) Report of the Scrutiny Support Officer entitled 'Scrutiny Investigation Connected Care – Additional Evidence from Hartlepool Carers' presented to the Health Scrutiny Forum of 29 March 2011

(n) Report of the Scrutiny Support Officer entitled 'Scrutiny Investigation into Connected Care – Feedback from Focus Group' presented to the Health Scrutiny Forum of 29 March 2011

(o) Callaghan, G., Quinn, J. (2009) *Hartlepool Key Lessons*, [online], Turning Point, Available from http://www.turning-point.co.uk/commissionerszone/centreofexcellence/Pages/Hartlepoolkeylessons.aspx?dm_t= (Accessed 21 March 2010)

(p) Minutes of the Health Scrutiny Forum of 22 June 2010, 23 November 2010, 1 February 2011, 1 March 2011 and 29 March 2011.

Appendix A

Hartlepool Mail

Sails project 'changing lives of isolated people'

Flagship scheme supporting the lonely

A PIONEERING partnership scheme is changing the lives of older people living in loneliness and isolation.

The flagship Supporting Access to Independent Living Services (Sails) project is aimed at keeping people healthy and happy in their own homes and also enjoying community pastimes.

It is being developed as part of an ongoing partnership to help people over the age of 60 enjoy a balanced lifestyle with advice on all aspects of their health, social and financial needs.

Central to the scheme is the link-up between IntraHealth's Wynyard Road medical practice and Connected Care, a Government pilot scheme to encourage co-operation between health, social care and housing services to offer integrated, personalised care and support.

Award-winning IntraHealth won a contract to provide GP services for NHS Hartlepool and works with a number of partner agencies to provide healthcare to people across the town.

It runs practices in Wynyard Road and at Hartfields.

The beauty of the Sails project is that those patients who are living lonely lives can be identified and contacted.

Elizabeth Carroll, IntraHealth's patient and community liaison officer said the programme, in the Owton Ward area of Hartlepool, is transforming lives.

She said: "The aim of the service is to enable residents to remain living independently in their own homes through a range of integrated support services. It is brilliant to be working with Connected Care to enable our patients to take advantage of this exciting initiative."

Those eligible must live in the south wards of Hartlepool and be either aged 60 or over, a carer, have a chronic or long-term illness, suffered a recent bereavement or feel isolated.

by Paul Watson

paul.watson@northnewspaper.co.uk

Everyone signing up to Sails gets an initial benefits assessment to see if they are receiving benefits due to them and their family. Patients do not have to divulge personal information such as savings if they do not want to.

Sails staff will contact each household on a daily or weekly basis, by agreement, either by phone or a home visit.

Dependent upon their needs, patients can access the meals on wheels service, handyman service and also a range of social activities on offer at the Manor Residents Association Resource Centre, in Kilmarnock Road.

Connected Care administrator Sammie Carroll, who runs the Sails project, said: "People should not have to worry about being lonely and isolated.

"The partnership aspect of Sails means that there is always someone we can call upon who will be able to help people who are isolated in the community.

"It helps to integrate people and also ensures their health and everyday needs are looked after. Nobody should have to feel they are alone or live an isolated existence.

"Our message is that we are here – so come and join us."

Patients or their relatives/carers who are interested in taking part in the Sails project should ring Mrs Carroll on (01429) 223195.

DELIGHTED WITH SCHEME: (Left to right) Doris Hargreaves, Elizabeth Carroll and Sammie Carroll. *(IRN: 517342)*

Difference made to Doris's life 'amazing'

PENSIONER Doris Hargreaves admits she was a virtual prisoner in her own home before the Sails project 'changed her life'.

The now-sprightly 83-year-old has become a regular visitor to the resource centre and both Elizabeth and Sammie keep in constant touch with her to make sure she is safe and well.

Doris, who moved to the town two years ago from Essex to be nearer family members, told the *Mail*: "If it was not for Liz and Sammie I don't know where I would be. They are brilliant.

"I can always ring one of them up and get help and advice straight away."

Mrs Hargreaves, who lives half-a-mile away from the Manor Residents Association Resource Centre, is contacted every Monday morning by telephone and collected on days that she wants to visit the centre for social activities.

She previously suffered a nervous breakdown but is now an active and sprightly member of the community and the Sails programme which helps people from 60 upwards with the oldest member of the programme aged 90.

Doris quipped: "I'm one of the younger ones!.

"This has been life-changing for me and I would urge any other elderly people in the area to get in touch and enjoy the benefits.

"Before this I would be sitting at home watching TV and looking out of the window.

"It means a great deal to me knowing that there is someone out there who I can contact and who have become very close friends for me.

"There was nothing like this in Essex and the difference in my life is amazing."

Connected Care facts and contacts

CONNECTED CARE was the first national pilot scheme and was launched in the Owton ward of Hartlepool three years ago.

It is a partnership between local residents, ward councillors, community associations and local services including health.

Its main aim is to improve the overall delivery of health and social care services in a targeted area and covers 2,900 households and almost 6,800 people.

It is regularly monitored to provide a model that can be rolled out in other parts of the country.

The Sails initiative is one part of the overall Connected Care programme which also runs schemes to improve community safety and tackle anti-social behaviour.

Connected Care can be contacted on freephone 0800 6340868 or (01429) 297201.

HEALTH SCRUTINY FORUM

29 March 2011

HARTLEPOOL BOROUGH COUNCIL

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.

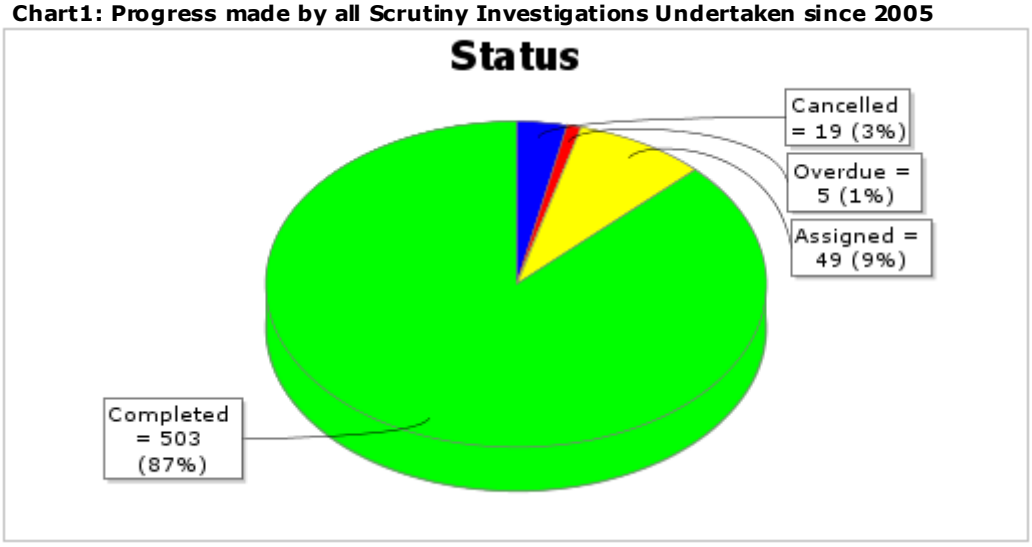
2. BACKGROUND INFORMATION

2.1 In November 2007 the Scrutiny Co-ordinating Committee approved the introduction of the Scrutiny Monitoring Database, an electronic database, to monitor the delivery of agreed scrutiny recommendations since the 2005/06 Municipal Year.

2.2 In March 2010 Scrutiny Chairs noted and agreed for the movement of the Scrutiny Monitoring Database into the Covalent, which is the Council's Performance Management System.

2.3 In accordance with the agreed procedure, this report provides for Members details of progress made against each of the investigations undertaken by the Forum, incorporating those investigations undertaken by the former Adult and Community Services & Health Scrutiny Forum. **Chart1** overleaf is the overall progress made by all scrutiny forums since 2005. **Appendix A** provides a detailed explanation of progress made against each scrutiny recommendation agreed by this Forum since the last update to this Forum on 12 October 2010.

Chart1: Progress made by all Scrutiny Investigations Undertaken since 2005



3. RECOMMENDATIONS

3.1 That Members:-

(a) Note progress against the Health Scrutiny Forum's (including the former Adult and Community Services & Health Scrutiny Forum) agreed recommendations, since the 2005/06 Municipal Year, and explore further where appropriate; and

(b) Retain **Appendix A** for future reference.

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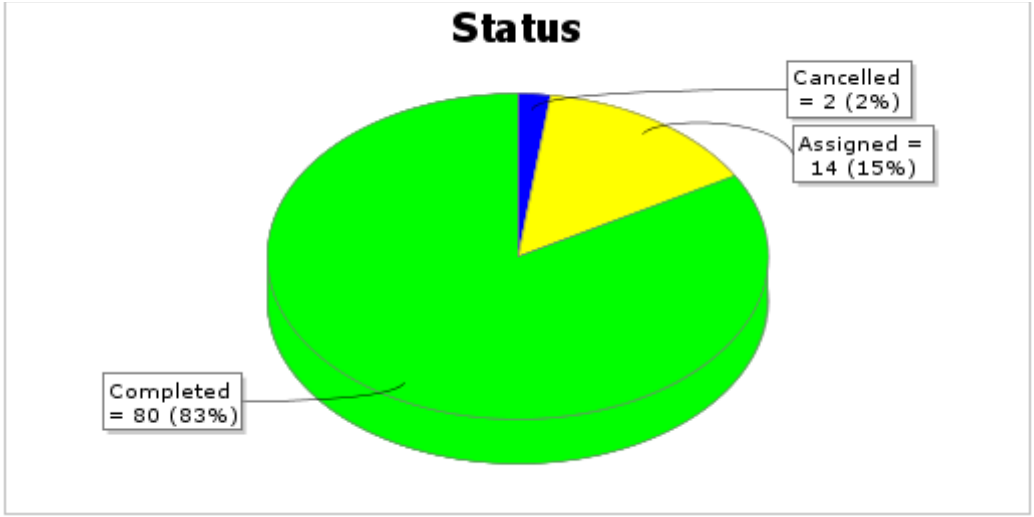
BACKGROUND PAPERS

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

Health Scrutiny Forum - All

Generated on: 17 March 2011



Year 2008/09
Investigation Reaching Families in Need

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
SCR-HSF/1a That the local authority take the lead in providing a co-ordinated leadership approach across the different providers in	SCR-HSF/1a/i	The government has provided guidance regarding a "Think Family" initiative that we are developing in Hartlepool. This initiative will support this recommendation and	Ann Breward; John Robinson	01 Mar 2011	01 Dec 2011	08 Mar 2011 We continue to develop the Think Family approach when working with families that have multiple needs. We are using this approach with	79% Assigned

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
order to facilitate a systematic approach to tackling health inequalities in the town.		will endeavour to lead a culture change in the way that our services are designed.				a number of families who require intensive interagency support.	
						12 Jan 2011 We continue to develop our services based on the Think Family phylosophy and there still appears to be real enthusiasm for this approach. We are learning from the young carers pathfinder that has focussed on removing youngsters from caring situations by providing for their parents. This project has had a major impact on these families involved and has resulted in children being less vulnerable. A great deal of work is still required across partners to further develop an integrated process and this work will need to continue next year.	
						27 Sep 2010 Think Family has not yet been adopted by the coalition government and consequently there is no central coordination of this process. The Think Family Grant has not been impacted upon in this financial year but it is unclear as to what will happen in 2011/12. The Think Family Services	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						continuie to make progress operationally and strategicall although at the current time there is not a requirement for a high level steering group. Partners from all sectors are involved in services that are operating in a way that puts the family at the centre of their work. Services for children and adults are being explored through the Young Carers Pathfinder and the Team Around processes. A Prevention/think family strategy is currently being prepared.	
						23 Feb 2010 Think Family Co-ordinator is now in post. Directors of Child and Adult Services is chair of the 'Think Family Steering Group'. Cross organisation social inclusion group is also in place to steer operationals aspects.	
SCR-HSF/1b That subject to the implementation of recommendation 1a, the local authority, acting as strategic leader, enter into formal arrangements with partner organisations (i.e.	SCR-HSF/1b	The Think Family Reforms will be reported through the Children's Trust that includes all major stakeholders in this process.	Ann Breward; John Robinson	01 Mar 2011	01 Dec 2011	08 Mar 2011 A strategic group is actively engaged in indentifying elements of multi-agency practice, including the FIP, that can from the basis of future work with the most complex families.	50% Assigned
						12 Jan 2011 The second	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
Police, PCT, FT, Housing Hartlepool and the Voluntary Sector).					draft of the prevention strtaegy has been circulated to Managers for discussion. In the light of a new budget framework it is expected that this may form the base of service redesign. Despite the change of government Hartlepool has maintained commitment to think family as a way to describe our approach to interventions.	
					27 Sep 2010 The Think Family Coordinator has left the authority and has not been replaced. The work under the Think Family Banner has continued and has been reported through the Portfolio Holder for Children's Services. Partners continue to be engaged and real progress is being made across parenting support, team around process and the Common Assessment Framework. The Prevention strategy is due for its second draft with a final draft in place for March 2011.	
					06 Apr 2010 The Think Family Coordinator is working with the	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						Parenting Commissioner to develop a Vision Statement that will be put before the Children's Trust Board for discussion and agreement in June 2010. This will form the basis of an integrated strategy that delivers a ThinK Family approach across services.	
						23 Feb 2010 Expected to achieve target.	
SCR-HSF/1c That the FIP Project be expanded in light of its effectiveness thus far in targeting hard to reach families.	SCR-HSF/1c	The Family Intervention Project (FIP) is currently being developed as an integrated part of the Team around the School initiative. This service has been designed to enable new services to be bolted onto it and to adopt the FIP approach to assertive support.	Ann Breward; John Robinson	01 Dec 2011	01 Dec 2011	08 Mar 2011 Like most services the FIP has taken a cut in funding for 2011/12. This has given the impetus to partners to engage in a process of redesign that will focus even more on those families at the more complex end of the spectrum.	0% Assigned
						12 Jan 2011 The FIP service continues to be effective and is leading on our integrated services for families. The coalition government has put the intensive interventions agenda at the forefront of its strategy for families with multiple needs. The resources available to provide services in the future are curently under discussion.	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					27 Sep 2010 The Family Intervention Project continues to provide a range of services through the team around the primary school process. The service is currently involved in developing intensive packages of support for children on the cusp of care or those that may require external placements. Service development will be impacted upon by the government spending review.	
					06 Jul 2010 The government has removed the funding ring fence on this programme and has consequently dropped its montoring responsibilities. This will enable Hartlepool to further develop the Family Intervention project as an integral part of the team around the school approach.We will continue to use this funding to explore tyhe development of direct support to targeted families. The Housing FIP is in a similar position and will be developed in line with other preventative services.	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						06 Apr 2010 In March 2010 Hartlepool was succesful in a bid to develop a Housing Challenge Family Intervention Project with Partners from Housing Hartlepool, NDC and Belle Vue Centre. This project will bring an additional £87,000 into the town and will link with the Team Around the School Initiative that concentrates on housing in the Belle Vue area.	
						23 Feb 2010 Service continues to develop with further opportunites being offered by government. Housing worker and 3 seperated parent workers have joined the team.	
SCR-HSF/1g That in order to strengthen links and communication routes between agencies, the establishment of a co-ordinated, single point of contact for the referral of information and referrals from any source be explored.	SCR-HSF/1g	We will explore current communication routes being developed by community safety, the Team Around the School Initiative and Family Information Service to further this action and provide a report to the Children's Trust and Cabinet.	Ann Breward; John Robinson	01 Mar 2011	01 Dec 2011	08 Mar 2011 The new funding context has resulted in the need to redesign prevention services and this will take place during 2011. The need for a single entry system still has to be realised.	54% Assigned
						12 Jan 2011 Thinking continues to change around the opportunities to get this process right and in place. As a consequence of budget	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					constraints services are being refocussed. The second draft of the prevention strategy has been circulated for comment and if accepted will get us closer to this aim but this is unlikely to be realised within this financial year.	
					27 Sep 2010 The prevention strategy is in its second draft and is on track for full implementation by March 2011. The issue of a single point of contact is not yet realised although a single point of referral is getting closer as a consequence of the team around process.	
					06 Jul 2010 After a development meeting to discuss the reintroduction of the Hartlepool Intervention Panel those present expressed the belief that this was not a system that is currently required the work including the circle of adults was seen as sufficient. We will return to this if needed.	
					06 Jul 2010 The Team	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					around the school process is refining referral routes operationally but needs to be cemented through policy and procedure The development of the Team Around the School processes will continue as the focus of a new preventative strategy that will be written during 2010/11	
					06 Apr 2010 The Parenting Commissioner has reinstigated the Hartlepool Intervention Panel to support the development of this work. The panel is made up of senior managers that have strategic and operational responsibilities who are in a position to make decisions regarding gaps in service, resource issues and "stuck cases" that are creating major concerns.	
					23 Feb 2010 Initially this process is to be looked at by the Family Intervention Project Steering Group. A YCAP database is being developed and a police officer has joined the TAPs team to look at some of the issues.	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
SCR-HSF/1h That the feasibility of introducing a similar way of gathering and sharing data in Hartlepool, as has been implemented by Westminster Council (i.e. a Multi-Agency Information Desk) be explored.	SCR-HSF/1h	We will investigate this issue as part of the development of the Common Assessment Framework linked in with the Children's Trust, the Local Safeguarding Children Board and the Safer Hartlepool Partnership. These developments will need to take account of the current sub regional agreements that are in place.	Ann Breward; John Robinson	01 Mar 2011	01 Dec 2011	08 Mar 2011 It is now highly unlikely that we have the structures that will enable Hartlepool to replicate the Westminster model. In the redesign of services there is an intention to develop a new assessment process that may enable us to move towards a similar process. 12 Jan 2011 A recent audit of CAF has shown that assessments are of variable quality and that as a system more progress needs to be made before it can be seen as fully integrated. There has been some delay with ECAF and it is still not cirtain that the system will be adopted in Hartlepool. A decision will be made on this soon. Currently due to budget constraints and service redesign across partners we are not in a position to develop a Westminster model in Hartlepool although it remains a model that practitioners are keen on. 27 Sep 2010 The CAF Coordinator has recently reported to the Children's Trust and the	39% Assigned

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					Safeguarding board regarding progress in development. The ECAF system is soon to go live and it is expected that this system will support better quality assessments and easier access. Hartlepool partners have not yet agreed a process based on the Westminster family recovery model although there are now several individual cases where the process of one information coordinator is in operation. This process will be monitored to ensure any learning is not lost.	
					06 Jul 2010 The CAF Coordinator is currently taking a quality audit of CAF that will result in new policy and guidance. This audit will be completd by October 2010.	
					06 Apr 2010 The CAF Coordinator is currently providing training for staff across agencies to support the development of this process. We are currently developing new monitoring systems based on family outcomes rather than	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					numbers of CAFs completed. This shows that we are entering a significant new development phase that will focus on quality rather than quantity.	
					23 Feb 2010 The Parent Commissioner attended a seminar on the Westminster model and has received all policy and operational documents, these will be considered as part of the development of Integrated Services.	

Year 2009/10
Investigation Alcohol Abuse - Prevention and Treatment

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
SCR-HSF/3c/ii Looks to pool resources in the treatment and prevention of alcohol related problems	SCR-HSF/3c/ii	The terms of reference for the Strategy Group and the self assessment/improvement plan confirm a commitment to pool and maximise resources for more effective responses. This will be influenced however by the Governments announcement on funding allocations and governance structures e.g. GP Commissioning and the abolition of Primary Care	Alison Mawson	30 Apr 2011	30 Apr 2011	03 Mar 2011 On 1/3/11 no decision had been made by the PCT on budget allocations for 2011/12. The decision is expected towards the end of March 2011. Changes to the guidance relating to the allocation of funding for drugs treatment from Dept of Health, indicate that a small proportion of funding can now be utilised for individuals who have significant	75% Assigned

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
		Trusts, the detail of which is not likely to be known until January 2011.				problem associated with alcohol misuse. 24 Jan 2011 There is commitment from PCT to provide 'invest to save' budget re hospital admissions, but still awaiting confirmation of local treatment budgets, although it is anticipated this will be forthcoming.	
SCR-HSF/3c/iv Develops a communication strategy that not only keeps the Health Scrutiny Forum update on progress, around alcohol misuse conjoining with all local community groups so that it effectively targets all of parts of Hartlepool.	SCR-HSF/3c/iv	A Communication Strategy has been developed and includes information made available through SHP website; a regular programme of events and campaigns and enhanced reporting arrangements with an annual report and quarterly performance management and progress reports. These reports will be provided to all major stakeholders, Hartlepool Partnership and the Council (including the Health Scrutiny Forum) as appropriate	Chris Hart	31 Jan 2011	30 Sep 2011	08 Mar 2011 Alcohol Strategy consultation completed and final document presented for approval and ratification by end of March. The Strategy and associated action plans will form work programme of Alcohol Strategy Group and from April will be monitored quarterly. Mid year and end of year report to be produced and made available to key partners. 21 Jan 2011 SHP website reviewed and improved. Consultation and final approvals nearing completion for going live in February. Regular articles and press releases issued. Website also contains minutes of meetings, strategic documents action plans and latest detail of activity, events	35% Assigned

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						and developments. Local substance misuse webite www. hiwecanhelp to have a link.	
SCR-HSF/3d/i Reducing opening hours of on-licensed premises as and when they come forward	SCR-HSF/3d/i	The current review of the Licensing Policy provides an early opportunity to place crime and disorder in the night time economy higher in the licensing agenda and set a more rigorous tone in a range of conditions that could be applied in appropriate cases in Hartlepool. Work is in hand with licensees to reach a voluntary agreement to reduce opening hours.	Ian Harrison	31 Jan 2011	31 Jan 2012	07 Mar 2011 There appears to be no realistic prospect of ALL licensed premises agreeing to an earlier closing time but premises are, one by one, either having their hours reduced by the Council's Licensing Sub-Committees or by voluntary agreement. The Shades has applied for a new licence with a closing time of 2:00 a.m., The Office has done the same. Rockies licence is being reviewed and its neighbouring premises, Busbys, has now voluuntarily applied to reduce its hours to 2:00. Sorrentos had its licence revoked by sub-committee on 7th March. The Council has adopted a new licensing policy that states new licences will not be granted after 2:00 a.m. and new legislation is still progressing through parliament that is likely to give local authorities the opportunity to close all premises at a	37% Assigned

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						specified terminal hour.	
						18 Jan 2011 Licence review has taken place for The Office and its hours were reduced. Also Sorrentos has had its hours reduced through variation and Shades has had its licence revoked by licensing committee. Negotiations are ongoing with other nightclubs to acheive a voluntary early closing time. More licence reviews are expected from Cleveland Police and legislation is currently passing through Parliament that would allow licensing authorities to close all premises earlier. Once law, this matter would be taken to Licensing Committee for consideration.	
SCR-HSF/3e/i The funding of alcohol treatment and prevention services is ring-fenced and mirrors illegal drug treatment and prevention	SCR-HSF/3e/i	NHS Hartlepool Board considered the recommendations of the investigation at the board meeting in July. It was acknowledged by the PCT Board that alcohol and the funding of treatment services is a key priority. Officers will continue to work to identify resources on a recurring basis through the QIPP	Louise Wallace	31 Mar 2011	31 Mar 2012	08 Mar 2011 NHS Hartlepool Board agreed in January 2011 that alcohol treatment and prevention services should be a priority. Currently in the process of identifying a supporting budget to secure funding for 2011/12 resource.	11% Assigned

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
		programme, particularly as it is recognised that there is a significant pressure on hospital services from alcohol related harm.					
SCR-HSF/3e/ii The current delivery model is made sustainable and the ability to increase the capacity of providers, whilst maintaining the current high standard, is prioritised.	SCR-HSF/3e/ii	NHS Hartlepool Board considered the recommendations of the investigation at the board meeting in July. It was acknowledged by the PCT Board that alcohol and the funding of treatment services is a key priority. Officers will continue to work to identify resources on a recurring basis through the QIPP programme, particularly as it is recognised that there is a significant pressure on hospital services from alcohol related harm.	Louise Wallace	31 Mar 2011	31 Mar 2012	08 Mar 2011 NHS Hartlepool Board agreed in January 2011 that alcohol treatment and prevention services should be a priority. Currently in the process of identifying a supporting budget to secure funding for 2011/12 resource.	1% Assigned
SCR-HSF/3f/i Address the problem of why people exhibiting risky behaviour in terms of alcohol don't utilise their GP as their first point of contact	SCR-HSF/3f/i	Work is ongoing to develop the GP Locally Enhanced Service (LES) to ensure GPs are able to offer effective and appropriate services for people in primary care. The LES has been drafted and is now in the process of being consulted on.	Louise Wallace	31 Mar 2011	31 Mar 2012	08 Mar 2011 LES is currently being consulted upon as part of the gradual 'hand-over' from NHS Hartlepool to the GP Consortia.	1% Assigned
SCR-HSF/3f/ii Ensure that all GP practices are trained in terms of brief interventions	SCR-HSF/3f/ii	Any training issues are expected to be identified through this process. This LES will ensure that GPs are a first point of contact as they will be actively engaging with patients who have hazardous and	Louise Wallace	31 Mar 2011	31 Mar 2012	08 Mar 2011 LES is currently being consulted upon as part of the gradual 'hand-over' from NHS Hartlepool to the GP Consortia.	1% Assigned

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
		harmful drinking behaviours.					
SCR-HSF/3g That licensees are encouraged to participate in a trial period of early closing and that the impact on alcohol related incidents is recorded	SCR-HSF/3g	Joint work between the Police, the Principal Licensing Officer and Hartlepool Licensees Association continues. Negotiations are reaching a satisfactory conclusion with the potential for a reduction in opening hours and an agreement on an appropriate closing time across establishments in the key area of Church Street.	Ian Harrison	31 Jan 2011	31 Jan 2012	07 Mar 2011 Efforts have been made through the Council, Police and Hartlepool Licensees Assn but it has not been possible to achieve a 100% agreement to an earlier closing time and no one has been prepared to do it unilateraly for fear of losing business to those who stayed open. However, through a robust approach adopted by the Police a number of licences have been called in for review and the Council has used this opportunity to revoke 2 licences (Shades and Sorrentos). Other licence reviews are pending. This approach has resulted in some premises now applying to have their licensed hours reduced to 2:00 a.m. To summarise, all licensees have been encouraged on a number of occasions but it may be necessary to await new legislation that is currently progressing through parliament before 100% early closing can be achieved.	50% Assigned

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						18 Jan 2011 Work between all agencies is continuing with licensed hours being reduced through a use of formal licence review powers and voluntary arrangement. Early closing may become easier in late 2011 as legislation is likley to be passed that will allow licensing authorities to close all premises early.	
SCR-HSF/3h In promoting safe, sensible drinking, that the Council be encouraged to evaluate any opportunities to work towards recognising the Town Centre as a Purple Flag zone.	SCR-HSF/3h	Securing Purple Flag status would be challenging and is an aspiration at this time considering the current level and baseline. Improvements would include not only the participation of licensees but also consideration of the wider night time economy environment which does need significant investment. There is however a tiered development plan in place to work towards this award. This includes more positive engagement with the trade to develop higher standards of customer care; more consideration of safe routes home and closer working with town centre management. One of the first stages is the voluntary adoption of voluntary codes by operators and moving to	Ian Harrison	30 Sep 2011	30 Sep 2011	07 Mar 2011 Marshalled taxi rank continues to operate on Saturday nights. A second Best Bar None meeting was held on 1st March but attendance was, once again, poor. One licensee has agreed to help promote the scheme but after discussions with Durham City council (whose BBN scheme won a national award in 2009) it would appear that significant Council resources will be required to promote and establish the scheme (DCC quoted 20 hours per week for first 3 months). Efforts will be made to secure private sector sponsorship but the success of this will be dependant upon obtaining more interest	70% Assigned

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
	the introduction of the Best Bar None scheme. There will also be a review of the impact of the Transport Interchange.				from the licensees themselves. Work is ongoing. Work has also begun on establishing a Street Pastor scheme with a meeting taking place involving SHP, Police, Council and Hartlepool Churches Together. A Steering Group has been formed and it is hoped Street Pastors will be operating later this year. Other steps taken include improving the street lighting in Lucan Street, erecting alley gates to the alleyways between Victoria Road and Lucan Street and Lucan Street and Middleton Lane (These alleys were used as late night short cuts but often resulted in assault, urinating etc), Taxi marshalling continues and a Taxi Shelter will be erected in Church Street to assist with this.	
					18 Jan 2011 Best Bar None Scheme has been discussed on two occasions at Hartlepool Licensees Assn meetings and one specific BBN meeting has taken place. Interest in the scheme is slowly developing. Marshalled taxi rank has	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						been operating in Church Street since October and is set to continue for 2011.	

Year 2008/09
Investigation Reaching Families in Need

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
SCR-HSF/1e That the use of the model of intervention implemented through the FIP Project and Connected Care Project be explored as a basis for a more far reaching Families in Need Strategy.	SCR-HSF/1e	The FIP and connected Care steering groups will be asked to undertake a review of the projects and look at the learning that can be identified from both projects. This will form the basis of an event in March 2010 that will enable stakeholders to analyse and respond to the learning. This event will help frame the issues in preparation for a decision regarding a Families in Need strategy.	Denise Ogden	01 Mar 2010	01 Mar 2010	02 Mar 2011 There have been several positive evaluations of the Connected Care approach and the outcomes achieved in Owton, and options are being explored to roll out the model to other parts of the town. Low level support and preventative services are key elements of the reablement model that is being developed within adult social care and we hope to secure some of the reablement funding to support this 25 Oct 2010 neighbourhood managers are working with C&A to roll out principles of connected care as appropriate 23 Feb 2010 Activities are underway within the	100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						Neighbourhood Action Plan areas	
SCR-HSF/1i That ways of providing and promoting programmes that are not badged as being run by official bodies be explored.	SCR-HSF/1i	(i)We will continue to develop our commissioning and procurement process to ensure that they are accessible to third sector organisations. (ii) We will continue to involve a wide range of stakeholders in the development of services and in particular involve local community based groups to provide services that are not perceived as stigmatising by users.	Ian Merritt	01 Mar 2011	01 Mar 2011	03 Mar 2011 -- enter new status update -- Routine contact is being maintained. A new Early Intervention Strategy for 2012 is being developed and colleagues from the VCS will be involved in its design and development. 23 Jun 2010 Meetings with key prividers from the VCS continue to take place. Potential workshop on the impact of cuts in Government funding during July or September. 13 Apr 2010 A workshop on commissioning was delivered in March 2010. Work with key providers to assist them in developing strategies to deal with the challenging circumstances anticikpated over the next few years is continuing. 23 Feb 2010 Proposals to ensure that the commissioning and procurement process children's services are more accessible to third	100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						sector organisations are being developed. It is anticipated that a report will be submitted to the Portfolio Holder for Children's Services early in 2010. Children's Services continue to involve stakeholders in the development of services and the 3rd Sector have been contracted to provide outreach to vulnerable families on behalf of SureStart Children's Centres.	
SCR-HSF/1j That a system be put in place to ensure that where new public buildings / facilities are constructed (i.e. the new health centre) the inclusion of a place where advice / assistance and other integrated services can be provided is explored.	SCR-HSF/1j/i	A generic facility for providing advice and assistance will be available in new integrated health centres.	Joanne Dobson	01 May 2010	01 May 2010	23 Feb 2010 The new Hartlepool integrated health centre will be operational from May 2010.	100% Completed

Year 2009/10
Investigation Alcohol Abuse - Prevention and Treatment

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
SCR-HSF/3a That Hartlepool Borough Council set up an	SCR-HSF/3a	Safer Hartlepool Partnership (SHP) Alcohol Strategy Group have the	Alison Mawson	31 Oct 2010	31 Oct 2010		100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
'Alcohol Task Force' linking all major stakeholder including Licensing, GPs, Cleveland Police, Cleveland Fire Authority, relevant voluntary groups and major off- and on- licensed retailers in the Town		responsibility and membership identified for an 'Alcohol Task Force'. This includes the five responsible authorities the Council (Community Safety and Protection, Licensing Officer, Child and Adult Services), Cleveland Police, Durham and Tees Valley Probation Trust and NHS Hartlepool (PCT). In addition there is a representative from the Licensee Association and communication with the voluntary sector is through an elected member of the Community Empowerment Network. Operational and task groups reporting to the Strategy Group include wider membership of the retailers and voluntary sector including service providers.					
SCR-HSF/3b That in addition to recommendation (a) the Council appoint an elected member to chair this group and to oversee and promote its work throughout every community in the town	SCR-HSF/3b	A review by the Alcohol Strategy Group in response to the CAA red flag agrees with the recommendation to appoint an elected member as a champion to lead the group. The appointment of an appropriate member to be identified by Cabinet.	Alison Mawson	31 Dec 2010	31 Dec 2010	24 Jan 2011 Alcohol strategy group now chaired by Cllr Brash	100% Completed
SCR-HSF/3c/i Works together to investigate what changes can be	SCR-HSF/3c/i	Hartlepool Alcohol Strategy and the associated action plans are currently being produced following a	Alison Mawson	30 Nov 2010	30 Nov 2010		100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
made as a collective to addressing the issue of alcohol abuse		comprehensive needs assessment and prioritisation exercise. A visit and recommendations by the NHS National Alcohol Support Team mid October will further strengthen the development of a cross cutting strategy that seeks to address alcohol related prevention, treatment and enforcement issues					
SCR-HSF/3c/iii Undertakes specific work in conjunction with on-licensed premises and major off-licence retailers to look at the issue of the pricing and promotion of the very cheapest alcohol	SCR-HSF/3c/iii	Police and Licensing Officers have positive relationships with the retailers and have had some success with limiting irresponsible promotions on licensed premises. Enforcement action will be a priority to address illegal supply of alcohol There is national work in hand to try to influence the larger retailers such as supermarkets who can sell alcohol at low cost which is causing licensees major economic pressure and fuelling anti social behaviour. In addition Hartlepool have strong working relationships with Balance and are supporting their regional campaigns and responses to government consultation on minimum pricing	Ian Harrison	29 Oct 2010	29 Oct 2010		100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
SCR-HSF/3d/ii Tasking Cleveland Police, Licensing and other stakeholders to gather detailed evidence to feed into the review, to enable licensees that are contributing to alcohol related violence to be held properly accountable	SCR-HSF/3d/ii	The CAA review process led to improved data sharing and needs assessment on the nighttime economy. There is also an independent study on the impact of the night time economy completed in December 2009, analysis of offending and offenders, and the Cardiff Model (hospital) data has now come on stream providing a more comprehensive understanding of problem areas and need for focused activity. The responsible authorities are now spearheading joint enforcement activity for the Top Ten problem premises. The Licensing Policy review will be able to take cognizance of this information and activity.	Alison Mawson	31 Jan 2011	31 Jan 2011	24 Jan 2011 the police have strengthened their licensing team and more evidence is being gathered on individual problem lincensed premises. 2 reviews have been carried out during Qtr 3, leading to changes to licensed conditiions being implemented.	100% Completed
SCR-HSF/3d/iii Ensuring that any new powers from central Government are used to their fullest extent so as to assist in reducing opening times.	SCR-HSF/3d/iii	The Licensing Review and guidance from Government will be applied and forms part of the Alcohol Strategy and associated Reducing Violence Strategy and plans.	Alison Mawson	31 Mar 2011	31 Mar 2011	24 Jan 2011 New licensing policy includes recommended earlier closing times for new licenses. Reviews will also take account of the policy change, although each case will be judged on it's merits.	100% Completed

Year 2009/10
Investigation Suspension of Greatham Clinic

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
SCR-HSF/2a/i That residents in Greatham are informed when this service is operational, what this service will provide and what options are available for accessing other health services including the clinical elements not currently provided for.	SCR-HSF/2a/i	Interim service are in place leaflet to all households completed. Interim services consist of; The Health Bus which is run by Hartlepool Families First, a registered charity has added Greatham to its stops. The bus will be in the village (opposite The Green) every Monday between 4pm and 6pm. The attached leaflet gives details of what the Health Bus can offer. For further details please contact Families First on 01429-867016 or email **info@hartlepoolfamiliesfirst.org.uk** Residents of Greatham who would have previously attended the drop-in clinic can also access the district nursing service for any reason that would have normally resulted in a visit to the nurse drop-in clinic by requesting a home visit by contacting the District Nurse either through their GP or directly on 078017818 The health trainers are providing advice and support to anyone over 18 years of age who wants to adopt a healthier diet, get more active or stop smoking. Residents can	Richard Harrety	29 Oct 2010	29 Oct 2010		100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
		access the health trainer service by calling the central office 01642 853998, or directly to Denise Murphy on 01429-285558 or 07748 112784 or email **denise.murphy@nhs.net**					
SCR-HSF/2a/ii That the feasibility of Greatham residents forming a steering group to influence the services to be provided be assessed.	SCR-HSF/2a/ii	Steering group was set up in June 2010 and has been meeting regularly.	Richard Harrety	29 Oct 2010	29 Oct 2010		100% Completed
SCR-HSF/2b/i Consultation being carried out with all Greatham residents.	SCR-HSF/2b/i	Options have been drawn up with the steering group and were presented for feedback from local residents on a meeting held on the 6th September. Next steps are to consult with local GP's and present final report to the November Board meeting.	Richard Harrety	30 Nov 2010	30 Nov 2010	28 Feb 2011 Final report presented to NHS Hartlepool Board Meeting of 25 November 2010.	100% Completed
SCR-HSF/2b/ii The outcome of the consultation being shared with the Health Scrutiny Forum	SCR-HSF/2b/ii	Upon decision by board, presentation will be given to Health Scrutiny Forum	Richard Harrety	31 Jan 2011	31 Jan 2011	28 Feb 2011 Outcome of consultation and decision from NHS Hartlepool Board presented to Health Scrutiny Forum on 1 March 2011.	100% Completed

HEALTH SCRUTINY FORUM

29 March 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 1 March 2011.

2. BACKGROUND INFORMATION

2.1 The agenda for recent Tees Valley Health Scrutiny Joint Committee Meetings is detailed below. 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 14 March 2011 when the following issues were discussed:-

(i) Out of Hours Care – Service Redesign

(ii) Capacity of Community Mental Health Services – Evidence Gathered

(iii) CAMHS & LD Short Break Services for Teesside – An Update

(iv) Personal Health Budget Pilot - Update

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
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BACKGROUND PAPERS

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