CABINET AGENDA

HARTLEPOOL
BOROUGH COUNCIL

Monday, 20 June 2011

at 9.15 am

in Committee Room B, Civic Centre, Hartlepool

MEMBERS: CABINET:

The Mayor, Stuart Drummond

Councillors Brash, Hall, Hargreaves, Hill, Jackson, Payne and H Thompson

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

   3.1 To receive the Record of Decision in respect of the meeting held on 6 June 2011 (previously circulated)

4. **BUDGET AND POLICY FRAMEWORK**

   No items

5. **KEY DECISIONS**

   No items

6. **OTHER ITEMS REQUIRING DECISION**

6.1 Raby Road Corridor – Resident Re-Housing and Home Loss Payments – *Director of Regeneration and Neighbourhoods*
6.2 Business Transformation Programme Board – *Assistant Chief Executive*

7. **ITEMS FOR DISCUSSION/INFORMATION**

7.1 A New Legal Framework for Social Care – The Law Commission Reports – *Director of Child and Adult Services*

8. **REPORTS FROM OVERVIEW OF SCRUTINY FORUMS**

8.1 Regional Review of the Health of the Ex-Service Community – Final Report – *Health Scrutiny Forum*
8.2 Connected Care – Final Report – *Health Scrutiny Forum*
8.3 Connected Care – Action Plan – *Director of Child and Adult Services*
8.4 Dust Deposits on the Headland – *Health Scrutiny Forum*

CABINET REPORT

20TH June 2011

Report of: Director of Regeneration and Neighbourhoods

Subject: RABY ROAD CORRIDOR – RESIDENT RE-HOUSING AND HOME LOSS PAYMENTS

SUMMARY

1. PURPOSE OF REPORT

To further update the Cabinet on the making of Home Loss Payments and the re-housing of residents pursuant to the Housing Market Renewal (HMR) programme in relation to the Raby Road Corridor site which comprises land contained in the Council of the Borough of Hartlepool (Land at Perth, Hurworth and Gray Streets, Turnbull Street (Nos 47 to 69), The West Hartlepool Rovers Amateur Quoits Club Grainger Street, Grainger Street (Nos 1 to 21), Raby Road (Nos 144 to 160 even) and No 40 Brougham Terrace North Central Hartlepool) Compulsory Purchase Order 2010 ("the CPO").

2. SUMMARY OF CONTENTS

The report provides a further update in relation to the Raby Road Corridor regeneration area and specifically issues relating to relocation of residents of the scheme and the making of Home Loss payments.

3. RELEVANCE TO CABINET

This project has strategic relevance across a range of Portfolios, including areas of housing, regeneration and finance.

4. TYPE OF DECISION

Non Key

5. DECISION MAKING ROUTE

Cabinet Meeting on the 20th June 2011.

6. DECISION(S) REQUIRED

Cabinet is recommended to :

i) note the contents of this report ;
ii) endorse and confirm the proposed approach to resident re-housing and payment of Home Loss Payments;
iii) and authorise the Director of Regeneration and Neighbourhoods to make discretionary payments pursuant to the Land Compensation Act 1973.

Report of: Director of Regeneration and Neighbourhoods

Subject: RABY ROAD CORRIDOR – RESIDENT RE-HOUSING AND HOME LOSS PAYMENTS

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1. PURPOSE OF REPORT

1.1 To further update the Cabinet on the making of Home Loss Payments and the re-housing of residents pursuant to the Housing Market Renewal (HMR) programme in relation to the Raby Road Corridor site which comprises land contained in the Council of the Borough of Hartlepool (Land at Perth, Hurworth and Gray Streets, Turnbull Street (Nos 47 to 69), The West Hartlepool Rovers Amateur Quoits Club Grainger Street, Grainger Street (Nos 1 to 21), Raby Road (Nos 144 to 160 even) and No 40 Brougham Terrace North Central Hartlepool) Compulsory Purchase Order 2010 ("the CPO").

2. BACKGROUND

2.1 Members have received a number of reports over recent years in respect of the above matter. Most recently it has been reported to Cabinet that on 12 May 2011 the Secretary of State for Communities and Local Government confirmed the CPO without modification. The statutory Notice of Confirmation was subsequently published in the local press on 20 May 2011 and notice served on parties affected by the Order.

2.2 Members will note that in a separate report it is recommended that a resolution be passed by Cabinet to implement the CPO by way of General Vesting Declaration ("GVD"). The GVD gathers up the properties and a CPO provides powers to use a GVD.

2.3 Compensation as set out in statute is payable pursuant to compulsory purchase. This report considers the payment of Home Loss Payments.

3. CURRENT POSITION

3.1 There remain some 56 or so households resident in the Order Lands. Recent discussion with residents has highlighted the poor condition of some of the properties, a strong desire by residents to be relocated and in some instances landlords' unwillingness to undertake their responsibilities in terms of essential repairs. Meetings with residents are taking place to discuss the issues and in response each tenant on the scheme has been visited where possible and their property

condition inspected. Work will be completed to bring properties to a safe standard as an interim measure until the relocation can begin. The position in respect of tenants re-housing needs has already been established through previous visits and the majority of residents have completed Compass Choice Based Lettings applications where required.

4. HOME LOSS PAYMENTS

4.1 Home Loss Payments are required to be paid under the Land Compensation Act 1973 to a person who is displaced from a dwelling. The purpose of a home loss payment is to provide additional compensation to a person who is displaced from a dwelling. In this instance two tests must be satisfied: displacement must be as a result of the compulsory purchase process; and the resident must either meet the statutory requirements in relation to occupation of the dwelling.

4.2 As regards the first test, in order for a person to be displaced pursuant to compulsory purchase they must not have vacated the premises prior to the date on which the acquiring authority are authorised to acquire them.

4.3 As regards the second test, a person must have been in occupation of a dwelling as his only or main residence by virtue of a freehold, leasehold, statutory tenancy or other specified interest for the period of one year ending with the date of displacement.

4.4 If these conditions are not satisfied on the date of displacement then the Council has discretion to make a payment of an amount not exceeding the amount of which the resident would have been entitled if he had satisfied those conditions throughout the period. The discretion does not extend to the question as to whether or not a person has been displaced from a dwelling in consequence of compulsory acquisition. There are other detailed provisions in the Act in respect of qualifying criteria for Home Loss Payments.

5. RESIDENT RELOCATIONS

5.1 Considering these issues it is therefore proposed to facilitate relocation as soon as practicable and, where entitlement arises, to make Home Loss Payments pursuant to the 1973 Act.

5.2 It is recommended that the Council proceed with the resident relocation process as soon as practicable. It is anticipated that the earliest that this process can commence will be 4th July 2011 following the expiry of the statutory six week challenge period as to the validity of the confirmation of the Order.

5.3 Moreover, it should be noted that the process may require the Council to work with tenants to find appropriate re-housing opportunities and to make Home Loss Payments to these tenants, and potentially before an agreed sale had been achieved with the owner of the property or a general vesting declaration has taken effect. It should also be noted that the resident relocation process may take considerable time due to the number of residents remaining on the site, requiring re housing within social housing stock in Hartlepool.

6. FINANCIAL RISK AND MANAGEMENT CONSIDERATIONS

6.1 Funding for the Council's HMR programme is primarily from external sources. Funding is secured for full scheme acquisition and is not dependent on private sector funding.

6.2 The proposals in respect of resident relocation have a level of risk associated with them which is dependent on the successful implementation of the CPO by means of general vesting declaration. Landlords seeking compensation as a result of the CPO may claim a loss of rental income arising from the relocation of tenants. However the owner/ landlord will have the duty to mitigate losses and the burden of proof will remain their responsibility. In the event that further tenants were to move into properties in the Order land area it is conceivable that in certain circumstances that additional Home Loss Payment rights might accrue if the tests above are satisfied.

7. RECOMMENDATIONS

7.1 Cabinet is recommended to :

i) note the contents of this report ;
ii) endorse and confirm the proposed approach to resident re-housing and payment of Home Loss Payments;
iii) and authorise the Director of Regeneration and Neighbourhoods to make discretionary payments pursuant to the Land Compensation Act 1973.

8. CONTACT OFFICER

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CABINET REPORT

20 June 2011

Report of: Assistant Chief Executive

Subject: BUSINESS TRANSFORMATION PROGRAMME BOARD

SUMMARY

1. PURPOSE OF REPORT

This report provides the opportunity for Cabinet to determine the future of the Business Transformation Board.

2. SUMMARY OF CONTENTS

Cabinet are requested to consider the future of the Business Transformation Board

3. RELEVANCE TO CABINET

The Business Transformation Board was established by Cabinet and any decision on its future is therefore a Cabinet Decision.

4. TYPE OF DECISION

Non key.

5. DECISION MAKING ROUTE

Cabinet 20 June 2011.

6. DECISION(S) REQUIRED

Cabinet are requested to consider the future of the Business Transformation Board

Report of: Assistant Chief Executive

Subject: Business Transformation Programme Board

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1. PURPOSE OF REPORT

This report provides the opportunity for Cabinet to determine the future of the Business Transformation Board.

2. BACKGROUND

2.1 The Business Transformation Programme Board was established to facilitate the management of the Business Transformation (BT) programme over the last two years. It has successfully assisted in this overall management and comprises members of the Executive, Scrutiny, the Trade Unions and Officers and was constituted following a decision by Cabinet.

(i) The Board has participated in the delivery of a programme of savings over the last two years of approximately £5.4m through a period of significant change for the council.

3.0 Matters for consideration

3.1 Recent discussions between the executive and other elected members has raised the question of the ongoing validity of the BT board and it is on this basis that this report has been prepared to enable Cabinet members to consider this, and other meetings and working groups, including the recently established Council Working Group and the role of scrutiny in the ongoing considerations around the budget.

3.2 The BT Board has provided an effective mechanism to manage and consider a plethora of projects and plans developed to address the budget deficit in a managed manner and for elected members and trade unions to be involved in this process.

4. RECOMMENDATIONS

4.1 Cabinet are recommended to:

Consider the future of the Business Transformation Board and provide guidance in respect of the mechanisms to be utilized for the consideration of those projects and activities contributing to addressing the budget deficit

5. BACKGROUND PAPERS

None

6. CONTACT OFFICER

Andrew Atkin
Assistant Chief Executive
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CABINET REPORT

20 June 2011

Report of: Director of Child and Adult Services

Subject: A NEW LEGAL FRAMEWORK FOR SOCIAL CARE - THE LAW COMMISSION REPORTS

SUMMARY

1. PURPOSE OF REPORT

1.1 To inform Cabinet of the recommendations put forward by the Law Commission for reforming adult social care law in England and Wales.

2. SUMMARY OF CONTENTS

2.1 On 11 May 2011 the Law Commission published 'Adult Social Care' which reviews adult social care law in England and Wales and contains recommendations for reform.

2.2 The Law Commission recommends a unified adult social care statute for both England and Wales. The statute would establish that the overarching purpose of adult social care is to promote or contribute to the wellbeing of a person.

2.3 Significant new proposals include:

- Legislation would set out overall principles which should be used to interpret more detailed legislation;
- A national framework for eligibility would 'stipulate basic minimum entitlements to services';
- Local Authorities would have a duty to assess the needs of carers and would have a duty to meet carers' eligible needs;
- People would be able to use direct payments to purchase residential accommodation;
- Local Authorities would be able delegate aspects of the assessment process to other organizations but would retain 'overall control of the process';

- Local Authorities would be required to do more to enable people with care needs to move from one Local Authority to another;
- The role of social services in leading and co-ordinating safeguarding of adults who are at risk of abuse or neglect would be set out in legislation rather than, at present, left to guidance.

2.4 The new legislation would make existing rights and entitlements clearer, the overall structure of the law would be simpler (a scheme comprising three elements; statute, regulations and code of practice) and guidance simplified. These changes to the way the law is set out would promote clarity for both Local Authorities and people who use services and their families.

2.5 The attached portfolio report sets out in more detail the report's proposals, recommendations and the potential implications for Local Authorities.

3. RELEVANCE TO CABINET

The Law Commissions proposals to simplify and modernise the law on adult social care will inform government legislation in 2012 and provide the foundation for the most significant single reform of social care law in sixty years.

4. TYPE OF DECISION

Non-key.

5. DECISION MAKING ROUTE

For information only.

6. DECISION(S) REQUIRED

For information only.

Report of: Director of Child and Adult Services

Subject: A NEW LEGAL FRAMEWORK FOR SOCIAL CARE : THE LAW COMMISSION REPORTS

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1. PURPOSE OF REPORT

1.1 To inform Cabinet of the recommendations put forward by the Law Commission for reforming adult social care law in England and Wales.

2. BACKGROUND

2.1 On 11 May 2011 the Law Commission published 'Adult Social Care' which reviews adult social care law in England and Wales and contains recommendations for reform.

2.2 The report recommendations follow a two year inquiry and are intended to simplify the complex set of rules and regulations governing care homes, day centres, domiciliary care and funding for equipment and house adaptations.

2.3 The government is set to consider the commission's recommendations alongside those of the Dilnot Commission on long-term care funding which will report in July. Legislation will follow this wide review of adult social care in 2012.

2.4 The full report and a summary can be found on the adult social care project pages of the Law Commission's website: www.lawcom.gov.uk.

2.5 The Law Commission report recommends a unified adult social care statute for both England and Wales. This statute would establish that the overarching purpose of adult social care is to promote or contribute to the well-being of the person.

2.6 Under these recommendations over 40 statutes would be repealed or amended. Francis Patterson, QC, the Public Law Commissioner leading the review, said that the report represented "a clearer and more coherent framework for adult social care … our recommendations will protect the strong rights that exist in adult social care law while, at the same time, ensuring that emerging policy objectives, such as personalisation and self-directed support, are recognized fully in statute law".

Paul Burstow, the Care Services Minister has stated that the Law Commission's final report provides "a strong foundation" for the significant reform of adult social care but suggested that the government may not adopt the 76 recommendations in their entirety.

3. PROPOSALS

3.1 The report recommends a three level structure containing new:

- statute / act
- regulations
- code of practice

} The overall 'scheme'

3.2 Assessments

The statute would set out a single clear duty to assess a person which is triggered where it appears to a Local Authority that a person may have needs that could be met by community care services.

The new scheme would not precisely define wellbeing but it would set out a checklist of factors that must be considered before a decision is made in relation to an individual. A decision maker would be required to:

- assume the person is the best judge of their own wellbeing except in cases where there is a lack of capacity to make the relevant decision;
- follow the person's views and wishes wherever practicable and appropriate;
- ensure decisions are based on a person's circumstances and not merely on age or aspects of behaviour which might lead to unjustified assumptions;
- give the person an opportunity to be involved in all aspects of the care pathway;
- achieve a balance with the wellbeing of others;
- safeguard adults from abuse and neglect;
- use the least restrictive solution where it is necessary to interfere with a person's rights and freedom of action.

To help prevent a 'service-led' approach to assessment, the new statute would specify that an assessment must focus on a person's care and support needs and the outcomes they wish to achieve. Teenagers could be assessed as adults from 16 years of age.

Adult Social Care Services would be provided at two levels:

i) Universal services to the wider community to help prevent or delay the need for more targeted interventions, ie, information, advice and assistance to people not eligible for services and self-funders. Local Authorities would also have a responsibility to stimulate the development of sufficient types of services and support in the local market.

ii) Targeted social care services following a community care assessment.

The Secretary of State would be required to make regulations prescribing how an assessment should be carried out.

A Local Authority would be able to authorize others to undertake an assessment on their behalf, subject to the Local Authority retaining overall control of the processes.

3.3 Eligibility

An assessment of need and the application of eligibility criteria would be the sole means by which a person's eligibility for community care services (including residential care) is determined.

The new scheme would require the Secretary of State to make regulations prescribing the eligibility framework for the provision of community care services and the code of practice would specify how Local Authorities should set their eligibility criteria including the needs which, at a minimum, must be met. The scheme would also enable the government to set eligibility criteria at a national level.

The duty to provide residential accommodation under section 21 of the National Assistance Act 1948 would be retained as a 'long-stop legal duty'. This would provide a right to residential accommodation to those who fall below the eligibility threshold but still have a need for care and attention which is not otherwise available to them.

3.4 Carers

There would be a single, standalone duty to undertake a carers' assessment. This new duty would remove the existing requirement for the carer to be providing a 'substantial amount of care on a regular basis'.

A carers' assessment would be required to focus on the carer's ability to provide care and also take into account whether the carer wishes to work or undertake education, training or any leisure activity.

The Secretary of State would be required to prescribe the process for carers' assessment and the eligibility framework for carers' services in regulations. Local authorities would be required to meet the eligible needs of carers.

3.5 The provision of services

Local Authorities must make arrangements for the provision of services where it is concluded that the person has eligible needs. In the scheme the range of provision which could be provided would be defined by reference to a list of general services and outcomes:

- residential accommodation;
- community and home based services;
- advice, social work, counseling and advocacy;
- financial or any other assistance.

The new scheme would set out the following list of outcomes to which the wellbeing principle must be directed:

- health and emotional wellbeing;
- protection from harm;
- education, recreation and training;
- contribution made to society;
- securing rights and entitlements.

The new scheme would place a duty on Local Authorities to ensure the production of a care/support plan. If a person falls below the eligibility threshold then the Local Authority would be required to put the reasons for that decision in writing.

The Secretary of State would be required to prescribe the form and content of plans in regulations:

- plans to be set out in writing and signed on behalf of the Local Authority;
- plans to include a summary of assessed needs, eligible needs and outcomes to be achieved;
- plans to specify the amount of the personal budget and how this has been calculated;
- plans must include a summary of services to be provided, whether a Direct Payment will be provided and any financial contributions;
- plans must be reviewed regularly;
- plans must be made available to the person using services.

3.6 Personal Budgets (PBs)

The statute would provide a legal framework for PBs and enable policy development in this area. The Secretary of State would be given a power to make regulations to require Local Authorities to allocate a PB to people who use services and carers. The regulations must then prescribe who is eligible for a PB and the circumstances in which budgets should not be allocated.

The existing legal provisions regulating direct payments (DPs) would be retained. However, the current restriction on DPs being used to purchase long term residential accommodation would be removed.

Regulation powers would be introduced to enable the Secretary of State to require or authorise Local Authorities to accommodate a person at the place of their choice and to allow for the making of additional payments as well as charging for residential and non-residential services. The existing power which enables services to be provided free of charge would be retained. As a minimum the existing services that must be provided free of charge would be included in regulations.

3.7 Adult Protection

The new scheme would set out the duties and powers of Local Authorities to safeguard adults from abuse and neglect. Local Authorities would have the lead co-ordinating responsibility for safeguarding and have a duty to

investigate adult protection cases or cause an investigation to be made by other agencies, in individual cases.

When the duty to investigate is triggered, the Local Authority could have this duty performed through a 'range of pathways'. However, Local Authorities would still retain a 'monitoring' role when they involve others in an investigation and would have a power to request co-operation and assistance from certain agencies (ie, health, police). The requested body would have give 'due consideration' to the request.

The duty to investigate would apply to an 'adult at risk' which would be defined as:

- The person must appear to have health or social care needs;
- The person must appear to be at risk of 'harm' rather than 'significant harm' set out in existing guidance;
- The person must appear to be unable to safeguard themselves from harm as a direct result of their health or social care needs;
- The Local Authority must be believe it is necessary to make enquiries.

Harm would be defined in the statute as including but not limited to:

- ill treatment (including sexual abuse, exploitation and forms of ill treatment which are not physical);
- impairment of health (physical or mental) or development (physical, intellectual, emotional, social or behavioural;
- self-harm and neglect;
- unlawful conduct which adversely affects property, rights or interests, ie, financial abuse.

The new scheme would give Local Authorities the lead role in establishing and maintaining adult safeguarding boards. The board's functions would be specified as:

- keeping under review the procedures and practices of public bodies which relate to safeguarding adults;
- giving information or advise or making proposals to any public body on the exercise of functions relating to safeguarding adults;
- improving the skills and knowledge of professions who have safeguarding responsibilities;
- producing a report every two years on the exercise of the board's functions.

The Local Authority, NHS and police would each be required to nominate a member of the Board with appropriate knowledge and skills. The Care Quality Commission (CQC) would have a power to nominate a representative. The Safeguarding Board would also be responsible for commissioning serious case reviews.

The new statute would not set out new compulsory and emergency powers of entry or exclusion. The existing power to remove a person from their home to suitable premises under Section 47 of the National Assistance Act 1948 would

be repealed on the basis of it being incompatible with the European Convention on Human Rights.

3.8 Ordinary Residence and Portability

The 'ordinary residence' rules are used to establish which Local Authority is responsible for providing community care services to a person.

Under the new scheme these rules would apply to all community care services and would establish that Local Authorities have a duty to provide services where the person is 'ordinarily resident in their area, subject to the eligibility criteria and a power to provide services for people not ordinarily resident or of no settled residence. In relation to carers, the primary responsibility for providing carers' services would remain with the Local Authority in which the cared-for person resides.

The new scheme would establish three mechanisms to facilitate portability of services by:

- establishing an enhanced duty to co-operate when a person moves to another area;
- establishing that when a person using services moves to another area, or has a clear intention to move, the receiving Local Authority must carry out an assessment;
- introducing a power for the Secretary of State to make regulations requiring that when a person using services moves to another area, the new Local Authority must provide the person with equivalent services or DPs to those provided by the original Local Authority until they undergo an assessment in the new Local Authority's area.

3.9 Other Recommendations

3.9.1 The existing statutory prohibitions on the provision of health care by Local Authorities would be retained and clarified.

3.9.2 The Secretary of State would be given the power to establish in regulations an eligibility framework for the provision of NHS continuing healthcare. This would specify what combination of needs establishes 'primary health needs' and triggers a person being eligible for NHS continuing healthcare which is free at the point of delivery.

3.9.3 The new scheme would establish a duty on each social services authority to make arrangements to promote co-operation with specified bodies including other Local Authorities, the NHS and Police. It would also introduce an enhanced duty to co-operate in particular circumstances, such as when a community care or carers' assessment is taking place, when services are being provided or during adult protection investigations. The duty would also require the social services authority to give consideration to requests to co-operate and give written reasons if it decides not to co-operate.

3.9.4 There is an existing right to advocacy in adult social care legislation which has never been implemented. This would be retained in the new statute with a power for the Secretary of State to implement the right and modify it to bring it into line with modern understandings.

3.9.5 The new scheme would replace the duty on Local Authorities to maintain a register of people with disabilities with a more discrete requirement to establish a register of people with impaired vision.

3.9.6 The new scheme would set out clearly whether prisoners should or should not be excluded from adult social care.

4. POTENTIAL IMPLICATIONS FOR LOCAL AUTHORITIES

4.1 Many of the principles that would be laid out in the new statute already underpin social work practice. However, statutory principles provide a firmer framework for initiating a judicial review case. This could potentially see a rise in cases with associated costs to Local Authorities. On the other hand, having a shorter and leaner list of principles may facilitate settling complaints before they go to court.

4.2 Local Authorities would have greater ability to delegate community care assessments to allied professions or bodies and teenagers could be assessed as adults from the age of 16 years. The ability to contract-out assessments may endanger the role of the Local Authority Social Worker. Independent social work practices could charge Local Authorities for carrying out assessments. Delivering assessments to younger adults could initially increase workloads but it should also make transitional arrangements less stressful for teenagers, families / carers and social workers.

4.3 The duty to provide a written care plan could provide stronger grounds for an appeal which could inflate costs for Local Authorities. However, this should also be seen as good practice being enshrined in statute.

4.4 Carers would no longer have to provide 'substantial' levels of care before being eligible for an assessment. Social workers could, therefore, have to carry out a greater number of assessments but, on the other hand, would no longer have to make a subjective judgement about whether a carer is providing 'substantial and regular care'. This change could potentially have implications for staff time and resources.

4.5 Currently adult safeguarding procedures have no statutory basis but are only laid down in regulation. The new statute would place a legal duty on Local Authorities to investigate suspected instances of adult abuse. NHS trusts and police will be required to appoint representatives to the required adult safeguarding boards. This would result in Local Authorities having greater impetus to investigate but without any additional powers to do so. The duty on other organisations to appoint representatives to Safeguarding boards together with the general duty to co-operate should engender a greater level of co-operation between agencies.

4.6 Currently DPs cannot be used to pay for residential accommodation whereas the new scheme could enable DPs to be used for this purpose. This could potentially place a greater pressure on council budgets if DPs are used to pay for residential care. Concern has also been expressed by industry experts that DPs may not be big enough to pay for residential care, leaving people with unmet needs. This proposal is likely to have cost implications. Unless Local Authorities are able to continue to demand the lowest price for residential care, the cost to them from those using DPs for residential care would increase budget pressures (self-funders routinely pay more than people funded by Local Authorities).

4.7 The new scheme could lead to the Secretary of State defining what constitutes continuing health care (CHC) whereas this is currently interpreted locally. A clear definition of who is eligible for CHC funding would make it easier for social workers to direct people to the correct part of the system. It also has the potential to reduce costs as current processes are labour intensive and time consuming.

5. CONSULTATION

5.1 The new legislation would include measures to make existing rights and entitlements clearer. The overall structure of the law would be simpler with different roles allocated to legislation, regulations and guidance. Guidance in particular, would be simplified. There is currently considerable confusion about the status of guidance and of policy documents such as 'Putting People First'. The Law Commission notes that the purpose of guidance should be to "guide social services authorities on the exercise of their functions under the statute and should not extend to policy exhortations or vague statements about 'the direction of travel' or social services' function".

5.2 These changes to the way the law is set out would help people who use services and their families to make use of the law, greater clarity would make it easier to settle disputes at an early stage and Local Authorities would be facilitated to comply with legislation.

5.4 The Law Commission's proposals to simplify and modernize the law on adult care will inform government legislation in 2012 and provide the foundation for the most significant single reform of social care law in sixty years.

6. CONTACT OFFICER

Geraldine Martin
Head of Adult Social Care Services

CABINET

20 June 2011

Report of: Health Scrutiny Forum

Subject: Regional Review of the Health of the Ex-Service Community – Final Report

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1. PURPOSE OF THE REPORT

1.1 To present to Members the Final Report agreed by the North East Regional Joint Health Overview and Scrutiny Committee after their recent scrutiny investigation entitled 'Regional Review of the Health Needs of the Ex-Service Community'.

2. BACKGROUND INFORMATION

2.1 At the Health Scrutiny Forum meeting of 2 February 2010 the Chair of the Health Scrutiny Forum confirmed that the 12 North East Local Authorities had been successful in a bid for funding from the Centre for Public Scrutiny (CfPS); through their Health Inequalities initiative; to carry out an investigation into the Health of the ex-Service Community.

2.2 Attached as **Appendix A** to this report is the Final Report entitled 'Regional Review of the Health Needs of the Ex-Service Community' which was agreed by the North East Regional Joint Health Overview and Scrutiny Committee at their meeting of 14 January 2011.

2.3 Members of Hartlepool's Health Scrutiny Forum have been actively involved in the scrutiny investigation into the 'Regional Review of the Health Needs of the Ex-Service Community' and the CfPS recognised the North East Regional Joint Health Overview and Scrutiny Committee's investigation at their recent 'Good Scrutiny Awards 2011', where the Committee were presented with the 'Joint Working' and 'Overall Impact' Awards.

2.4 Members will note that pages 21-32 of the report (attached as **Appendix A**) details all of the recommendations identified during the investigation. However, **Appendix B** details those recommendations which are directly relevant for the Local Authority.

2.5 Members will also note that suggestions have been made next to the recommendations in **Appendix B** to detail where a local or regional approach from the Local Authority maybe necessary to action each recommendation.

3. RECOMMENDATION

3.1 That Members note the content of the report and determine a response to the North East Regional Joint Health Overview and Scrutiny Committee in relation to the recommendations identified in **Appendix B**.

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BACKGROUND PAPERS

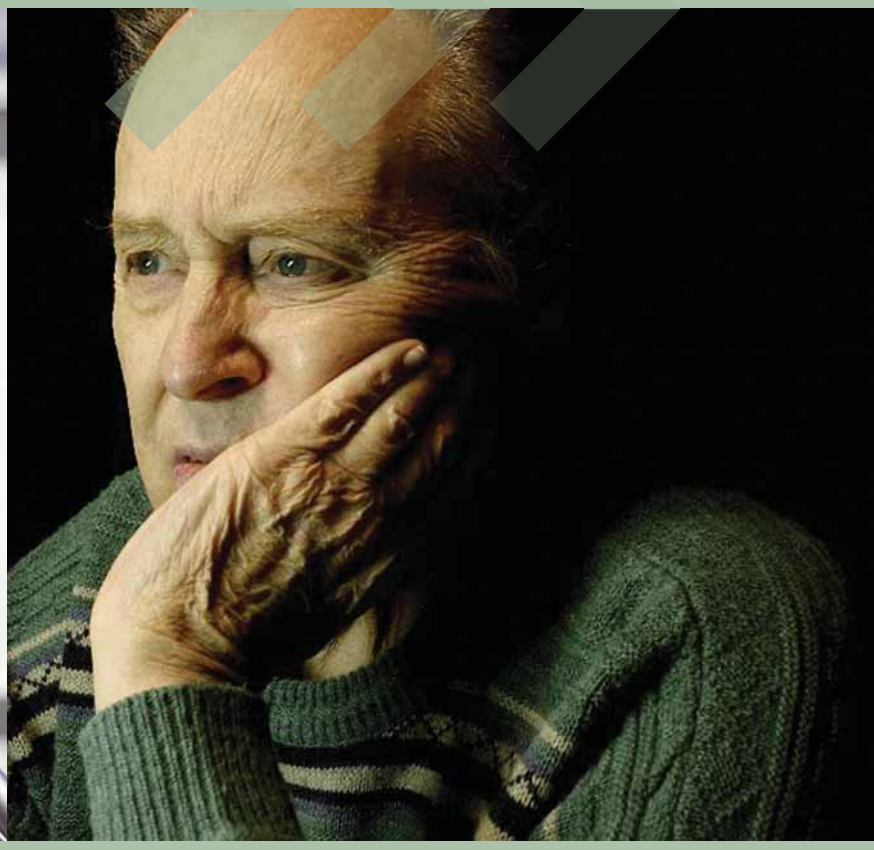
The following background papers were used in the preparation of this report

(a) Minutes of the Health Scrutiny Forum held on 2 February 2010.

Joint Health Overview and Scrutiny Committee of North East Local Authorities

Regional Review of the Health Needs of the Ex-Service Community

Final Report
January 2011



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DARLINGTON BOROUGH COUNCIL

Durham County Council

Gateshead Council

HARTLEPOOL BOROUGH COUNCIL

Middlesbrough moving forward

Newcastle City Council

North Tyneside Council

NORTHUMBERLAND COUNTY COUNCIL

REDCAR & CLEVELAND BOROUGH COUNCIL

South Tyneside Council

Stockton-on-Tees BOROUGH COUNCIL

Sunderland City Council

Contents

This report summarises the conclusions of three workstreams that considered the following issues in more detail: Physical Health, Social and Economic Wellbeing and Mental Health.

The final reports of the workstreams can be found at:
www.stockton.gov.uk/yourcouncil/scrutinfo/selectcomm/health/

Foreword

This scrutiny review, which examines the health needs of the ex-service community and their families, represents the culmination of a year of intensive work by the members and officers of the North East Joint Health Overview and Scrutiny Committee working in close partnership with a wide range of individuals and agencies.

In recent years, people have begun to talk about a "military covenant", but the idea is much older: the members of our armed services put their lives on the line for us, and put special demands on their families and dependents. We must not let them down.

Making sure that the ex-service community does not suffer disadvantage because of the particular experiences of its members requires a lot of detailed thought to support that simple idea. This report represents an attempt by local Councillors across the North East region to supply some of that thought.

This is the first time that Councillors from all the local authorities in the North East have come together in this way, and I would like to thank all my colleagues who have worked so smoothly together in the common interests of our residents. I would also like to thank the huge range of individuals and organisations, military and civil, public and voluntary, who have so thoughtfully and enthusiastically helped us with evidence, ideas and support.

Sometimes scrutiny work raises confusion, even hostility from those who think they might appear badly under the spotlight. But I don't believe that I have ever seen such a universally positive and enthusiastic response to a review as to this one.

This report is a collaborative effort, and collaborative effort is what is most needed to make the changes which will support our soldiers, sailors, airmen and their families both now and in the future.

We do not intend to let this report sit on the shelf, but will be working actively with all our partners to ensure that real good comes of the recommendations they have helped us to make.

Although our task initially looked very daunting, the importance of the subject, and the quality of the advice and support we received, has resulted we hope in proposals that can make a genuine difference. It is with great pleasure that I commend this report to you.

Councillor Ann Cains

Chair, North East Regional Joint Health Overview and Scrutiny Committee

Summary

The importance of the wellbeing and health of the ex-service community

1 Roughly one person in twelve in the UK is a member of the ex-service community: either a veteran of the armed forces or a carer, dependant or close family member of a veteran. A systematic attempt to understand the effects on the health and wellbeing of the ex-service community of their common life experiences is a necessary step towards ensuring that no-one suffers disadvantage as a result of their service. But in the past, this has not happened.

2 This is changing. This scrutiny review was prompted in part by the publication of the command paper The Nation's Commitment in 2008. While the review was being undertaken, an increased commitment to understanding and adapting to ex-service needs has been demonstrated by the creation of Armed Forces Health Forums in every NHS region, by the government's acceptance of the Murrison report on armed forces mental health, and by the publication of the report by the Task Force on the Military Covenant, among many other developments. We hope that our report will make a further substantial contribution.

North East England health overview and scrutiny

3 All twelve local authorities in the North of England have Health Overview and Scrutiny Committees, made up of Councillors who are not part of the decision-making structures of their Councils, to provide an independent view of the health and wellbeing needs of their residents and of the services provided for them.

4 The twelve committees have a long history of close co-operation across local authorities and in sub-regional groups. They have now formed a single regional Joint Health Overview and Scrutiny Committee, in recognition of the common interests of citizens across the North East. This is the first published report of that Joint Committee.

The Centre for Public Scrutiny Health Inequalities Programme

5 The review has been supported by the Centre for Public Scrutiny, which has provided support, advice and funding through its Health Inequalities programme, having nominated the North East as a Scrutiny Development Area in January 2010. The Centre will help to make sure that what we have learned from this review is spread across England and Wales.

Aims and purpose of the review

6 The review set out to establish the extent of the available local and regional information about:

- the health needs and access to services of the ex-service communities compared with civilians of similar socio-economic backgrounds;

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- the different needs of the ex-service communities, including, for example, looking at older and younger veterans, veterans of different conflicts; veterans of different Services and the families of those groups, specifically addressing socio-economic wellbeing as well as physical and mental health;
- the extent to which ex-service communities are able to access services and support (including psycho-social support), access to employment and training, drug and alcohol misuse, family breakdown, housing difficulties and involvement with the criminal justice system;
- good and bad practice across the region, including specific issues such as priority access to NHS treatment for veterans, but also more generally in terms of the quality of communications between agencies and partnership working and the resulting support for ex-service communities;
- what awareness veterans and their families have about the services that are available to them.

Organisation of the review

7 The review was responsible to a project board, which was also the standing Joint Health Overview and Scrutiny Committee, made up of the chairs of the committees in each of the twelve local authorities, or their deputies.

8 The review was formally launched with an overview day on 28 June 2010, in which all participating Councillors were able to hear from, and talk to, key stakeholders including the co-Chair of the joint Ministry of Defence/Department of Health Partnership Board and the Surgeon-General's Cross-Government Health Lead, as well as representatives of the armed forces, the Royal British Legion, the regional Strategic Health Authority, one of the Directors of Adult Services in the North East, and the Career Transition Partnership. Councillors then split into three "workstreams", one each dealing with the physical health of the ex-service community, with mental health, and with social and economic wellbeing. Separate reports are being published by each workstream. This report draws together common conclusions.

9 Each workstream was supported by scrutiny officers from four local authorities. The lead officers from each workstream formed a Project Support Group, together with officers from the lead local authority for the review as a whole, which helped to co-ordinate activity.

10 Methods used included presentations, round table discussions, face-to-face interviews, focus groups, questionnaires, reviews of the literature and site visits.

Summary

Key participants

11 This review would have been impossible without the enthusiastic co-operation of a wide range of witnesses and contributors from the armed forces, NHS, local government, central government and the community and voluntary sector, as well as ex-service personnel themselves. A full list of those who took part can be found in the acknowledgements at Appendix 1.

Main conclusions

12 The review reached a number of general conclusions, which form the basis of 47 separate recommendations. These include:

- improved ways of identifying the ex-service community (see recommendations 1-4);
- proposals for better communication and sharing of information and more joined up work (see recommendations 5, 21-22, 24-26, 27-29, 37 and 39);
- suggestions for further qualitative research into the needs of the ex-service community (see recommendations 6 and 7);
- approaches to improving health and wellbeing which address wider determinants than the commissioning of health and social care services (see recommendations 8-13, 32 and 36), including improving the take-up of low-cost housing products by the ex-service community (recommendation 33);
- ways to address the need to raise awareness amongst local authorities and other partner organisations, employers and service providers of the very specific needs of the ex-service community (recommendations 17-19, 38 and 40);
- and also ways to address the need to raise the level of awareness within the ex-service community about the wide range of support currently available (recommendations 14-16 and 20);
- on the evidence we have examined, we believe that there is a need for the establishment of a formal network, connecting the voluntary sector, local authorities, the NHS, the Armed Forces and others (recommendations 23 and 42);
- strengthening support for personnel leaving the services, by going beyond signposting for more vulnerable service leavers (recommendations 30, 31 and 49);
- implementing the recommendations of the Murrison report on mental health should be complemented by other steps being taken within the region (recommendations 44-48).

Recommendations

13 We make a number of detailed recommendations below. The Joint Health Overview and Scrutiny Committee will examine at regular intervals how far these recommendations have been taken forward and what effect they are having.

Summary

Promoting effective communication and co-ordination across agencies, providers and the third sector

Information

Recommendation 1: that local authorities across the region consider what might be the costs, benefits and best methods of collecting in future information about members of the Armed Forces 'soon to leave', their likely destination and the demands that will place on localities.

Recommendation 2: that local authority services should actively ask the question of those they provide services for: 'have you served in the UK Armed Forces?

Recommendation 3: that all organisations providing (or potentially providing) services for ex-service community should encourage veterans to voluntarily identify themselves by asking 'have you served in the UK Armed forces?'

Recommendation 4: that HM Government should consider the potential for an individual's NHS or National Insurance number to be used to identify their veteran status to improve identification of needs and services that may be available. This might be considered alongside the proposal by the Task Force on the Military Covenant for the creation of Veterans' Cards.

Recommendation 5: that formal information sharing protocols and arrangements are established between the armed forces and local authorities across the NE region. This will enable local authorities to properly assess and plan to meet the needs of the ex-service community as a specific group.

Recommendation 6: local authorities in the North East should consider dedicating a chapter in their Joint Strategic Needs Assessments to vulnerable service leavers and their needs and identifying as a target population the ex service community within their strategic planning processes in relation to social exclusion, anti-poverty, homelessness and offending.

Recommendation 7: that local authorities across the region take research forward as part of the development of Joint Strategic Needs Assessments across the region, and that the North East Public Health Observatory should also consider what data and research support it can provide.

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Recommendation 8: that local authorities across the North East request the NE National Housing Federation to carry out a mapping exercise to quantify current provision of ex-service community housing provided by their members and analyse best practice both nationally and within the North East.

Recommendation 9: that the North East Housing Federation works closely with NE local authorities to help plan future provision.

Recommendation 10: that the armed forces and the Career Transition Partnership work more closely with local authorities across the region and provide them with an assessment of the likely level of demand and need for employment and skills related services in order to inform future economic and financial inclusion strategies and future provision.

Recommendation 11: that prison and probation services be encouraged undertake more detailed work on the needs and nature of offending veterans.

Recommendation 12: that prison and probation services should consider how to make available more 'signposting' to veteran's charities of offenders subject to short sentences.

Recommendation 13: that prisons, probation trusts and other partners in the statutory and voluntary sectors promote the sharing of best practice and information (data and needs analysis).

Awareness

Recommendation 14: as some sections of the ex-service community are vulnerable and hard to reach it is recommended that local authorities work with third sector bodies which provide an outreach service (such as ex-service charities and Norcare) to raise awareness and improve access to available support mechanisms.

Recommendation 15: that all agencies should make use of and promote local directories of services provided by the voluntary and community sector and statutory provision for those seeking help and for those making referrals, such as the web-based directory provided by Veterans North-East and Finchale College Durham.

Recommendation 16: that North East local authorities examine opportunities for using digital media to improve communication with the ex-service community and raise awareness of available support mechanisms.

Recommendation 17: that the North East National Housing Federation is requested on behalf of local authorities across the region to carry out work with Registered Social Landlords to raise awareness of the housing needs of the ex-service community.

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Recommendation 18: that an awareness raising campaign is carried out amongst staff throughout the Tyne and Wear and Tees Valley Unlimited City Regions regarding the importance of asking whether individuals are ex-service to ensure that they can be appropriately referred on to Job Centre Plus and receive their entitlement to early access to New Deal Programmes.

Recommendation 19: PCTs should begin conversations now with the embryonic GP Commissioning Consortia regarding the merits of commissioning for ex-service community. PCTs and Consortia should report back to Members how the needs of the ex-service community are going to influence commissioning strategy during the transitional period and when Consortia have formally taken control of Commissioning budgets.

Improving responsiveness within organisations

Recommendation 20: that local authorities and other key partner organisations across the region should consider identifying a senior figure who can act as a champion for the ex-service community and establishing a central point of contact in each local authority area or sub - region to assist when members of the community experience difficulties. Examples of possible approaches include:

a. within local authorities, a Member Armed Forces Champion to drive improvements in services for service veterans.

b. within local authorities, a named senior officer to assist the ex-service community and act as a facilitator and conduit in dealings with Councils and beyond.

c. within Primary Care Trusts, named senior staff to act as Case officers/co-ordinators in PCTs to act on behalf of the ex-service community whilst assistance is required, and to consider how best to pass these responsibilities forward to GP consortia and local Health and Wellbeing Boards.

Improving co-ordination across organisations

Recommendation 21: that the Association of North East Councils should be asked to explore with the NHS, the armed forces and other partners across the region how stronger networking within and between existing groups may be taken forward. This should include consideration of joined-up planning and performance monitoring.

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Recommendation 22: that local authorities should consider how to bring together voluntary organisations large and small with a specific interest in the welfare of the ex-service community, in the light of the Government's response to the Task Force on the Military Covenant.

Recommendation 23: we strongly recommend that local authorities across the region should explore options for establishing and publicising a central point of contact telephone number - to increase the chances of people getting the help they need and to provide a consistent standard of contact across the region. Ex-service charities, Citizens Advice Bureau operating in the region, the Career Transition Partnership and Job Centre Plus have all indicated that this would be likely to prove beneficial. The model adopted by Hampshire County Council, in which telephone enquiries from the ex-service community are channeled to a specific staff member, is particularly worth consideration.

Recommendation 24: that the Homes and Communities Agency is requested on behalf of local authorities across the region to consider how it may broker assistance and ensure better co-ordination of work across the region to ensure that services are being directed at the right people, including the ex-service community, and how it might assist with sharing examples of best practice as part of its enabling role and within the local investment planning process undertaken with local authorities.

Recommendation 25: that the positive work being taken forward by Job Centre Plus in the Tees Valley is shared with Armed Forces Champions across the rest of the region with a view to ensuring a consistent approach in supporting the training and employment needs of the ex-service community.

Recommendation 26: local authorities within the North East should consider the developing a regional veterans charter to establish uniform good practice across the region, possibly through existing regional structures such as the Association of North East Councils (ANEC).

The transition of Armed Forces personnel to civilian services following discharge

Recommendation 27: that the Career Transition partnership continues to work with local authorities and Primary Care Trusts (and successor bodies as PCTs are abolished) to ensure that the Transition Protocol is understood and that specific individuals are mandated appropriately to take on these roles.

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Recommendation 28: that local NHS organisations work with military colleagues to ensure that people leaving the services are registered with GPs and dentists before formal discharge, so they have a 'foot in both camps' towards the end of their active service. This would ensure a smoother transition to civilian health services.

Recommendation 29: that the armed forces and the Career Transition Partnership work more closely with local authorities and third sector organisations such as ex service charities, Norcare and Mental Health North East with a view to developing a formal process for referring vulnerable service leavers into specific services.

Recommendation 30: that action is taken, by the Armed Forces, on discharge to ensure that Early Service Leavers are provided with effective advice and 'signposting' in relation to the mental health issues they may experience on discharge from service.

Recommendation 31: the effectiveness of improvements to the armed forces resettlement provision for early service leavers should be kept under review by the armed forces to ensure there is effective identification of potential vulnerability issues.

Recommendation 32: local authorities should encourage Strategic Housing Authorities and registered social landlords, where possible, to adopt allocation policies which recognise the needs of the ex-service community.

Ensuring equality of access for Armed Forces Families

Recommendation 33: that the Homes and Communities Agency is requested to examine on behalf of local authorities across the region identifying take-up of low-cost housing products by the ex-service community and whether providers are assisting the ex-service community as well as other parts of the community.

Recommendation 34: that the Homes and Communities Agency is requested to examine opportunities for the ex-service community within any revised funding arrangements as an outcome of the comprehensive spending review.

Recommendation 35: that local authorities across the region examine the scope to provide housing related support for ex-service tenants once a property has been identified.

Summary

Veterans' mental health services

Recommendation 36: that the new Health and Wellbeing Boards prioritise veterans' mental health issues, taking a lead in ensuring that on day 1 of discharge into civilian life that services are in place to meet the needs of the ex-service community in relation to both NHS and social care provision.

Recommendation 37: that:

a. appropriate training is provided and required by commissioners of NHS services;

b. guidance should also be developed specifically for primary care providers and GPs to:

i) explain the priority healthcare entitlement;

ii) encourage them to identify ex-servicemen and women (for example, by asking patients to indicate that they have served in the UK Armed Forces);

iii) explain how they can adapt their systems to accommodate priority treatment for ex-service community; and

iv) how to accept referrals from ex-service charities, including the Royal British Legion and Combat Stress, but also smaller local organisations who are providing for some of the most marginalised/excluded ex-service personnel.

Recommendation 38: Joint Strategic Needs Assessments should specifically identify the mental health needs of the ex-service community including families and dependants.

Recommendation 39: NHS commissioners must ensure that GP consortia arrangements prioritise the needs of the ex-service community.

Recommendation 40: local authorities and GP Consortia should be actively engaged in joint planning and commissioning of services with the NHS.

Recommendation 41: local authorities should be actively engaged in the NHS Armed Forces Network and consider how they can take on a leadership role in relation to veterans mental health issues – perhaps linked to the formation of the new Health and Wellbeing Boards.

Recommendation 42: consideration should be given by central government to the need for some form of accreditation to be available to ex-service charities (particularly the newly emerging charities). How this might best be taken forward should be considered in the light of the Government's response to the Task Force on the Military Covenant. Local authorities should consider drawing up approved lists of service providers.

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Recommendation 43: that voluntary organisations and the NHS promote self-referral routes for ex-service personnel in a wide range of different ways that will help maximise their opportunity to access services.

Recommendation 44: that primary care and acute trusts should take steps to improve awareness of veterans' mental health issues among health workers generally, including appropriate training and supervision.

Recommendation 45: the Tees, Esk and Wear Valleys NHS Foundation Trust and the Department of Health should share widely the learning from the evaluation of the Community Veteran Mental Health Pilot, and particularly with commissioners, providers and the North East Mental Health Development Unit. Learning from the pilot must help to shape future statutory of provision and the linkages with, and support for, the voluntary sector in the context of the Increasing Access to Psychological Therapies programme.

Recommendation 46: Trusts should provide better basic information to veterans with clear diagnoses of Post Traumatic Stress Disorder about their condition.

Recommendation 47: prison health services need to identify veterans and evaluate needs with a particular focus on mental health and PTSD.

Next steps

14 This is a large body of recommendations, addressed to a wide range of organisations. We have emphasised the need for co-operation and co-ordination among the many groups with which the ex-service community comes into contact. In keeping with that spirit, we will invite all those to whom we have addressed recommendations to come together to a single event to discuss how to move forward. We are currently planning to hold this event in March 2011.

15 Thereafter, we will meet to examine progress after six months and after one year. We ask that the organisations involve help us with those assessments.

16 The review group appreciates that further developments in support for the ex-service community must take place within the overall resource constraints set by the emergency Budget and Comprehensive Spending Review 2010, which affect not only local authorities, the NHS, the armed forces and other public sector bodies, but also community and voluntary groups. However, we believe that any of our recommendations can be taken forward for little or no cost, or will generate savings through improved efficiency.

The Health of the Ex-Service Community

17 People who have served in the armed forces, together with their relatives, dependents and carers, make up a large group of the population whose wellbeing and health needs, and relationship with services, have been affected by a significant common experience.

18 Most people leave the armed services healthy, and make a successful transition to civilian life. Their wellbeing and health needs are often best addressed on an individual basis. But evidence suggests that there are distinct patterns which affect ex-service personnel and their dependents (collectively called here "the ex-service community") which make it worthwhile to understand too their needs as a group.

> "We need to improve our information about how veterans' health needs differ from those of the population generally. Most healthcare professionals do not have direct knowledge of the Armed Forces and may not be sensitive to their particular needs. We will look at whether more needs to be done to assess the healthcare needs of veterans. We will raise awareness among healthcare professionals about the needs of veterans so that these needs are met."
> ("The Nation's Commitment", Government Command paper, July 2008, Cm 7424)

The national picture

19 There are very few hard facts available. Because the ex-service community has rarely been approached as a group until recently, the state of knowledge about their numbers, location, identity and needs is patchy. A number of our recommendations are therefore about improving the information available to service providers and others. But a very general picture can be drawn.

20 The Royal British Legion's Welfare Needs Research Programme reported in 2006 that:

- The ex-service community in the UK was made up of about 10.5 million people, of whom just under half were veterans themselves. This number was expected to fall to around 8.5 million by 2020.
- The average age of the ex-service community was 63 years, compared with 47 years for the adult population. The number of people in the community aged over 85 was expected to triple over the period to 2020, with a small increase in the number of 16-24 year olds, and a fall in the numbers of those in-between.
- Over half (52%) of the ex-service community report having a long-term illness or disability, compared with 35% in the general population.
- In the 16-44 age group:
  - the number of mental health disorders among members of the ex-service community was three times that of the UK population of the same age;
  - there was a higher prevalence of musculo-skeletal complaints.

- In the 45-64 age group:
  - members of the ex-service community were more prone to cardio-vascular or respiratory conditions than their peers;
  - both men and women who are economically inactive reported significantly higher levels of ill-health in the ex-service community than in the general population.
- But members of the ex-service community aged 65-75 report less ill health than their peers in the general population, while those aged over 75 reported similar health to everyone else of that age.

21 The Ministry of Defence and the NHS have a partnership board for working on issues surrounding the health and well-being of the armed forces community – that is, including currently serving service personnel and their families, as well as veterans. In 2009, the Board commissioned the Centre for Military Health Research at King's College London to review recent and upcoming research publications. The King's Centre found that:

- Among the 3.8 million ex-service personnel in England, overall health was broadly comparable to the general population.
- But there were common mental health diagnoses of alcohol problems, depression and anxiety disorders. In particular, those who leave the services early and young were up to three times more likely to commit suicide than the general population.

22 These factors were identified by King's as increasing the risk of alcohol misuse and/or mental health problems:

- being young;
- being male;
- being in the Army, rather than another branch of service;
- holding a lower rank;
- experiencing childhood adversity;
- being exposed to combat;
- a deployment length over the "Harmony Guidelines" (in the case of the Army, roughly 12 months front-line service over a 3-year period);
- being a Reserve
- having a mental health problem while in Service
- Being an early service leaver.

23 Post-traumatic stress disorder makes up only a minority of cases of mental health disorders. An earlier study by King's found that "personnel who were deployed for 13 months or more in the past three years were more likely to fulfill the criteria for post-traumatic stress disorder". But this effect was substantially less marked than in similar studies of US personnel.

24 DASA (Defence Analytical Services and Advice), a part of the Ministry of Defence, maintains statistics on war disability pensions and the Armed Forces and Reserve Forces Compensation Scheme (AFCS) which replaced war pensions in 2005. These show that:

- 145,525 War Disablement Pensioners and 29,645 War Widows were receiving pensions at 30 September 2010.
- 225 veterans and 390 surviving dependents were receiving Guaranteed Income Payments under the AFCS.
- 8,645 lump sum payments had been made under the AFCS between 1 November 2005 and 30 September 2010.
- The most common injuries resulting in lump sum payments (mostly made to personnel still in the Services) were:
  - musculo-skeletal disorders (41.3%)
  - fractures and dislocations (29.7%)
  - injury, wounds and scarring (13.5%)

  But "injury, wounds and scarring" was the most common reason for the highest payments, accounting for 39.2% of this category.

North East England

25 The picture in any particular part of the country is harder to establish. The Ministry of Defence does not keep central records of where service personnel are recruited, where they go on leaving the services, or where they move to subsequently. Some may be members of veterans' organisations, but not all. The Department of Health has issued new guidance about identifying veterans on medical records, but this remains optional – patients may prefer not to be identified this way. In addition, the definition of "North East England" used by the armed forces includes areas of Yorkshire and Humberside not included in the definitions used by the Department of Health and the Office of National Statistics. The findings in this section of the report are therefore tentative.

26 The Royal British Legion survey of 2006 found that ex-service personnel were spread roughly evenly around the country, implying an ex-service community in North East England of around 500,000.

27 But estimates of recruitment into the armed forces suggest that around 10% come from North East England, while 10-15% of war pension recipients live here. By comparison, the North East only contains 4% of the general population of the UK. This would seem to imply an ex-service community of 1 million or more.

28 A possible explanation of this discrepancy is that the largest age group among the ex-service community is made up of those who served under conscription, in World War 2 and in subsequent National Service. Conscripts came roughly evenly from around the country. The subsequent professional armed forces seem to have recruited disproportionately from the North East of England.

29 According to figures from the Directorate of Resettlement, in the last two years 5,620 service leavers indicated a preference to settle in the North East area (covering Humber to the Borders). These comprised 3,700 Army, 1,100 RAF, and 820 Navy.

30 There are approximately 1,500 early service leavers each year from 15 Brigade at Catterick and 40% of these are from the North of England, the majority young, single men who have been part of the infantry. These are over and above the 5,620 service leavers. The garrison at Catterick covers the geographical area Hull to Berwick to Carlisle and is the largest training garrison in Europe, with 40,000 regulars, reserves, cadets and dependents. As will be discussed below, early service leavers, with less than 4 years service, may face particular difficulties returning to civilian life.

Commitments to support the wellbeing and health needs of the ex-service community

> "Only on the basis of absolute confidence in the justice and morality of the cause can British soldiers be expected to give their lives for others. This unlimited liability on the part of the individual in turn demands collective responsibility of the nation for the welfare of all servicemen and women, serving and retired, and their dependants." ("Soldiers: The Military Covenant", Ministry of Defence, 2000, quoted in "Honour the Covenant", Royal British Legion Policy Briefing, September 2007)

31 Members of the ex-service community draw upon the same services and resources as the rest of the population to support their wellbeing and health: the voluntary sector, the National Health Service, local authority social services, housing associations, schools, Job Centre Plus, and so on.

32 There are also a number of groups working specifically with service leavers, ex-service personnel and the broader ex-service community. These include the Career Transition Partnership, which provides a range of support for service personnel moving into civilian life, the Service Personnel and Veterans Agency, and a number of community and voluntary organisations, large and small, that specialise in this field, including the Royal British Legion, the Soldiers, Sailors, Airmen and Families Association (SSAFA), Forces for Good, Combat Stress, Military Mental Health, Resettlement Armed Forces Training (RAFT) and others.

33 In 2008, the then Government published a review of cross-government support to the armed forces, their families and veterans, called "The Nation's Commitment". The report set the "essential starting point" was the principle of "No disadvantage".

"The essential starting point is that those who serve must not be disadvantaged by what they do – and this will sometimes call for degrees of special treatment."

34 The Nation's Commitment set out, as "enduring principles", that service personnel and their families should have:

- as much lifestyle choice as any other citizen;
- continuity of public services;
- proper return for sacrifice;
- [recognition that] the Armed Forces' constituency matters.

35 The command paper contained a wide range of specific commitments. It also provided a framework for future development. The Ministry of Defence/NHS Partnership Board, after consulting with stakeholders, proposed the following key themes for 2010:

- Promoting effective communication and coordination across agencies, providers and the third sector.

- The transition of Armed Forces personnel to NHS care following medical discharge
- Ensuring equality of access for Armed Forces families
- Veterans' mental health services

These priorities form the structure of the recommendations in this report.

36 The Coalition Government formed in May 2010 issued a new version of the NHS Operating Framework which made these commitments relating to the ex-service community:

- There is a guarantee that all those seriously injured will receive an early and comprehensive assessment of their long term needs before they leave the Armed Forces;
- There should be high quality care for life for those with continuing healthcare needs based on a regular review of their needs overseen by an NHS case manager;
- There is grant funding with Combat Stress (that they are matching) to work directly with mental health trusts to ensure that the services they provide are accessible to and appropriate for military veterans;
- There will be closer NHS links with a full range of third sector partners and charities with extensive experience of working with veterans, to share advice, knowledge and best practice to improve services for veterans;
- There is an entitlement for all veterans who have lost a limb whilst serving in the Armed Forces to receive, where clinically appropriate, the same standard of prosthetic limb from the NHS that they received or would receive today from Defence Medical Services as a result of major technological advances.
- Responsible Directors are to be identified within each Strategic Health Authority, together with Primary Care Trust champions, will be identified to ensure the needs of the armed forces, their families and Veterans are fully reflected in local plans and service provision; and
- There should be improved transfer of medical records to the NHS on retirement from the armed forces, including greater GP awareness of veteran status of new patients to ensure veterans receive their entitlement to priority treatment for any injuries or illness attributable to their time serving in the Armed Forces.

37 The Government has also accepted the findings of a report by Andrew Murrison MD MP, "Fighting Fit: A mental health plan for servicemen and veterans", whose principal recommendations were:

- Incorporation of a structured mental health systems enquiry into existing medical examinations performed whilst serving.
- An uplift in the number of mental health professionals conducting veterans outreach work from Mental Health Trusts in partnership with a leading mental health charity.

- A Veterans Information Service (VIS) to be deployed 12 months after a person leaves the Armed Forces.
- Trial of an online early intervention service for serving personnel and veterans.

38 In December 2010, the Government published the report of a Task Force on the Military Covenant, chaired by Professor Hew Strachan. The Government is considering the Task Force's recommendations, but has already accepted the proposal that there should be Community Covenants across the country, supported by local authorities. We hope that the recommendation we make here can help add substance to the framework of such covenants.

Conclusions and recommendations

General considerations

39 The review was conducted largely in three workstreams, addressing respectively social and economic wellbeing, mental health and physical health. Full separate reports have been published detailing the findings of each workstream.

40 For the purpose of this report, we have consolidated findings and recommendations into four categories, in line with priorities identified by stakeholders in "The Nation's Commitment":

1. Promoting effective communication and coordination across agencies, providers and the third sector.
2. The transition of Armed Forces personnel to NHS care following medical discharge (which has been expanded here to include discharge generally)
3. Ensuring equality of access for Armed Forces families
4. Veterans' mental health services

41 Many of these recommendations need to be seen in the light of the proposals for reforming the National Health Service set out in the 2010 White Paper "Equity and Excellence: Liberating the NHS". Salient points include proposals that:

- Public health responsibilities will be split off into a new national Public Health Service. Local directors of public health will be appointed jointly by the Public Health Service and local authorities.
- There will be a National Commissioning Board. This will commission and directly fund GP consortia across the country.
- GP consortia will be responsible for commissioning most services for their patients. Patients will have a choice of GP, and GP consortia will be able to commission services from "any willing provider". The right of patients to have a choice of provider will be extended to some mental health services and to long-term conditions.
- The National Commissioning Board will commission directly a number of services where the Government believes it is impractical for GP consortia to do the job. These include dentistry, community pharmacy, primary opthalmic services, maternity services, national and regional specialised services.
- Local Health and Wellbeing Boards, led by local authorities, will be asked to co-ordinate health services (including health promotion) within their areas. This will include preparation of Joint Strategic Needs Assessments (JSNAs), setting local health priorities.

42 The review group also appreciates that further developments in support for the ex-service community must take place within the overall resource constraints set by the emergency Budget and Comprehensive Spending Review 2010, which affects not only local authorities, the NHS, the armed forces and other public sector bodies, but also community and voluntary groups. However, we believe that many of our recommendations can be taken forward for little or no cost, or will generate savings through improved efficiency.

1 Promoting effective communication and coordination across agencies, providers and the third sector

Information

43 As we have seen, information about the health needs of the ex-service community is patchy. Collecting information has costs as well as benefits, and so does analysing it, storing it and sharing it. But the review group believes that the needs of this community are sufficiently distinctive, and the moral imperative implied by the Military Covenant sufficiently strong, to warrant doing more.

44 Identification of the ex-service community is a key issue. The ex-service community's status is very rarely recorded when individuals access services – there is some evidence that this might be impacting on their current ability to effectively access certain services and that recording this status improves access. Organisations such as the Probation Service, the Prison Service and the housing charity Norcare are now actively seeking to record such information in order to ensure that certain services are effectively targeted towards the specific needs of the ex-service community.

It will also be important to gather intelligence about those 'soon to leave', their likely destination and the demands that will place on localities. This work should be periodically refreshed to ensure it remains relevant.

Recommendation 1: that local authorities across the region consider what might be the costs, benefits and best methods of collecting in future information about members of the Armed Forces 'soon to leave', their likely destination and the demands that will place on localities.

Recommendation 2: that local authority services should actively ask the question of those they provide services for: 'have you served in the UK Armed Forces?

Recommendation 3: that all organisations providing (or potentially providing) services for ex-service community should encourage veterans to voluntarily identify themselves by asking 'have you served in the UK Armed forces?'

Recommendation 4: that HM Government should consider the potential for an individual's NHS or National Insurance number to be used to identify their veteran status to improve identification of needs and services that may be available. This might be considered alongside the proposal by the Task Force on the Military Covenant for the creation of Veterans' Cards.

45 There needs to be **better communication and sharing of information and more joined up work** between the armed forces, local authorities, partners and ex-service charities.

Recommendation 5: that formal information sharing protocols and arrangements are established between the armed forces and local authorities across the NE region. This will enable local authorities to properly assess and plan to meet the needs of the ex-service community as a specific group.

46 Local authorities have a key role in shaping their communities and building the wider determinants of good health and working to support individual families and communities. There is evidence that a proportion of the ex -service community across the region are vulnerable and require targeted support.

Recommendation 6: local authorities in the North East should consider dedicating a chapter in their Joint Strategic Needs Assessments to vulnerable service leavers and their needs and identifying as a target population the ex service community within their strategic planning processes in relation to social exclusion, anti-poverty, homelessness and offending.

47 Given the current lack of hard data regarding the health and well being needs of the ex-service community **there is a need for further qualitative research into the needs of the ex-service community.**

Recommendation 7: that local authorities across the region take research forward as part of the development of Joint Strategic Needs Assessments across the region, and that the North East Public Health Observatory should also consider what data and research support it can provide.

48 **Wellbeing depends on wider determinants than the commissioning of health and social care services.** Other factors, such as housing and employment, are also vital.

Recommendation 8: that local authorities across the North East request the NE National Housing Federation to carry out a mapping exercise to quantify current provision of ex - service community housing provided by their members and analyse best practice both nationally and within the North East.

Recommendation 9: that the North East Housing Federation works closely with NE local authorities to help plan future provision.

49 As the Marmot report on health inequalities demonstrated, employment is an important factor underlying health and wellbeing, and it is likely to remain a challenge as the country emerges from the recession.

Recommendation 10: that the armed forces and the Career Transition Partnership work more closely with local authorities across the region and provide them with an assessment of the likely level of demand and need for employment and skills related services in order to inform future economic and financial inclusion strategies and future provision.

50 A thorny issue is the presence of **ex-service personnel in the criminal justice system.** The National Offender Management Service (NOMS) has been taking steps to better understand the situation.

Recommendation 11: that prison and probation services be encouraged undertake more detailed work on the needs and nature of offending veterans.

Recommendation 12: that prison and probation services should consider how to make available more 'signposting' to veteran's charities of offenders subject to short sentences.

Recommendation 13: that prisons, probation trusts and other partners in the statutory and voluntary sectors promote the sharing of best practice and information (data and needs analysis).

51 It is crucial that Strategic Health Authorities, and their successor bodies, take a regional lead and commission detailed and accurate work to establish the true size and nature of the ex-service community.

Awareness

52 Two types of awareness need to be addressed.

53 There is a need to raise **awareness amongst local authorities and other partner organisations**, employers and service providers across the region of the very specific needs of the ex-service community.

54 There is also a need to raise the level of **awareness within the ex-service community** and to communicate effectively with them about the wide range of support currently available to them and how they may access relevant support services and removing any stigma from seeking help and support.

Recommendation 14: As some sections of the ex-service community are vulnerable and hard to reach it is recommended that local authorities work with third sector bodies which provide an outreach service (such as ex-service charities and Norcare) to raise awareness and improve access to available support mechanisms.

Recommendation 15: that all agencies should make use of and promote local directories of services provided by the voluntary and community sector and statutory provision for those seeking help and for those making referrals, such as the web-based directory provided by Veterans North-East and Finchale College, Durham.

Recommendation 16: that North East local authorities examine opportunities for using digital media to improve communication with the ex-service community and raise awareness of available support mechanisms.

Recommendation 17: that the North East National Housing Federation is requested on behalf of local authorities across the region to carry out work with Registered Social Landlords to raise awareness of the housing needs of the ex-service community.

Recommendation 18: that an awareness raising campaign is carried out amongst staff throughout the Tyne and Wear and Tees Valley Unlimited City Regions regarding the importance of asking whether individuals are ex-service to ensure that they can be appropriately referred on to Job Centre Plus and receive their entitlement to early access to New Deal Programmes.

55 **General Practice** has a new role as future commissioners of health services. It is imperative that General Practice is aware of the priority treatment schemes for veterans and that it is utilised when appropriate if referrals are necessary. PCTs should emphasise this point to General Practice now.

Recommendation 19: PCTs should begin conversations now with the embryonic GP Commissioning Consortia regarding the merits of commissioning for ex-service community. PCTs and Consortia should report back to Members how the needs of the ex-service community are going to influence commissioning strategy during the transitional period and when Consortia have formally taken control of Commissioning budgets.

Improving responsiveness within organisations

Recommendation 20: that local authorities and other key partner organisations across the region should consider identifying a senior figure who can act as a champion for the ex-service community and establishing a central point of contact in each local authority area or sub - region to assist when members of the community experience difficulties. Examples of possible approaches include:

a. within local authorities, a Member Armed Forces Champion to drive improvements in services for service veterans.

b. within local authorities, a named senior officer to assist the ex-service community and act as a facilitator and conduit in dealings with Councils and beyond.

c. within Primary Care Trusts, named senior staff to act as Case officers/co-ordinators in PCTs to act on behalf of the ex-service community whilst assistance is required, and to consider how best to pass these responsibilities forward to GP consortia and local Health and Wellbeing Boards.

Improving co-ordination across organisations

56 Experience throughout the country suggests that considerable improvements in the wellbeing and health of the ex-service community could be achieved by better communication, sharing of information and more joined up work between the armed forces, local authorities, partners and ex-service charities.

57 There is some evidence to support the need for the establishment of **some kind of formal network** involving local authorities which focuses on the needs of the ex-service community. Several different co-ordinatory groups are currently in existence, such as the recently established NHS Armed Services Forum, the NE Regional Veterans Network and the MoD Military / Civil Integration Forum.

Recommendation 21: that the Association of North East Councils should explore with the NHS, the armed forces and other partners across the region how stronger networking within and between existing groups may be taken forward. This should include consideration of joined-up planning and performance monitoring.

58 There is a case for more leadership, co-ordination and co-operation across the voluntary sector. This would help to bind what appears to be a fragmentation of provision, to help share good practice, and enable the sector to speak with a stronger voice. It could be assisted by the proposals of the Task Force on the Military Covenant for improved co-ordination,

Recommendation 22: that local authorities should consider how to bring together voluntary organisations large and small with a specific interest in the welfare of the ex-service community, in the light of the Government's response to the Task Force on the Military Covenant.

59 There are also several specific measures which the review group believes could improve co-ordination of services.

Recommendation 23: we strongly recommend that local authorities across the region should explore options for establishing and publicising a central point of contact telephone number - to increase the chances of people getting the help they need and to provide a consistent standard of contact across the region. Ex-service charities, Citizens Advice Bureau operating in the region, the Career Transition Partnership and Job Centre Plus have all indicated that this would be likely to prove beneficial. The model adopted by Hampshire County Council, in which telephone enquiries from the ex-service community are channeled to a specific staff member, is particularly worth consideration.

Recommendation 24: that the Homes and Communities Agency is requested on behalf of local authorities across the region to consider how it may broker assistance and ensure better co-ordination of work across the region to ensure that services are being directed at the right people, including the ex-service community, and how it might assist with sharing examples of best practice as part of its enabling role and within the local investment planning process undertaken with local authorities.

Recommendation 25: that the positive work being taken forward by Job Centre Plus in the Tees Valley is shared with Armed Forces Champions across the rest of the region with a view to ensuring a consistent approach in supporting the training and employment needs of the ex-service community.

60 This report has emphasised the need for local authorities to work closely with other partners. They may find this easier to do if they establish common standards.

Recommendation 26: local authorities within the North East should consider the developing a regional veterans charter to establish uniform good practice across the region, possibly through existing regional structures such as the Association of North East Councils (ANEC).

2 The transition of Armed Forces personnel to civilian services following discharge

61 The evidence suggests that the vast majority of ex-service personnel experience the transition from military to civilian life positively. A range of tailored support is provided both by the services themselves and by the Career Transition Partnership. The National Audit Office concluded that the UK "is at the forefront of providing tailored professional help to military personnel as they leave."

62 There is a Transition Protocol for all those with identified health problems on discharge.

Recommendation 27: that the Career Transition partnership continues to work with local authorities and Primary Care Trusts (and successor bodies as PCTs are abolished) to ensure that the Transition Protocol is understood and that specific individuals are mandated appropriately to take on these roles.

Recommendation 28: that local NHS organisations work with military colleagues to ensure that people leaving the services are registered with GPs and dentists before formal discharge, so they have a 'foot in both camps' towards the end of their active service. This would ensure a smoother transition to civilian health services.

63 There is some evidence that **signposting is not enough for the more vulnerable service leavers** with specific problems and there is a need for more integrated pathways to services for these individuals.

Recommendation 29: that the armed forces and the Career Transition Partnership work more closely with local authorities and third sector organisations such as ex service charities, Norcare and Mental Health North East with a view to developing a formal process for referring vulnerable service leavers into specific services.

64 The risk factors identified by King's College suggest that early service leavers may be among those most likely to be vulnerable. They are also the group most likely to be leaving the services for negative reason. However, unless they are being discharged on medical grounds, early service leavers are entitled only to very limited support from the Career Transition Partnership.

Recommendation 30: that action is taken, by the Armed Forces, on discharge to ensure that Early Service Leavers are provided with effective advice and 'signposting' in relation to the mental health issues they may experience on discharge from service.

Recommendation 31: the effectiveness of improvements to the armed forces resettlement provision for early service leavers should be kept under review by the armed forces to ensure there is effective identification of potential vulnerability issues.

65 As always, it is not only health and social care provision that determines wellbeing. It is of crucial importance that registered social landlords are aware of the prevalence of the ex-service community in the north east and they ensure that their allocation policies make specific reference to accommodating the ex-service community.

Recommendation 32: Local authorities should encourage Strategic Housing Authorities and registered social landlords, where possible, to adopt allocation policies which recognise the needs of the ex-service community.

3 Ensuring equality of access for Armed Forces families

66 Given the time limits on this review, its attention has been focused mostly on housing needs.

67 At the moment there does not seem to be a way of identifying take up of low cost housing products by the ex-service community or identifying whether providers are assisting the ex-service community as well as other parts of the community.

Recommendation 33: that the Homes and Communities Agency is requested to examine on behalf of local authorities across the region identifying take-up of low-cost housing products by the ex-service community and whether providers are assisting the ex-service community as well as other parts of the community.

Recommendation 34: that the Homes and Communities Agency is requested to examine opportunities for the ex-service community within any revised funding arrangements as an outcome of the comprehensive spending review.

Recommendation 35: that local authorities across the region examine the scope to provide housing related support for ex-service tenants once a property has been identified.

4 Veterans' mental health services

68 Significant effort is being put in nationally and locally to improve mental health services for veterans. The review group welcomes Dr Murrison's report and the Government's response to it.

69 At a local level, the proposals in the NHS White Paper give a strong role to the new local Health and Wellbeing Boards in assessing needs and co-ordinating service provision.

Recommendation 36: that the new Health and Wellbeing Boards prioritise veterans' mental health issues, taking a lead in ensuring that on day 1 of discharge into civilian life that services are in place to meet the needs of the ex-service community in relation to both NHS and social care provision.

70 There is a need for enhanced awareness among primary care providers and GPs of the particular mental health needs of the ex-service personnel and particularly of the need for priority treatment for health care needs arising from their service.

Recommendation 37: that:

a. appropriate training is provided and required by commissioners of NHS services;

b. guidance should also be developed specifically for primary care providers and GPs to:

v) explain the priority healthcare entitlement;

vi) encourage them to identify ex-servicemen and women (for example, by asking patients to indicate that they have serviced in the UK Armed Forces);

vii) explain how they can adapt their systems to accommodate priority treatment for ex-service community; and

viii) how to accept referrals from ex-service charities, including the Royal British Legion and Combat Stress, but also smaller local organisations who are providing for some of the most marginalised/excluded ex-service personnel.

Recommendation 38: Joint Strategic Needs Assessments should specifically identify the mental health needs of the ex-service community including families and dependants.

Recommendation 39: NHS commissioners must ensure that GP consortia arrangements prioritise the needs of the ex-service community.

Recommendation 40: local authorities and GP Consortia should be actively engaged in joint planning and commissioning of services with the NHS.

Recommendation 41: local authorities should be actively engaged in the NHS Armed Forces Network and consider how they can take on a leadership role in relation to veterans mental health issues – perhaps linked to the formation of the new Health and Wellbeing Boards.

71 There is general support across the voluntary sector that there should be some regulation or accreditation of voluntary organisations for the purpose of providing quality assurance of their services. This will ensure confidence that organisations are meeting certain standards in advice or care provided, and thereby instilling confidence that they can be referred to and attract funding support and that they gain the credibility to refer directly to GPs.

Recommendation 42: consideration should be given by central government to the need for some form of accreditation to be available to ex-service charities (particularly the newly emerging charities). How this might best be taken forward should be considered in the light of the Government's response to the Task Force on the Military Covenant. Local authorities should consider drawing up approved lists of service providers.

Recommendation 43: that voluntary organisations and the NHS promote self-referral routes for ex-service personnel in a wide range of different ways that will help maximise their opportunity to access services.

72 The Government has announced an increase in the number of specialised outreach officers working to improve the mental health of veterans, but many of the ex-service community may find themselves, at least initially, in contact with health workers who are not specialised in this field.

Recommendation 44: that primary care and acute trusts should take steps to improve awareness of veterans mental health issues among health workers generally, including appropriate training and supervision.

73 The National Health Service has a programme for Improving Access to Psychological Therapies (IAPT). As part of this the Tees, Esk and Wear Valleys NHS Foundation Trust has undertaken a Community Mental Health Pilot scheme.

Recommendation 45: the Tees, Esk and Wear Valleys NHS Foundation Trust and the Department of Health should share widely the learning from the evaluation of the Community Veteran Mental Health Pilot, and particularly with commissioners, providers and the North East Mental Health Development Unit. Learning from the pilot must help to shape future statutory of provision and the linkages with, and support for, the voluntary sector in the context of the IAPT.

Recommendation 46: Trusts should provide better basic information to veterans with clear diagnoses of PTSD about their condition.

74 Some groups within the ex-service community may need special attention, including prisoners and early service leavers (those who leave the service after less than four years).

Recommendation 47: prison health services need to identify veterans and evaluate needs with a particular focus on mental health and PTSD.

Undertaking this review

75 This is the first time that the twelve local authorities in the North East of England have combined to undertake a joint scrutiny review about a matter of common concern, and especially about an aspect of health inequalities in the region.

76 There has been a long history of co-operation between the health overview and scrutiny committees in the region. The five authorities in the Tees Valley area have operated a standing joint committee for several years, while the seven local authorities to their north have formed a number of separate scrutiny committees to examine particular health issues under an agreed protocol. The Chairs of individual local authorities have come together in a network to discuss matters of common interest, as have their support officers.

77 In 2009, the network members decided that it was time to move this process on a stage, by undertaking a joint scrutiny review and forming a standing Joint Health Overview and Scrutiny Committee. An invitation by the Centre for Public Scrutiny (CfPS) for joint bids by groups of local authorities to become Scrutiny Development Areas in the field of health inequalities acted as a catalyst. The network's bid was successful and the Centre provided support in the form of £5,000 and 6.5 free days support by a CfPS expert advisor, Shaun Gordon. In return, this review is contributing to the Centre's health inequality scrutiny toolkit.

78 The formal Joint Health Overview and Scrutiny Committee was not set up until partway through the review, so the original bid was agreed by the network in December 2009, and a separate Memorandum of Understanding was drawn up setting up a Project Board for the review. Like the Joint Committee which formed later, this was made up of the Chairs of the individual local authority health overview and scrutiny committees, or their deputies. Meetings were chaired variously by Councillors Ann Cains (Stockton-on-Tees), Robin Todd (Durham) and Lawrence Hunter (Newcastle), until Councillor Cains was elected as Chair of the new Joint Committee in September 2010.

79 The Joint Health Overview and Scrutiny Committee has adopted a protocol and terms of reference to formalise its governance arrangements, which will be of value in any future joint scrutiny.

80 The subject of the joint review was quickly agreed, winning support across all twelve local authorities in the region. Reviewing ways to improve the health of the ex-service community was not just a matter which fired the enthusiasm of Councillors, it would bring a local and regional perspective to the initiatives being taken nationally by the Ministry of Defence and the Department of Health and their partners, as set out in the Command Paper The Nation's Commitment.

81 Once the overall direction of the project was set by Councillors, officers started to research background information and to identify contacts.

82 At the end of June, 22 scrutiny Councillors from the 12 different local authorities and 34 guests from a range of national, regional and local organisations gathered in Durham to discuss the health needs of the ex-service community at an evidence-gathering overview day.

83 They listened to and questioned speakers including the Co-Chair of the joint Ministry of Defence/Department of Health Partnership Board and the Surgeon-General's Cross-Government Health Lead, as well as representatives of the armed forces, the Royal British Legion, the regional Strategic Health Authority, one of the Directors of Adult Services in the North East, and the Career Transition Partnership, and they took part in round-table discussion with public health specialists, commissioners and clinicians.

84 Following the overview day, Councillors split into three workstream groups, looking at physical health, mental health, and social and economic wellbeing.

85 A Chair and lead authority was identified for each of these workstreams, but they were otherwise open to Councillors from any authority, irrespective of political alignment. Each worksteam was supported by officers from four local authorities. The social and economic wellbeing group was chaired by Councillor Stuart Green (Gateshead), the mental health group by Councilor Robin Todd (Durham) and the physical health group by Councillor Eddie Dryden (Middlesbrough).

86 Each workstream undertook its own work programme, including interviews, focus groups and site visits. These are detailed further in the individual reports of the workstreams. A project support group of officers was set up to help co-ordinate the project and avoid duplication. This was made up of officers from the workstream lead authorities, from Newcastle, which acted as overall project lead, and from Redcar & Cleveland, which handled publicity.

87 All the workstream reports, together with the overall project report, were considered by the Joint Committee in its role as project board, and shared with as many contributors as possible before publication.

88 This has been a long process, which has made demands both on the review group and on the many people from a wide range of organisations who have helped the group reach its conclusions. The group is extremely grateful for the enthusiasm, time and commitment of everyone who contributed and hope that, by participating in this review, those organisations have gained new perspectives, new contacts and new ideas even beyond the scope of this report.

Monitoring the implementation of review recommendations

89 This report includes recommendations that are aimed at a wide variety of organisations. These are listed at Appendix 3.

90 The organisations that are referred to in this report will be contacted and asked to support the recommendations, and indicate how they will be taking them forward.

91 The Committee will meet to examine progress after six months and after one year. It will ask that the organisations involved help us with those assessments.

Appendix 1

Final Report

Acknowledgements

The review was carried out by the following councillors and officers:-

Members of the Project Board and workstream groups

Cllr Ian Haszeldine, Darlington
Cllr Wendy Newall, Darlington
Cllr Marian Swift, Darlington
Cllr Jean Chaplow, Durham
Cllr David Farry, Durham
Cllr Robin Todd, Durham
Cllr Pauline Dillon, Gateshead
Cllr Stuart Green, Gateshead
Cllr Brenda Osborne, Gateshead
Cllr Stephen Akers-Belcher, Hartlepool
Cllr Mary Fleet, Hartlepool
Cllr Sheila Griffin, Hartlepool
Cllr Eddie Dryden, Middlesbrough
Cllr Len Junier, Middlesbrough
Cllr Veronica Dunn, Newcastle
Cllr Doreen Huddart, Newcastle
Cllr Lawence Hunter, Newcastle
Cllr Sharon Pattison, Newcastle
Cllr Margaret Finlay, North Tyneside
Cllr Barbara Stevens, North Tyneside
Cllr Margaret Richards, Northumberland
Cllr Terry Robson, Northumberland
Cllr Steve Kay, Redcar & Cleveland
Cllr Wendy Wall, Redcar & Cleveland
Cllr Ernest Gibson, South Tyneside
Cllr John McCabe, South Tyneside
Cllr Ann Cains, Stockton-on-Tees
Cllr Dick Cains, Stockton-on-Tees
Cllr Julia Cherrett, Stockton-on-Tees
Cllr Aidan Cockerill, Stockton-on-Tees
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Karen Brown, Sunderland

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Project support

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Contributors

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Dave Britton, Regional MH Commissioning Team	Overview Day
Gary Cameron, Director, Military Mental Health	Mental Health
Sir Andrew Cash, Co-chair, MoD/UK Departments of Health Partnership Board	Overview Day
Joe Chadanyika, Health Improvement Specialist (Mental Health), NHS Stockton-on-Tees	Mental Health
Joe Connolly, Welfare Officer, Royal British Legion	Mental Health
Symon Day, Lead Consultant Clinical Psychologist, HealthTees Esk & Wear NHS Foundation Trust	Overview Day, Mental
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Flight Sgt Danny Downs, RAF	Overview Day
Andrew Drake MBE, Royal British Legion	Overview Day, Physical Health
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Heather Nicholson, Regional Manger, Career Transition Partnership	Overview Day
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Ken Ross, NHS County Durham and Darlington Public Health Specialists	Overview Day
Dave Rutter, Department of Health Military Health	Overview Day
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Philip Whitfield, Assistant Director, Strategic Intelligence Stockton PCT	Overview Day
Lynn Wilson, Regional MH Commissioning Team	Overview Day
Michelle Winship, Director, Resettlement Armed Forces Training	Mental Health, Physical Health
Tony Wright, Forces for Good	Mental Health
A small sample of the ex-service community across the region	Social & Economic Wellbeing

Appendix 1

Commander of Catterick Garrison	Social & Economic Wellbeing
MOD Military / Civil Integration Project	Social & Economic Wellbeing
Career Transition Partnership	Social & Economic Wellbeing
Homes and Communities Agency	Social & Economic Wellbeing
Housing providers across the region	Social & Economic Wellbeing
Norcare	Social & Economic Wellbeing
NE Royal British Legion	Social & Economic Wellbeing
Soldiers, Sailors, Airmen and Families Association, North East (SSAFA - NE)	Social & Economic Wellbeing
Service Personnel and Veterans Agency	Social & Economic Wellbeing
About Turn CIC / Forces for Good	Social & Economic Wellbeing
Military Mental Health	Social & Economic Wellbeing
Job Centre Plus	Social & Economic Wellbeing
Principal of Finchale College, Durham	Social & Economic Wellbeing
Mental Health North East / Northern Pine Tree Trust	Social & Economic Wellbeing
North East Employers Coalition	Social & Economic Wellbeing
Citizens Advice Bureau (CAB), Middlesbrough	Social & Economic Wellbeing
Director of Adult Care and Housing, Gateshead	Social & Economic Wellbeing
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Head of Economic Development, Gateshead	Social & Economic Wellbeing
Labour Market Co-ordinator, Stockton-on-Tees Borough Council	Social & Economic Wellbeing

Appendix 2

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Dr A Murrison MP *Fighting Fit - A mental health plan for servicemen and veterans*, Ministry of Defence, October 2010

M.Marmot *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post - 2010*, The Marmot Review, February 2010

Appendix 3

Organisations Identified to Implement Recommendations

The following organisations have been identified to take forward the implementation of the recommendations:

- Armed Forces
- Local Authorities
- Career Transition Partnership
- NHS
- Voluntary Sector
- Job Centre Plus
- ANEC
- Primary Care Organisations
- GP Consortium Pathfinders
- Royal British Legion
- Soldiers, Sailors and Airmen's Family Association (SSAFA)
- Norcare
- Mental Health North East
- Tees Esk and Wear Valleys NHS Foundation Trust
- Department of Health
- Registered Social Landlords
- Department of Work and Pensions
- HM Government
- Homes and Communities Agency
- NHS National Commissioning Board (when established)
- Local Health and Wellbeing Boards (when established)
- North East Public Health Observatory
- NE National Housing Federation
- Combat Stress
- NHS North East Armed Forces Network
- National Offender Management Service
- Northumberland, Tyne and Wear Foundation Trust
- Prison Health Commissioners and Service Providers
- Tyne and Wear and Tees Valley Unlimited City Regions

The North East Joint Health Overview and Scrutiny Committee.
Above: Members.
Below: Supporting Officers.


DARLINGTON
BOROUGH COUNCIL

Durham
County Council

Gateshead
Council

HARTLEPOOL
BOROUGH COUNCIL

Middlesbrough
moving forward

Newcastle
City Council

North Tyneside Council

NORTHUMBERLAND
COUNTY COUNCIL

REDCAR & CLEVELAND
BOROUGH COUNCIL

South Tyneside Council

Stockton-on-Tees
BOROUGH COUNCIL

Sunderland
City Council

OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN **8.1 Appendix B**

NAME OF FORUM: North East Regional Joint Overview and Scrutiny Committee

NAME OF SCRUTINY ENQUIRY: Health Needs of the Ex-Service Community

DECISION MAKING DATE OF FINAL REPORT: June 2011

	RECOMMENDATION	LOCAL DELIVERY	REGIONAL DELIVERY
1	That local authorities across the region consider what might be the costs, benefits and best methods of collecting in future information about members of the Armed Forces 'soon to leave', their likely destination and the demands that will place on localities.		✓
2	That local authority services should actively ask the question of those they provide services for: 'have you served in the UK Armed Forces?	✓	
5	That formal information sharing protocols and arrangements are established between the armed forces and local authorities across the NE region. This will enable local authorities to properly assess and plan to meet the needs of the ex-service community as a specific group.		✓
6	Local authorities in the North East should consider dedicating a chapter in their Joint Strategic Needs Assessments to vulnerable service leavers and their needs and identifying as a target population the ex service community within their strategic planning processes in relation to social exclusion, anti-poverty, homelessness and offending.	✓	
7	That local authorities across the region take research forward as part of the development of Joint Strategic Needs Assessments across the region, and that the North East Public Health Observatory should also consider what data and research support it can provide.	✓	
8	That local authorities across the North East request the NE National Housing Federation to carry out a mapping exercise to quantify current provision of ex - service community housing provided by their members and analyse best practice both nationally and within the North East.		✓
9	That the North East Housing Federation works closely with NE local authorities to		✓

NAME OF FORUM: North East Regional Joint Overview and Scrutiny Committee

NAME OF SCRUTINY ENQUIRY: Health Needs of the Ex-Service Community

DECISION MAKING DATE OF FINAL REPORT: June 2011

	RECOMMENDATION	LOCAL DELIVERY	REGIONAL DELIVERY
	help plan future provision.		
10	That the armed forces and the Career Transition Partnership work more closely with local authorities across the region and provide them with an assessment of the likely level of demand and need for employment and skills related services in order to inform future economic and financial inclusion strategies and future provision.		✓
14	As some sections of the ex-service community are vulnerable and hard to reach it is recommended that local authorities work with third sector bodies which provide an outreach service (such as ex-service charities and Norcare) to raise awareness and improve access to available support mechanisms.		✓
15	That all agencies should make use of and promote local directories of services provided by the voluntary and community sector and statutory provision for those seeking help and for those making referrals, such as the web-based directory provided by Veterans North-East and Finchale College Durham.		✓
16	That North East local authorities examine opportunities for using digital media to improve communication with the ex-service community and raise awareness of available support mechanisms.		✓
17	That the North East National Housing Federation is requested on behalf of local authorities across the region to carry out work with Registered Social Landlords to raise awareness of the housing needs of the ex-service community.		✓
20	That local authorities and other key partner organisations across the region should consider identifying a senior figure who can act as a champion for the ex-service community and establishing a central point of contact in each local authority area or sub - region to assist when members of the community experience difficulties.	✓ (a & b)	✓ (c)

NAME OF FORUM: North East Regional Joint Overview and Scrutiny Committee

NAME OF SCRUTINY ENQUIRY: Health Needs of the Ex-Service Community

DECISION MAKING DATE OF FINAL REPORT: June 2011

	RECOMMENDATION	LOCAL DELIVERY	REGIONAL DELIVERY
	Examples of possible approaches include: a. Within local authorities, a Member Armed Forces Champion to drive improvements in services for service veterans. b. Within local authorities, a named senior officer to assist the ex-service community and act as a facilitator and conduit in dealings with Councils and beyond. c. Within Primary Care Trusts, named senior staff to act as Case officers/co-ordinators in PCTs to act on behalf of the ex-service community whilst assistance is required, and to consider how best to pass these responsibilities forward to GP consortia and local Health and Wellbeing Boards.		
22	That local authorities should consider how to bring together voluntary organisations large and small with a specific interest in the welfare of the ex-service community, in the light of the Government's response to the Task Force on the Military Covenant.		✓
23	We strongly recommend that local authorities across the region should explore options for establishing and publicising a central point of contact telephone number - to increase the chances of people getting the help they need and to provide a consistent standard of contact across the region. Ex-service charities, Citizens Advice Bureau operating in the region, the Career Transition Partnership and Job Centre Plus have all indicated that this would be likely to prove beneficial. The model adopted by Hampshire County Council, in which telephone enquiries from the ex-service community are channeled to a specific staff member, is particularly worth		✓

NAME OF FORUM: North East Regional Joint Overview and Scrutiny Committee

NAME OF SCRUTINY ENQUIRY: Health Needs of the Ex-Service Community

DECISION MAKING DATE OF FINAL REPORT: June 2011

	RECOMMENDATION	LOCAL DELIVERY	REGIONAL DELIVERY
	consideration.		
24	That the Homes and Communities Agency is requested on behalf of local authorities across the region to consider how it may broker assistance and ensure better co-ordination of work across the region to ensure that services are being directed at the right people, including the ex-service community, and how it might assist with sharing examples of best practice as part of its enabling role and within the local investment planning process undertaken with local authorities.		✓
26	Local authorities within the North East should consider the developing a regional veterans charter to establish uniform good practice across the region, possibly through existing regional structures such as the Association of North East Councils (ANEC).		✓
27	That the Career Transition partnership continues to work with local authorities and Primary Care Trusts (and successor bodies as PCTs are abolished) to ensure that the Transition Protocol is understood and that specific individuals are mandated appropriately to take on these roles.		✓
29	That the armed forces and the Career Transition Partnership work more closely with local authorities and third sector organisations such as ex service charities, Norcare and Mental Health North East with a view to developing a formal process for referring vulnerable service leavers into specific services.		✓
32	Local authorities should encourage Strategic Housing Authorities and registered social landlords, where possible, to adopt allocation policies which recognise the needs of the ex-service community.	✓	
34	That the Homes and Communities Agency is requested to examine on behalf of local		✓

NAME OF FORUM: North East Regional Joint Overview and Scrutiny Committee

NAME OF SCRUTINY ENQUIRY: Health Needs of the Ex-Service Community

DECISION MAKING DATE OF FINAL REPORT: June 2011

	RECOMMENDATION	LOCAL DELIVERY	REGIONAL DELIVERY
	authorities across the region identifying take-up of low-cost housing products by the ex-service community and whether providers are assisting the ex-service community as well as other parts of the community.		
35	That local authorities across the region examine the scope to provide housing related support for ex - service tenants once a property has been identified.		✓
38	Joint Strategic Needs Assessments should specifically identify the mental health needs of the ex-service community including families and dependants.	✓	
39	NHS commissioners must ensure that GP consortia arrangements prioritise the needs of the ex-service community		✓
40	Local authorities and GP Consortia should be actively engaged in joint planning and commissioning of services with the NHS.	✓	
41	Local authorities should be actively engaged in the NHS Armed Forces Network and consider how they can take on a leadership role in relation to veterans mental health issues – perhaps linked to the formation of the new Health and Wellbeing Boards.		✓
42	Consideration should be given by central government to the need for some form of accreditation to be available to ex-service charities (particularly the newly emerging charities). How this might best be taken forward should be considered in the light of the Government's response to the Task Force on the Military Covenant. Local authorities should consider drawing up approved lists of service providers.		✓

CABINET REPORT

20 June 2011

Report of: Health Scrutiny Forum

Subject: CONNECTED CARE – FINAL REPORT

SUMMARY

1. PURPOSE OF REPORT

1.1 The purpose of this report is to outline the findings and conclusions of the Health Scrutiny Forum's investigation into 'Connected Care'.

2. SUMMARY OF CONTENTS

2.1 The Final Report outlines the overall aim of the scrutiny investigation, terms of reference, methods of investigation, findings, conclusions, and subsequent recommendations.

3. RELEVANCE TO CABINET

3.1 It is Cabinet's decision to approve the recommendations in this report.

4. TYPE OF DECISION

4.1 This is a Non-key decision.

5. DECISION MAKING ROUTE

5.1 The final report was approved by Scrutiny Co-ordinating Committee on 15 April 2011. Cabinet is requested to consider, and approve, the report at today's meeting.

6. DECISION(S) REQUIRED

6.1 Cabinet is requested to approve the recommendations outlined in section 13.1 of the bound report, which is attached to the back of the papers for this meeting.

HEALTH SCRUTINY FORUM

FINAL REPORT
CONNECTED CARE

JUNE 2011

HARTLEPOOL
BOROUGH COUNCIL

CABINET

20 June 2011

Report of: **Health Scrutiny Forum**

Subject: **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) Identifying the needs of the individual community from residents and ensuring the delivery of a bespoke service that covers any gaps in existing provision;

(iii) Ensuring that partnership arrangements are in place for current service providers and that duplication of work does not occur for those providers already delivering relevant services in that community; and

(iv) 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.

(d) That in order to ensure the safety of Connected Care Navigators and as part of a multi-disciplinary approach to meeting the needs of individuals, that a feasibility study be undertaken into Navigators accessing Care First, Rio, Employee Protection Register and other related systems.

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

April 2011

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 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@northeastpress.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.

CABINET REPORT

20 June 2011

Report of: Director of Child and Adult Services

Subject: CONNECTED CARE – ACTION PLAN

SUMMARY

1. PURPOSE OF REPORT

1.1 To agree an Action Plan in response to the findings and subsequent recommendations of the Health Scrutiny Forum's investigation into 'Connected Care'.

2. SUMMARY OF CONTENTS

2.1 The report provides brief background information into the 'Connected Care' scrutiny investigation and provides a proposed Action Plan (**Appendix A**) in response to the Scrutiny Forum's recommendations.

3. RELEVANCE TO CABINET

3.1 To assist the Cabinet in its determination of either approving or rejecting the proposed recommendations of the Health Scrutiny Forum, attached as **Appendix A** is the proposed Action Plan for the implementation of these recommendations which has been prepared in consultation with the appropriate Portfolio Holder(s).

4. TYPE OF DECISION

4.1 Non-Key.

5. DECISION MAKING ROUTE

5.1 The Action Plan and the progress of its implementation will be reported to the Health Scrutiny Forum on 11 August 2011 (subject to availability of the appropriate Portfolio Holder(s)).

6. DECISION REQUIRED

6.1 That Members of the Cabinet approve the Action Plan **(Appendix A** refers**)** in response to the recommendations of the Health Scrutiny Forum's investigation into 'Connected Care'.

Report of: Director of Child and Adult Services

Subject: CONNECTED CARE – ACTION PLAN

---

1. PURPOSE OF REPORT

1.1 To agree an Action Plan in response to the findings and subsequent recommendations of the Health Scrutiny Forum's investigation into 'Connected Care'.

2. BACKGROUND INFORMATION

2.1 To assist the Cabinet in its determination of either approving or rejecting the proposed recommendations of the Health Scrutiny Forum's investigation into 'Connected Care', attached as **Appendix A** is the proposed Action Plan for the implementation of these recommendations which has been prepared in consultation with the appropriate Portfolio Holder(s).

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

3. ACTION PLAN

3.1 As a result of the Health Scrutiny Forum's investigation into 'Connected Care', the following recommendations have been made:-

(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) Identifying the needs of the individual community from residents and ensuring the delivery of a bespoke service that covers any gaps in existing provision;

(iii) Ensuring that partnership arrangements are in place for current service providers and that duplication of work does not occur for those providers already delivering relevant services in that community; and

(iv) 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.

(d) That in order to ensure the safety of Connected Care Navigators and as part of a multi-disciplinary approach to meeting the needs of individuals, that a feasibility study be undertaken into Navigators accessing Care First, Rio, Employee Protection Register and other related systems.

3.2 An Action-Plan in response to these recommendations has now been produced in consultation with the appropriate Portfolio Holder(s) and is attached at **Appendix A** which is to be submitted to the Health Scrutiny Forum on 11 August 2011 (subject to the availability of appropriate Portfolio Holder(s)).

4. RECOMMENDATION

4.1 Cabinet is requested to approve the Action Plan attached as **Appendix A** in response to the recommendations of the Health Scrutiny Forum's investigation into 'Connected Care'.

OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN

NAME OF FORUM: Health Scrutiny Forum **8.3 Appendix A**

NAME OF SCRUTINY ENQUIRY: Connected Care

DECISION MAKING DATE OF FINAL REPORT: June 2011

	RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION	FINANCIAL IMPLICATIONS	LEAD OFFICER	DELIVERY TIMESCALE
(a)	That a strategy is devised to identify those communities within Hartlepool who may benefit from the delivery of the Connected Care model	Implement agreed 2 year pilot programme to evaluate the development of the Connected Care model across the borough	£200K existing recurrent HBC and PCT funding + £480K re-ablement funding from NHS over 2 years	J Harrison G Martin	July 2011 – May 2013
(b)	That once recommendation (a) is completed, Connected Care is rolled-out to other communities in Hartlepool:-	Development of the CC model into other areas of the borough has been agreed by portfolio holder and implementation will begin summer 2011.	As above	G Martin	Over 2 years to May 2013
	(i) Ensuring that the necessary governance structure is in place;	Work with CC Board to develop robust governance and ensure representation from central and north areas of the town on the board	Cost neutral	G Wistow R Harriman G Martin	September 2011
	(ii) Identifying the needs of the individual community from residents and ensuring the delivery of a bespoke service that covers any gaps in existing provision;	Burbank audit completed. CC will continue to work with residents from central and north areas to identify services required in each area	Cost neutral	R Harriman G Martin	Over 15 months to September 2012

OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN

NAME OF FORUM: Health Scrutiny Forum **8.3 Appendix A**

NAME OF SCRUTINY ENQUIRY: Connected Care

DECISION MAKING DATE OF FINAL REPORT: June 2011

	RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION	FINANCIAL IMPLICATIONS	LEAD OFFICER	DELIVERY TIMESCALE
	(iii) Ensuring that partnership arrangements are in place for current service providers and that duplication of work does not occur for those providers already delivering relevant services in that community; and	CC will remain committed to working with 3rd sector services within local communities and has already commenced talks with other providers in the town.	Emphasis on rationalising resources to avoid duplication and maximise financial efficiencies	R Harriman G Martin	Commenced and ongoing to May 2013
	(iv) That a feasibility study is carried out into support for the Connected Care roll-out through the transfer of staff and / or resources.	Monitor development of the Connected Care model across the borough to determine whether positive re-ablement/preventative outcomes justify the transfer of resources in the future	Cost neutral	J Harrison G Martin	March 2013
(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	Disseminate research findings from LSE to Health Scrutiny Forum	Cost neutral	G Martin	July 2012

OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN

NAME OF FORUM: Health Scrutiny Forum **8.3 Appendix A**

NAME OF SCRUTINY ENQUIRY: Connected Care

DECISION MAKING DATE OF FINAL REPORT: June 2011

	RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION	FINANCIAL IMPLICATIONS	LEAD OFFICER	DELIVERY TIMESCALE
	(ii) That where evidence demonstrates the financial benefits of Connected Care, those organizations benefitting from early intervention by Connected Care, are invited to support or further support the Connected Care programme through resource allocation.	Drive partnership working across the health and social care economy and use positive outcomes from the LSE research to encourage pooling resources to maximise outcomes for all agencies benefitting from the preventative/early intervention approach	Potential for cost savings by increasing the number of agencies contributing funding to the Connected Care model of services	G Martin	September 2012
(d)	That in order to ensure the safety of Connected Care Navigators and as part of a multi-disciplinary approach to meeting the needs of individuals, that a feasibility study be undertaken into Navigators accessing Care First, Rio, Employee Protection Register and other related systems.	Work has already commenced to look at accessing Navigators to the Care First data system and the Employee Protection Register (EPR)	Unclear at this time but some cost may be necessary for any additional lines / equipment	T Smith	December 2012

CABINET

20 June 2011

Report of: Health Scrutiny Forum

Subject: DUST DEPOSITS ON THE HEADLAND

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1. PURPOSE OF REPORT

1.1 To present the findings of the Health Scrutiny Forum following its receipt of a report by the Executive Director of Public Health, NHS Tees entitled 'Health Profile of the Population Living in the Headland of Hartlepool'

2. BACKGROUND INFORMATION

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

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

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

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

2.3 Subsequently, the Health Scrutiny Forum and Members of the Neighbourhood Services Scrutiny Forum, met on 1 February 2011 to consider the report by the Executive Director for Public Health, NHS Tees

entitled 'Health Profile of the Population Living in the Headland of Hartlepool', attached as **Appendix A** to this report.

2.4 Members present at the meeting of the Health Scrutiny Forum of 1 February 2011, heard evidence from the Executive Director for Public Health, NHS Tees that:-

"The health of the population in the Headland of Hartlepool is influenced by the local socio-economic and living environment as well as lifestyle choices…There is no indication of any excess ill health caused by environmental factors."

3. CONCLUSIONS

2.5 The Members of the Health Scrutiny Forum and Neighbourhood Services Scrutiny Forum who met on 1 February 2011 concluded:-

(a) That due to the detailed level of investigation undertaken by the Executive Director for Public Health, NHS Tees, there is no evidence at the moment that dust deposits on the Headland are causing specific health problems to affected residents; and

(b) That work carried out by the Executive Director for Public Health, NHS Tees, highlighted the Health Inequalities that currently exist in the Town and therefore the health of people on the Headland is comparable to the health of the people in the rest of Hartlepool

4. RECOMMENDATIONS

4.1 That Members note the content of this report and the report of the Executive Director of Public Health attached as **Appendix A** to this report.

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

BACKGROUND PAPERS

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

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

(b) Minutes of the meeting of the Health Scrutiny Forum held on 1 February 2011.

NHS
Tees

Health profile of the population living in the Headland of Hartlepool

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

8.

Contents

Executive Summary

Background
Health concerns about the possible effects of dust from the docks close to the Headland of Hartlepool (area within the St Hilda ward) have been raised for many years. Previous meetings between residents, Hartlepool Borough Council, Public Health, responsible companies and other agencies have resulted in agreements to mitigate the dust emission and travelling and information on health and lifestyle.
In October 2009 the health scrutiny committee of Hartlepool Borough Council asked Prof Peter Kelly for evidence of possible health effects of dust and noise originating from the docks. Professor Kelly presented information on respiratory, liver and skin disease contained in this report and agreed to further investigate respiratory disease in children, mental health, cancer incidence and prevalence and asbestos related disease.
Primary and secondary care information, cancer registry information and other sources were used to compile this report.

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

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

Conclusions

The health of the population in the Headland of Hartlepool is influenced by the local socio-economic and living environment as well as lifestyle choices.
The level of deprivation, smoking, binge drinking and obesity in St Hilda are particularly high, while the air quality and housing is comparably good. The life expectancy and general health are similar to the Hartlepool average and the burden of disease seen in general practice is similar for patients from the Headland and patients from elsewhere in Hartlepool. Cancer incidence is similar in St. Hilda, Hartlepool and the North East whilst cancer mortality, particularly for women in St Hilda, has been higher in Hartlepool than in the North East in the period 2003/06.
The evidence presented in this report suggests that the burden of disease of the population of the Hartlepool Headland is consistent with the age of the population, level of deprivation and proportion of smokers in the population. There is no indication of any excess ill health caused by environmental factors.

8.

Definitions

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

1. Background

1.1 Health concerns at Hartlepool Headland

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

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

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

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

Envoy recommended the company to

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

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

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

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

1. 2 Health Effects of Substances found in the Environment

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

Aluminium

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

Iron

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

Titanium

Titanium dioxide is a product of titanium mineral. No negative health effects have been reported for ingestion and skin absorption. Inhalation of Titanium particles has been studied among groups of titanium exposed workers and included impaired lung function, pleural disease and mild fibrotic changes. However the workers were simultaneously exposed to asbestos and silica. Titanium dioxide is possibly carcinogenic.[3]

Zinc

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

Particles in the air

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

Asbestos related disease

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

Four main diseases are associated with inhalation of asbestos fibres:

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

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

Lung cancer deaths caused by asbestos are clinically indistinguishable from those caused by other agents such as tobacco smoke. This means that the exact number of cases cannot be determined. Estimates expect approximately one asbestos related lung cancer death per mesothelioma each year. The ten occupations found to have the highest risk of mesothelioma for males were Carpenters, plumbers, electricians, labourers in other construction trades, metal plate workers, pipe fitters, contraction operatives, managers in construction, construction trade and energy plant operatives. Non occupational exposure to asbestos such as living within a mile of a potential environmental hazard such as an asbestos factory disposal site, shipyard or power plant caused no additional risk before the age of 30 and a slight but not significant increased risk when being exposed more than 20 years.

2. Purpose of this report

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

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

3. Methods

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

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

Graph 1: Map of Hartlepool GP practices and wards

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

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

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

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

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

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

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

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

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4. Health Profile

4.1 Population

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

Table 3 : Population

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

Source: ONS, Neighbourhood Statistics, 2001

4.2 Wider determinants of health

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

Deprivation

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

Table 4: Index of multiple deprivation

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

Source: ONS, Neighbourhood Statistics,2007

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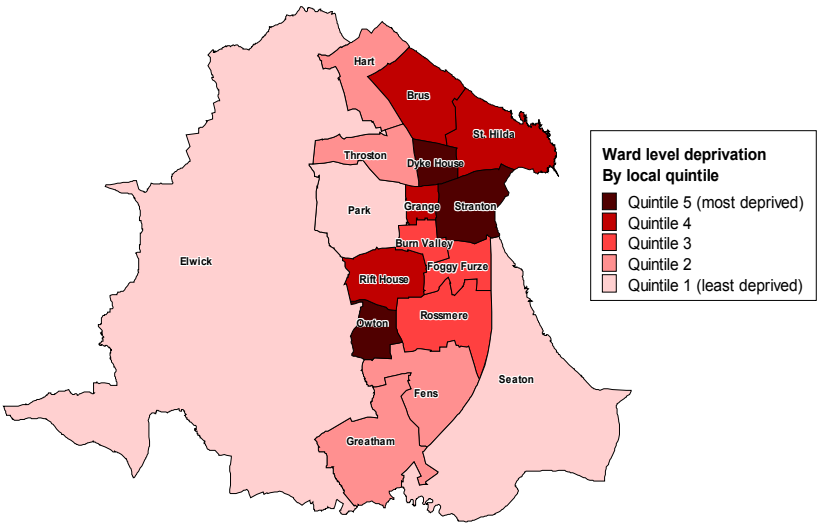
Compared to the whole of Hartlepool the St Hilda ward is within the fourth most deprived quintile, which means that the population in 60% of all wards in Hartlepool is less deprived. But it also means that the population in 20% of all wards in Hartlepool is more deprived. In total there are 7936 wards in Britain. The wards are ranked in order with rank 1 meaning the most deprived ward. Stranton, Dyke House, St Hilda and Brus are within the 3% most deprived wards in Britain. Stranton (49) and Dyke House (rank 63) have a higher level of deprivation than St Hilda (rank 153) and Brus (rank 222).

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



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

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

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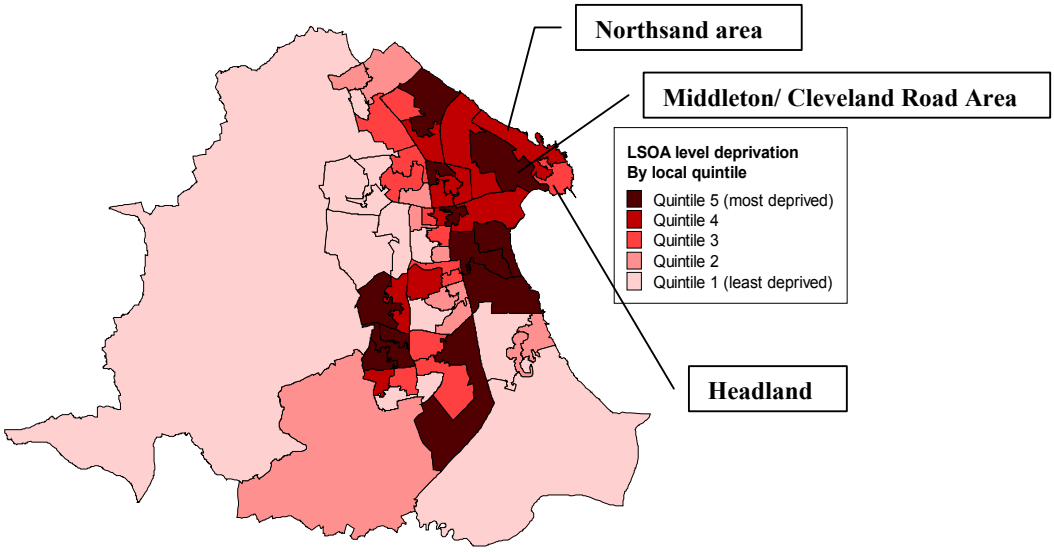

Northsand area
Middleton/ Cleveland Road Area
LSOA level deprivation
By local quintile
Quintile 5 (most deprived)
Quintile 4
Quintile 3
Quintile 2
Quintile 1 (least deprived)
Headland

8.

Environment

The quality of the living environment of an area is measured by the quality of housing, road traffic accidents and air quality (PM 10, Nitrogen Dioxide, Sulphur Dioxide and Benzene) of an area. The living environment in the Headland of Hartlepool is ranked high in comparison with other areas in England which indicates a good quality of housing and air quality. The neighbouring area of Northsands ranks lower while Middleton/Cleveland Road ranks higher.
The air quality in the Headland is also rated as better than average the PM 10 indicator which measures particles (dust) in the air. The Headland has better scores for most indicators than the neighbouring areas.

Table 5: Living environment

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

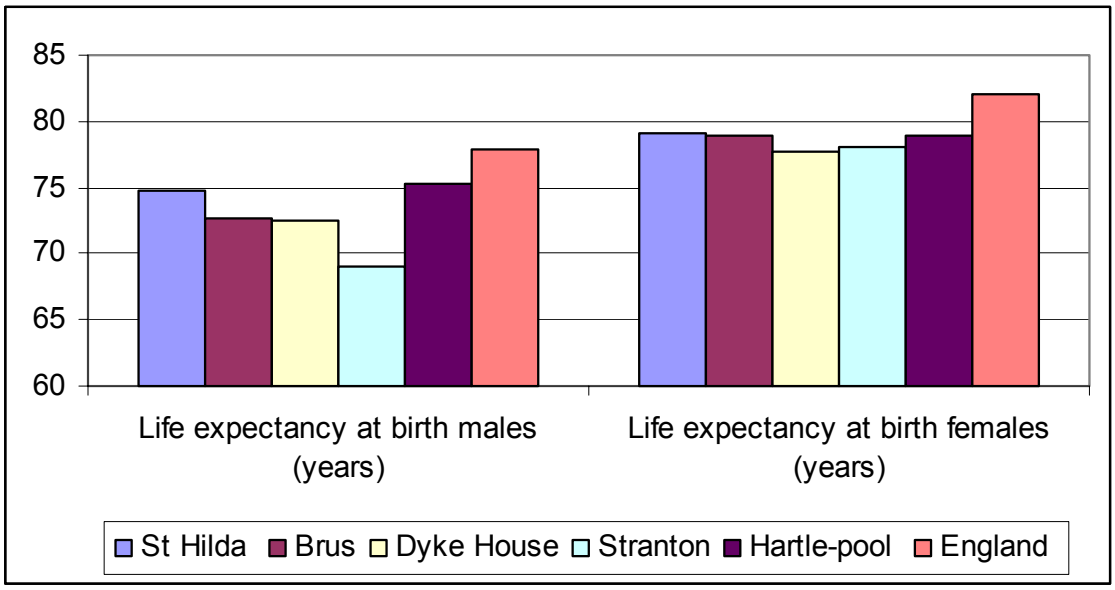
Source: Index of multiple Deprivation 2007
* Rank 1 is the most deprived and rank 32,482 is the least deprived LSOA in England
** A higher value implies poorer quality
*** A ratio of less than 1 indicates that the area has lower values of pollution

4.3 Health Status

Life expectancy

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

Graph 4: Life expectancy at birth by sex and wards



Source: ONS Neighbourhood Statistics

Table 6: Life expectancy

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

Source: ONS Neighbourhood Statistics, 2006-2008

8.

General health

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

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

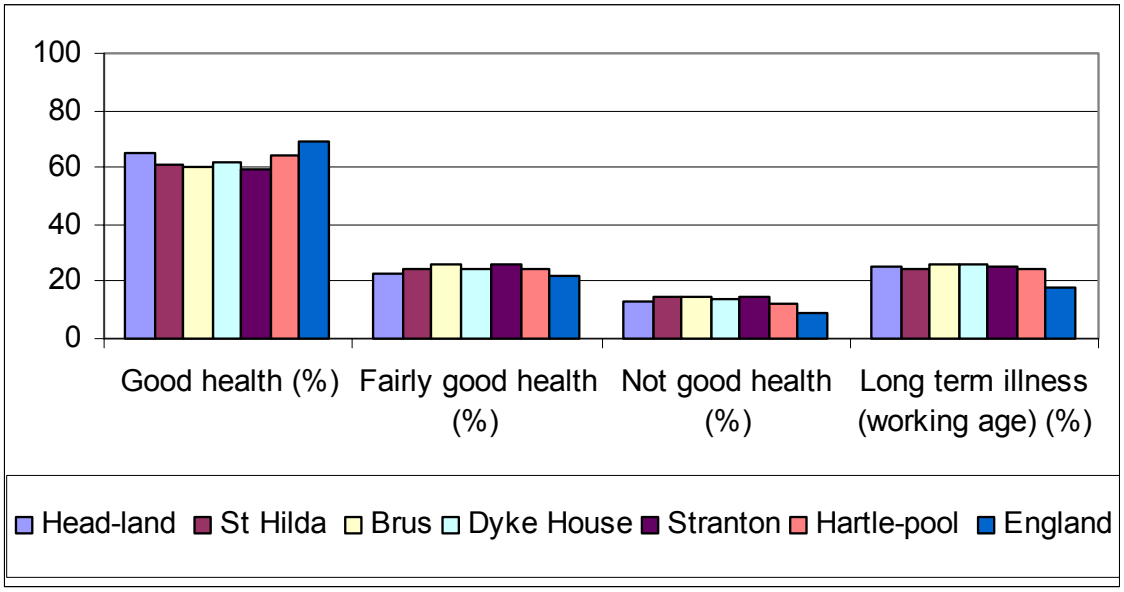


Table 7: General health

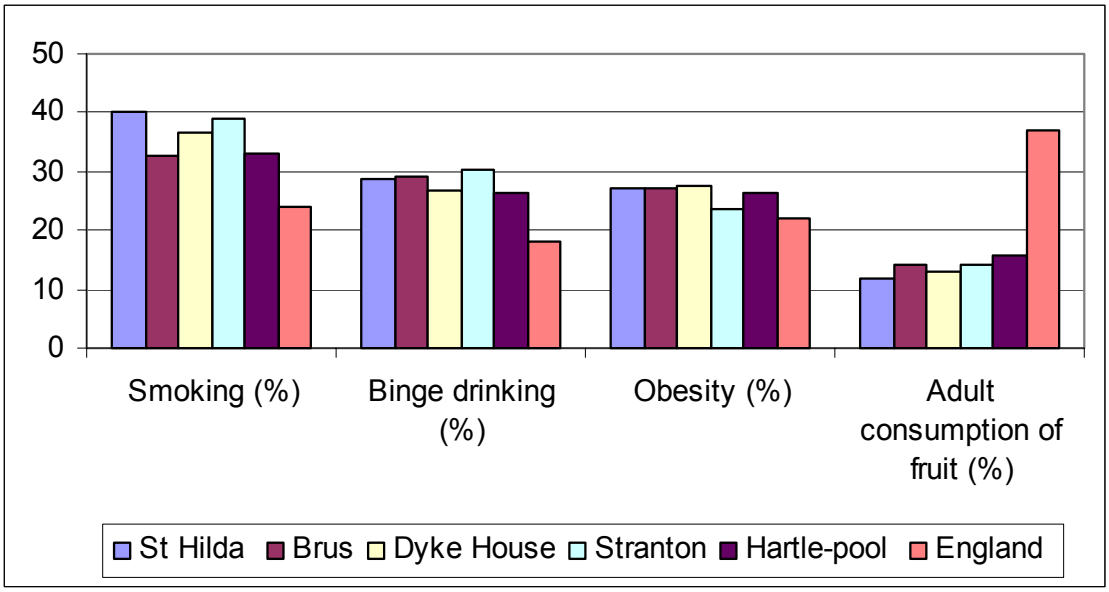
	Head-land	St Hilda	Brus	Dyke House	Stranton	Hartle-pool	England
Good health (%)	65	61	60	62	59	64	69
Fairly good health (%)	23	24	26	24	26	24	22
Not good health (%)	13	15	15	14	15	12	9
Long term illness (working age) (%)	25	24	26	26	25	24	18

Source: ONS Neighbourhood Statistics

Lifestyle behaviour

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

Graph 7: Lifestyle behaviours by ward



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

Table 8: Lifestyles

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

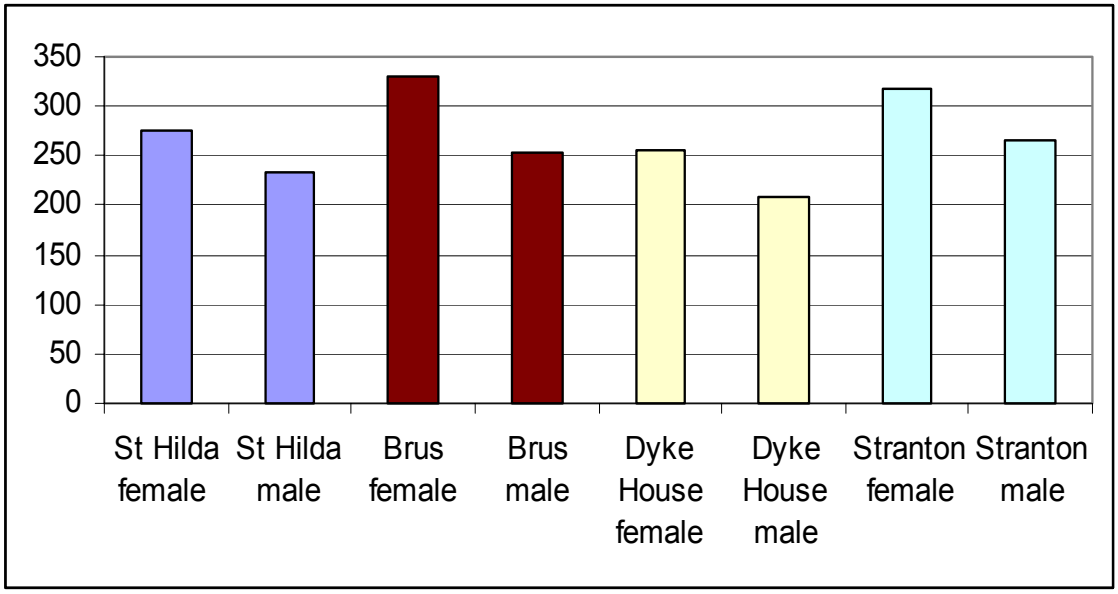
Source: JSU ward data 2003-05 synthetic estimates for healthy behaviour, not available for LSOAs

8.

Mental Health

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

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



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

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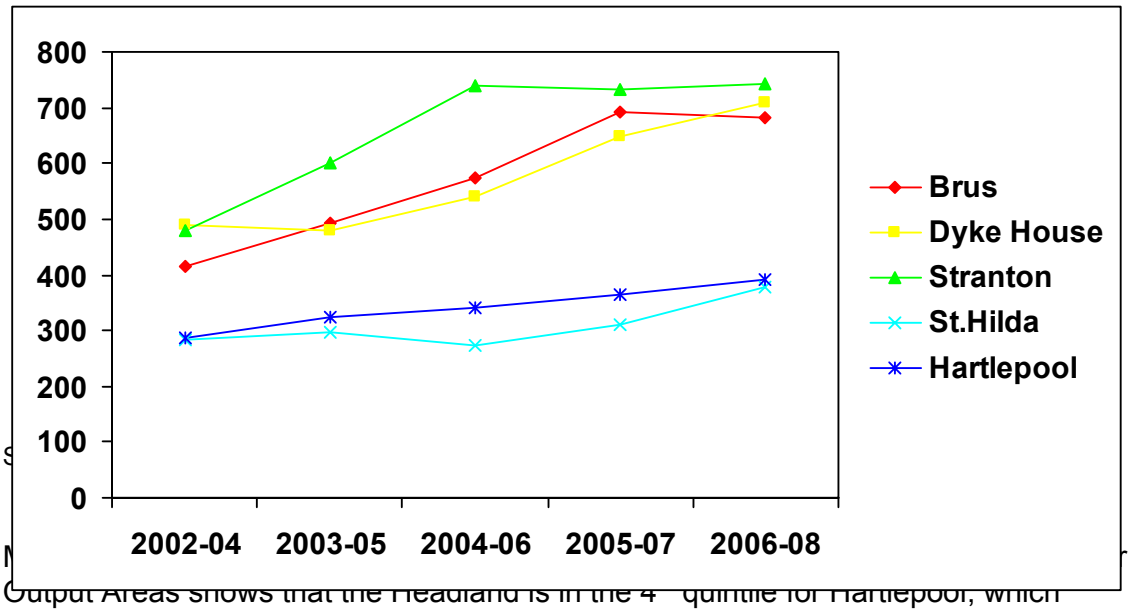
Respiratory disease

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

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

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



Output Areas shows that the Headland is in the 4th quintile for Hartlepool, which means that the rate of hospital admissions for lower respiratory disease is higher than in 60% of Hartlepool. However hospital admissions in the Headland are similar or lower than neighbouring areas.

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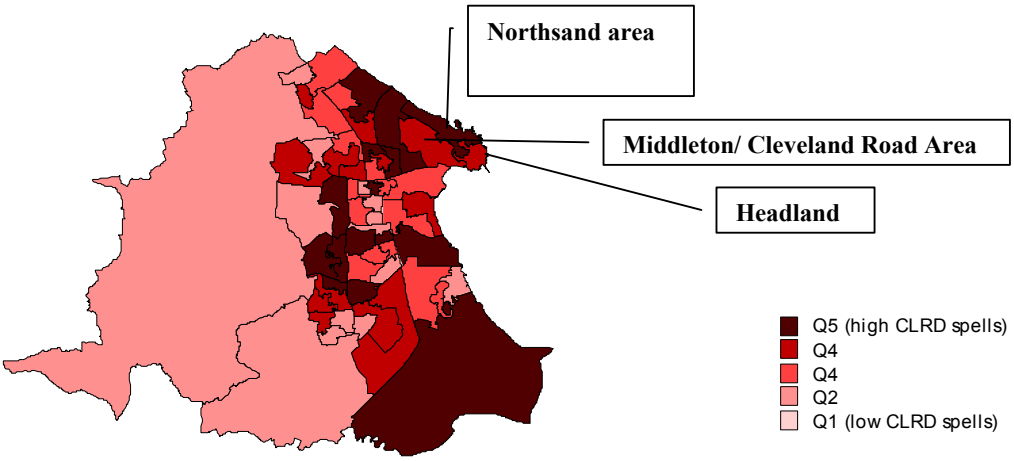
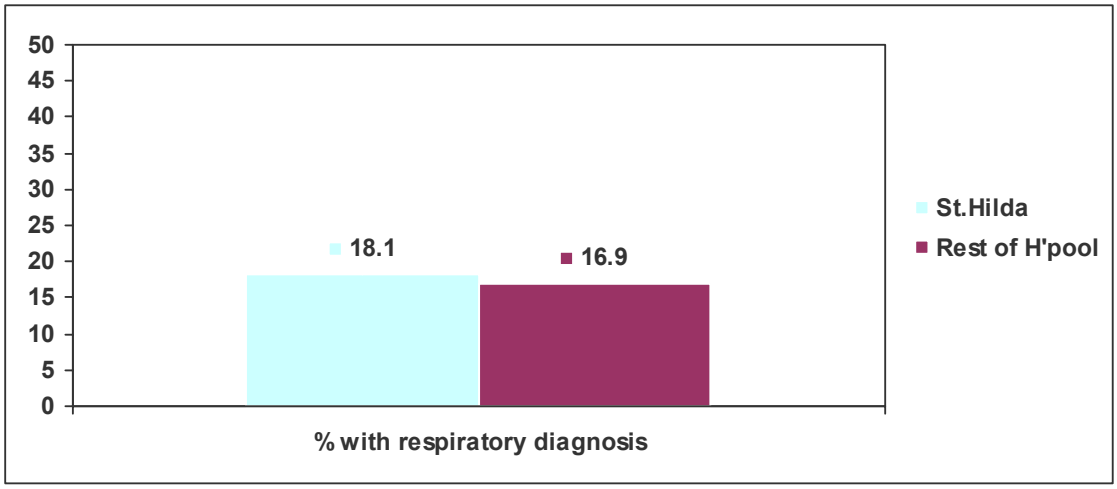
Graph 10: Directly age-standardised Chronic Lower Respiratory Disease spells /100,000 by LSOA and quintile



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

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

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



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

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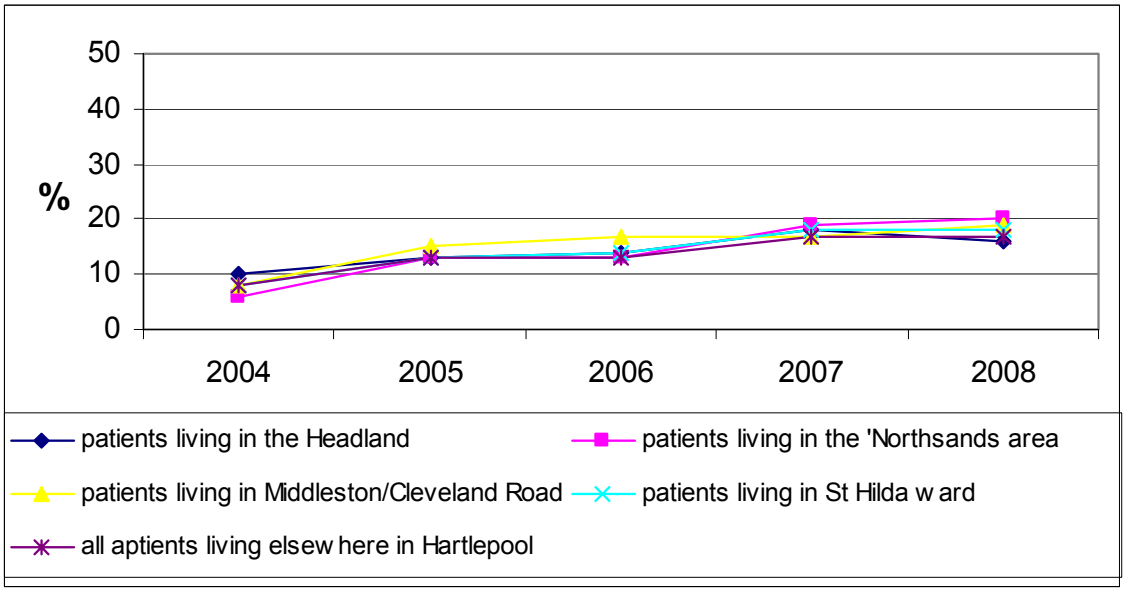
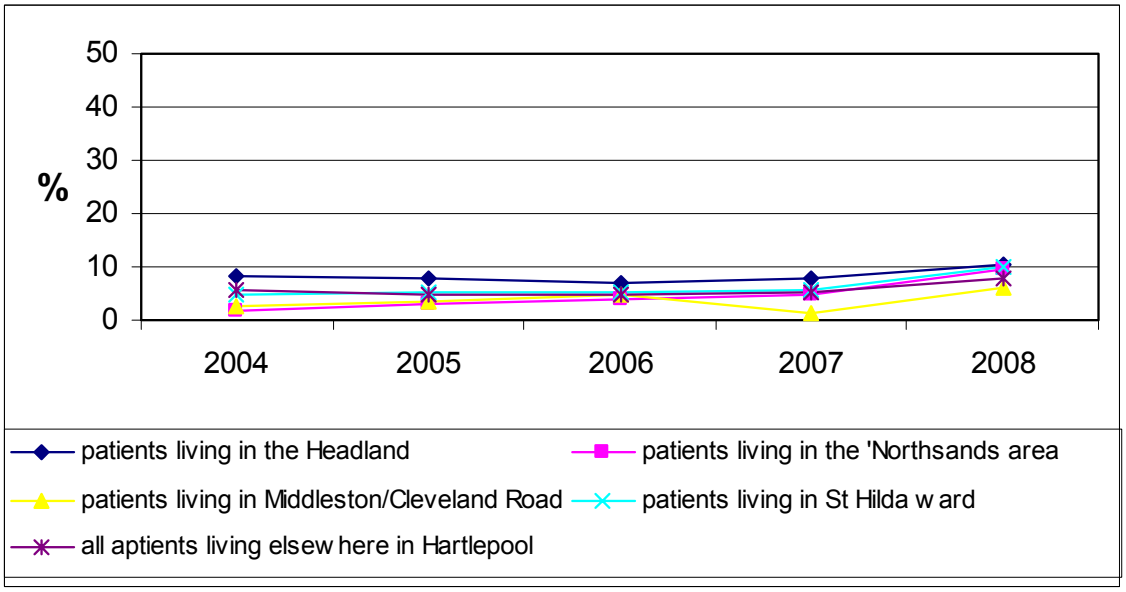
Graph 12: Prevalence rate of respiratory disease (all ages) in the Headland Practice 2004-2008



Source: Headland Practice/ Health Information NHS Tees

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

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



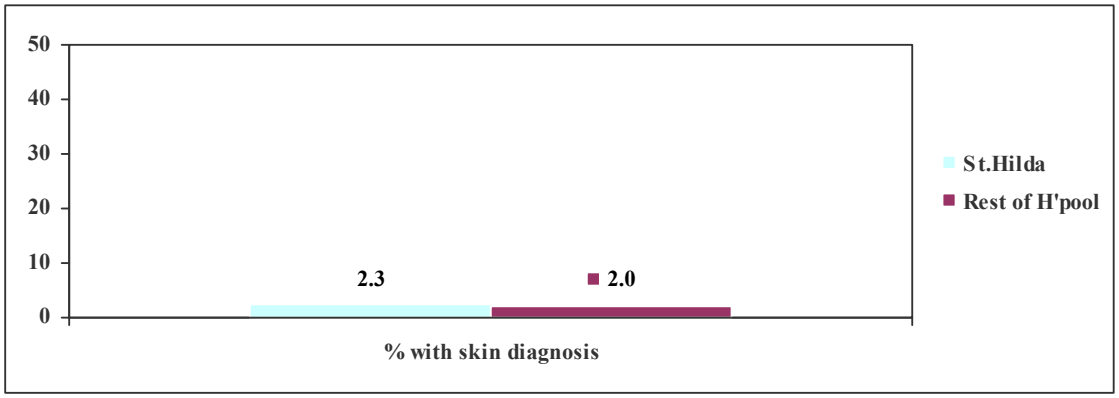
Source: Headland Practice/ Health Information NHS Tees

8.

Skin disease

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

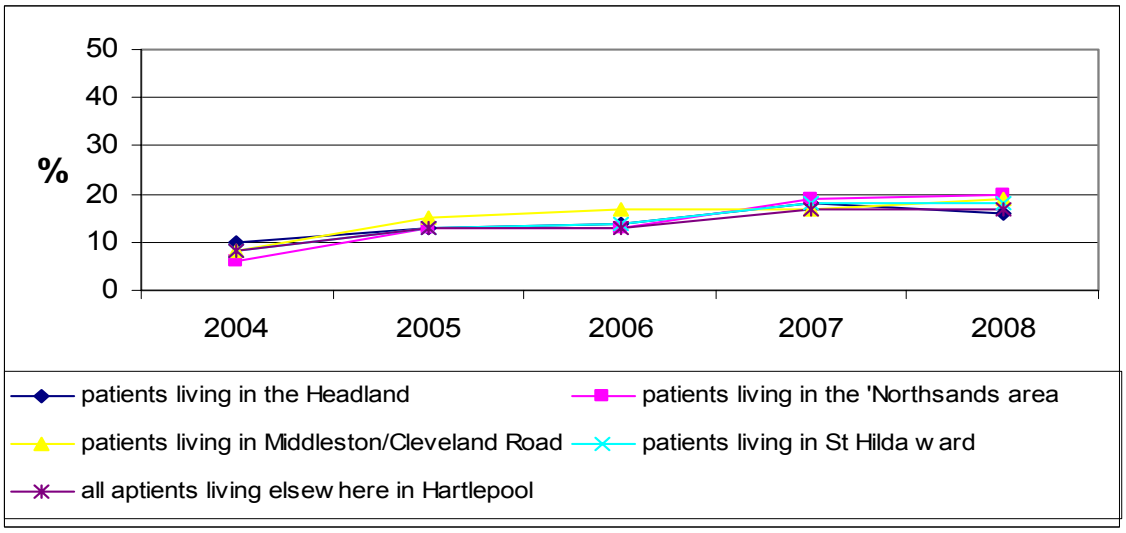
Graph 14: Prevalence rate of skin disease in the Headland Practice population 2008



Source: Headland Practice/ Health Information NHS Tees

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

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



Source: Headland Practice/ Health Information NHS Tees

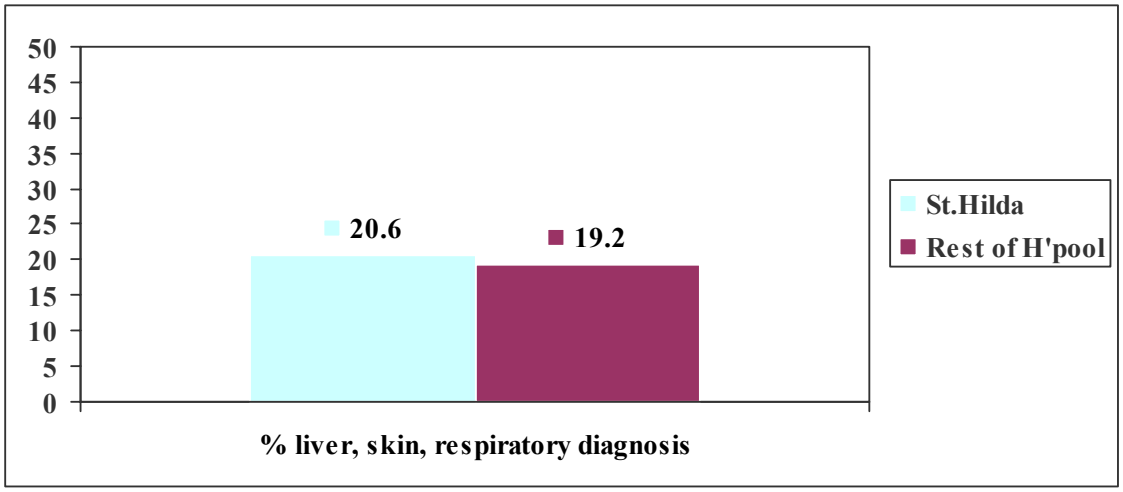
Liver disease

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

Respiratory, skin and liver disease

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

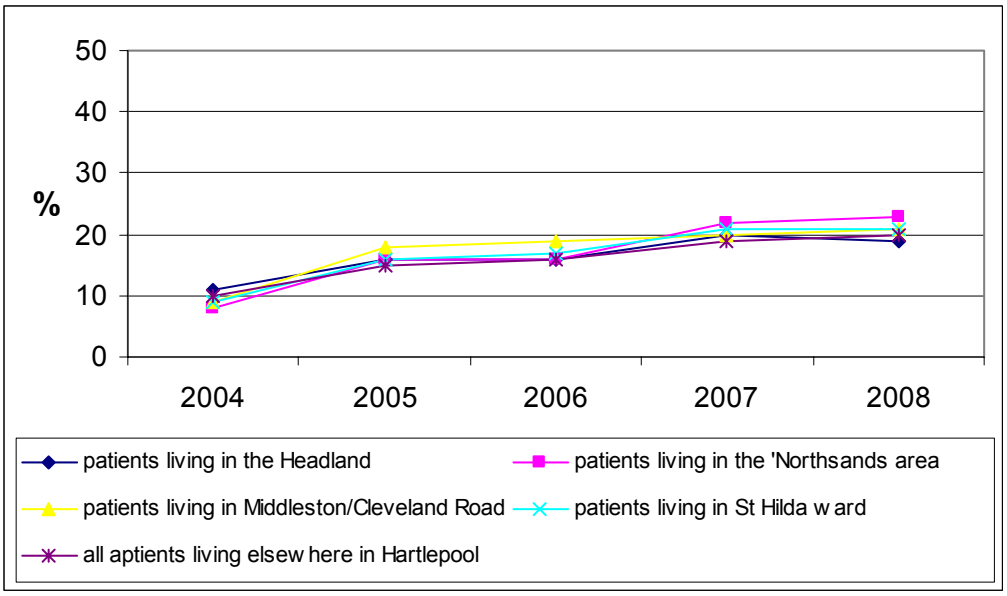
Graph 16: Prevalence rate of respiratory, skin and/or liver disease in the Headland Practice population 2008
Source: Headland Practice/ Health Information NHS Tees



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

8.

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



Source: Headland Practice/ Health Information NHS Tees

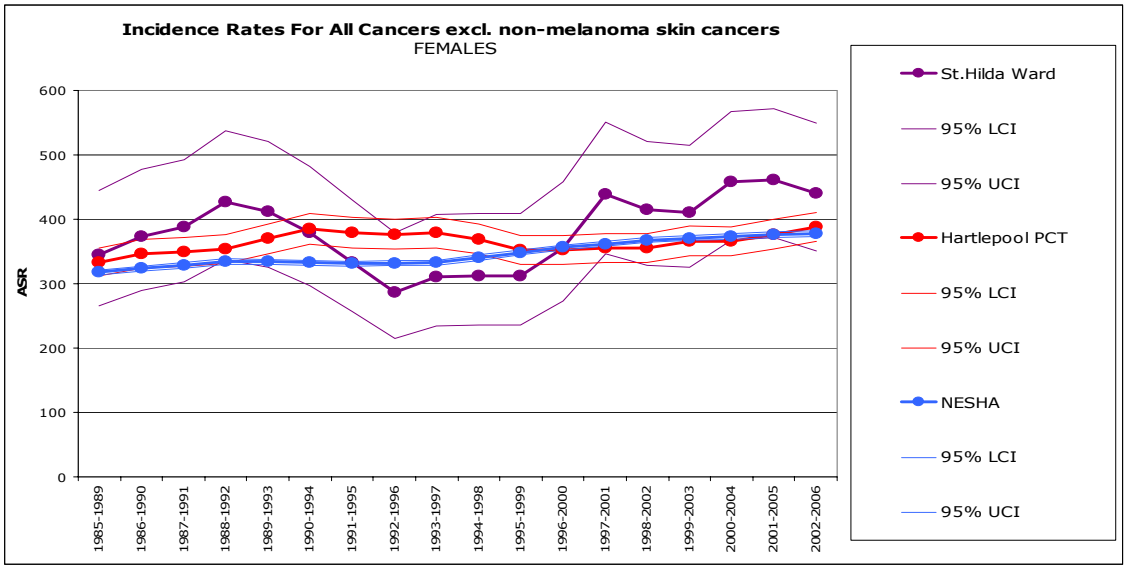
8.

Cancer

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

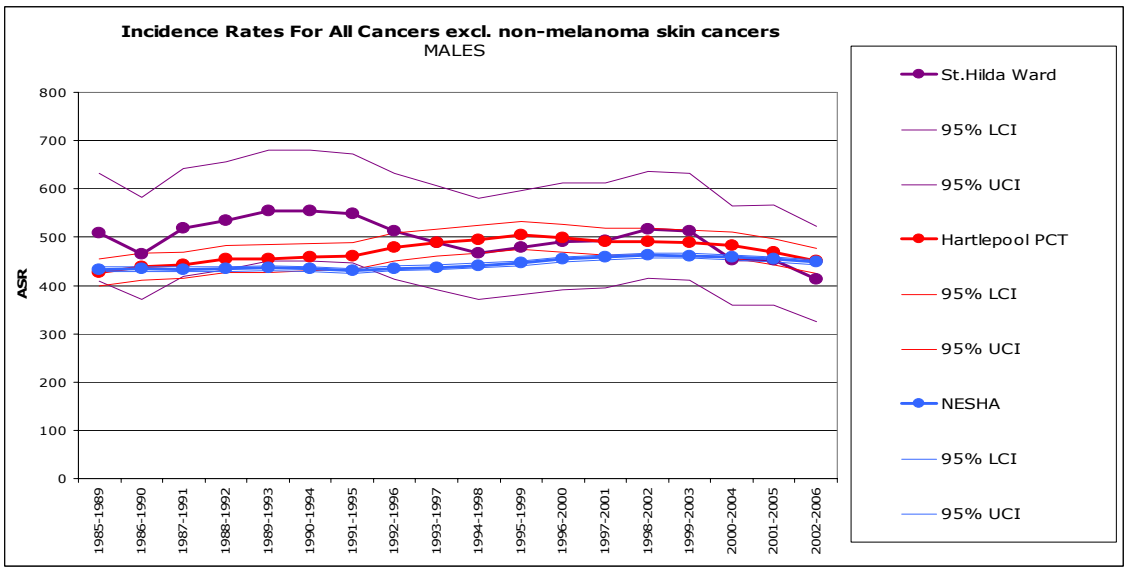
Cancer incidence has been rising for women and remained stable for men in the North East.
Cancer incidence in Hartlepool has been higher for many years but is similar to the North East in 2003-2006. Cancer incidence in St Hilda appears higher, especially in women, but the confidence intervals show no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

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



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

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

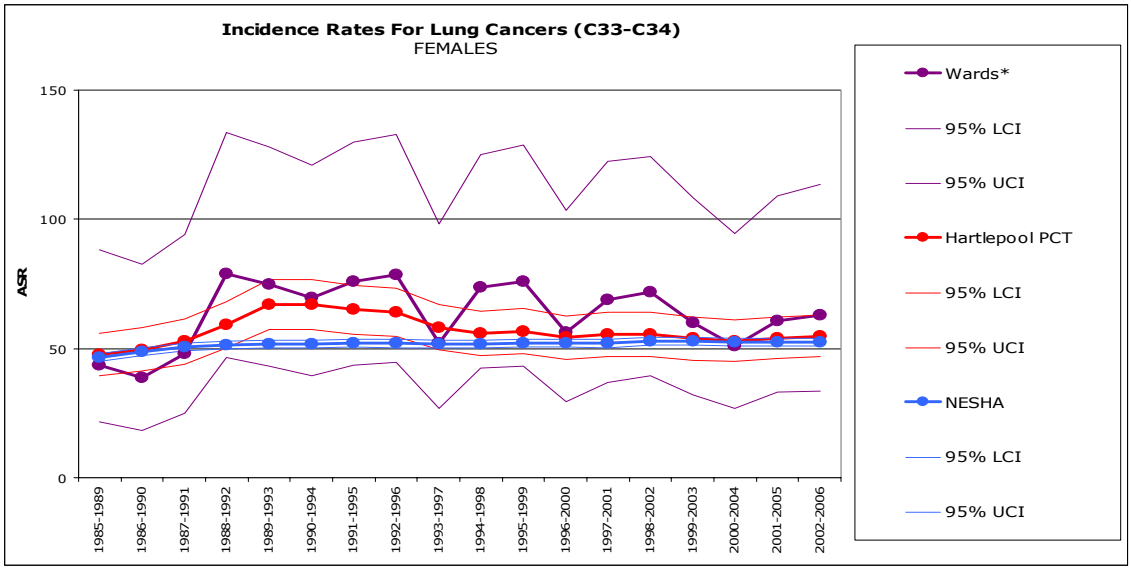


Source: NYCRIS (Northern and Yorkshire Cancer Registry and Information Service)

8.

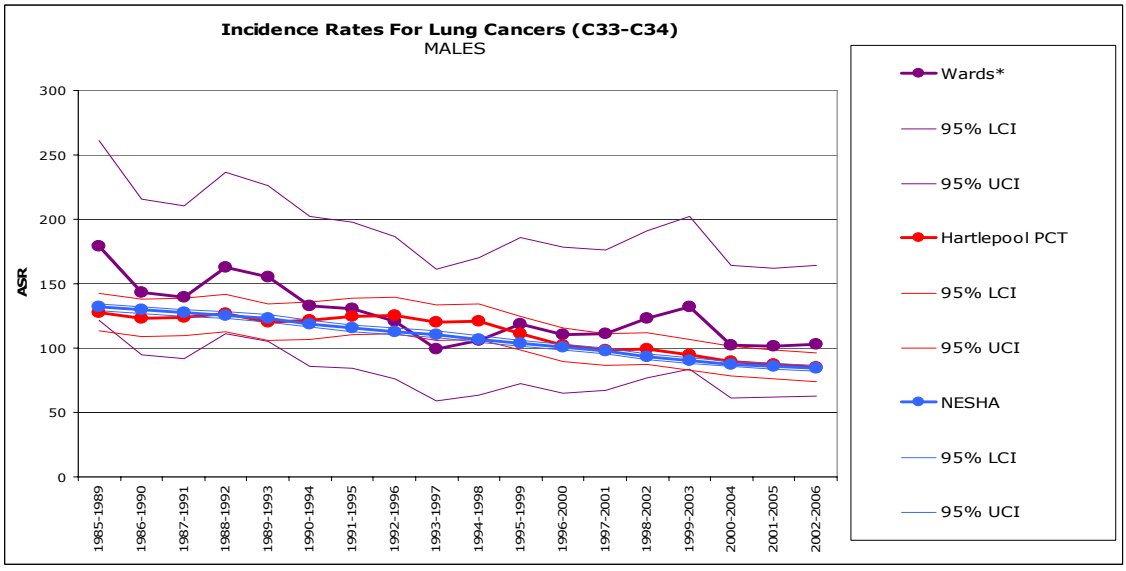
The incidence of lung cancer in St Hilda, Hartlepool and the North East has increased slightly for women and decreased notably for men. Lung cancer incidence for women in Hartlepool has been higher in the mid-1990s but is now similar to the incidence in the North East for both men and women. Lung cancer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

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



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

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



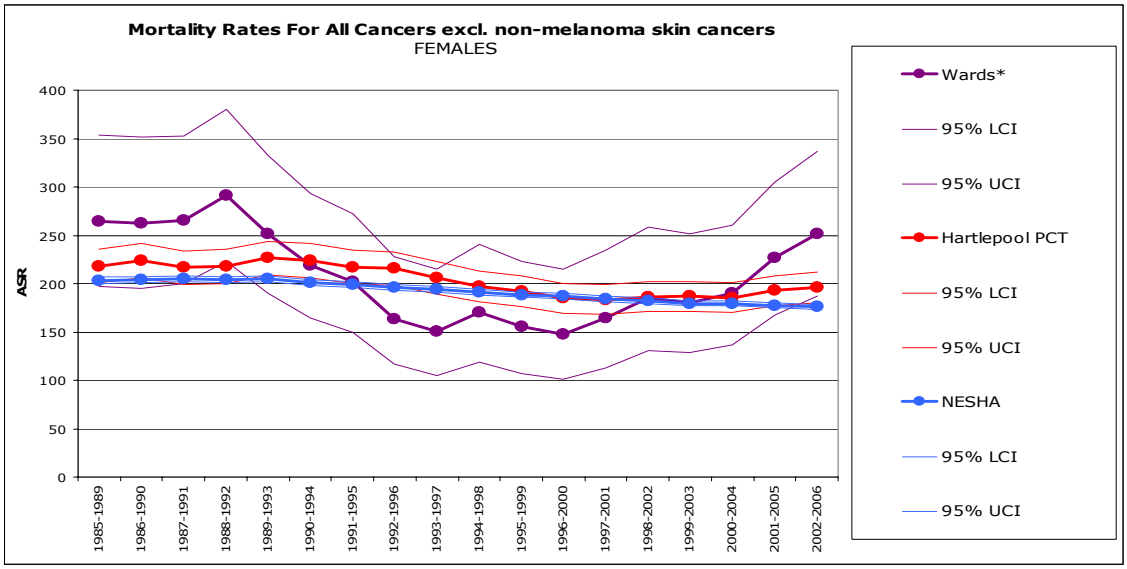
Source: NYCRIS (Northern and Yorkshire Cancer Registry and Information Service)

8.

Cancer mortality

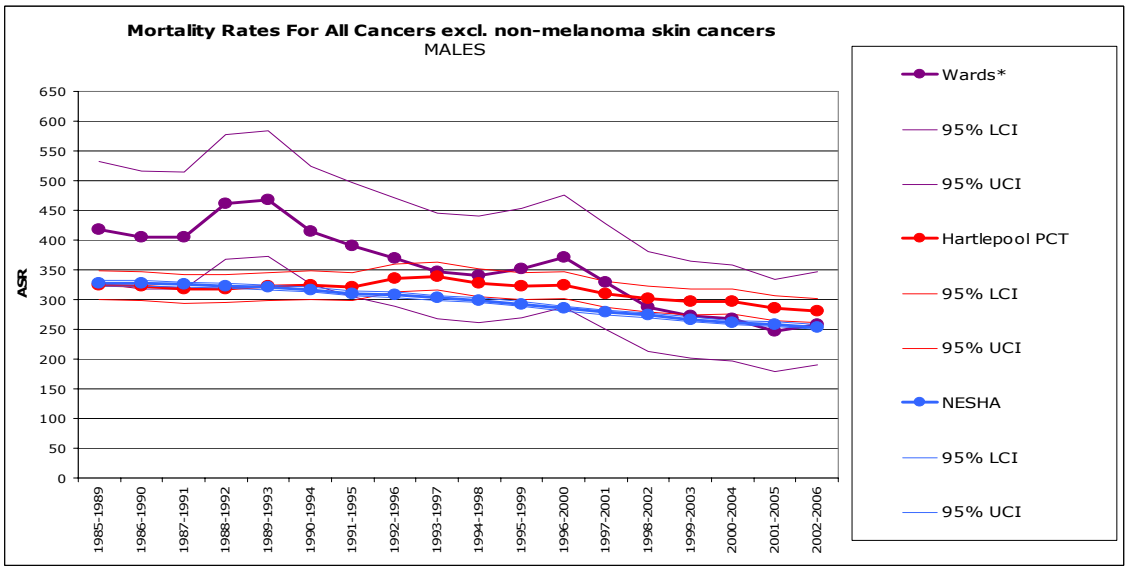
Cancer mortality has been declining in the North East for both men and women, but more markedly for men. Cancer mortality in Hartlepool has been declining but is higher than the cancer mortality in the North East for both men and women in 2003-2006. Cancer mortality in Hartlepool has been significantly higher for men since 1992. In St Hilda cancer mortality has been declining for men and is similar to the mortality in the North East and Hartlepool. Cancer mortality for women in St Hilda has declined between 1985 and 1997 but increased since 1997. In 2003-2006 mortality has been significantly higher than in the North East, but similar to Hartlepool.

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



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

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

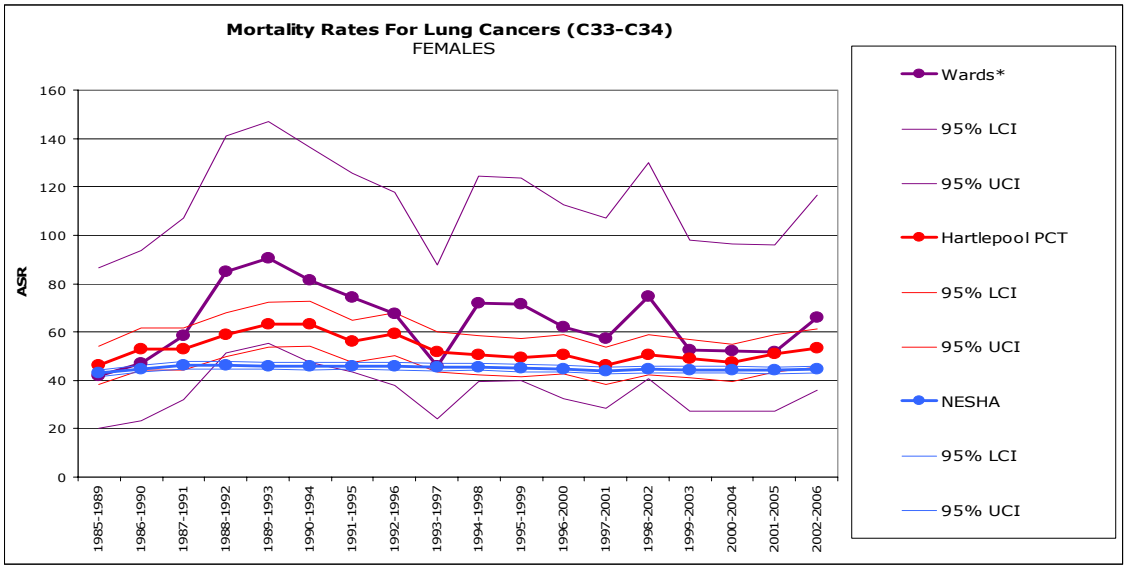


Source: NYCRIS (Northern and Yorkshire Cancer Registry and Information Service)

8.

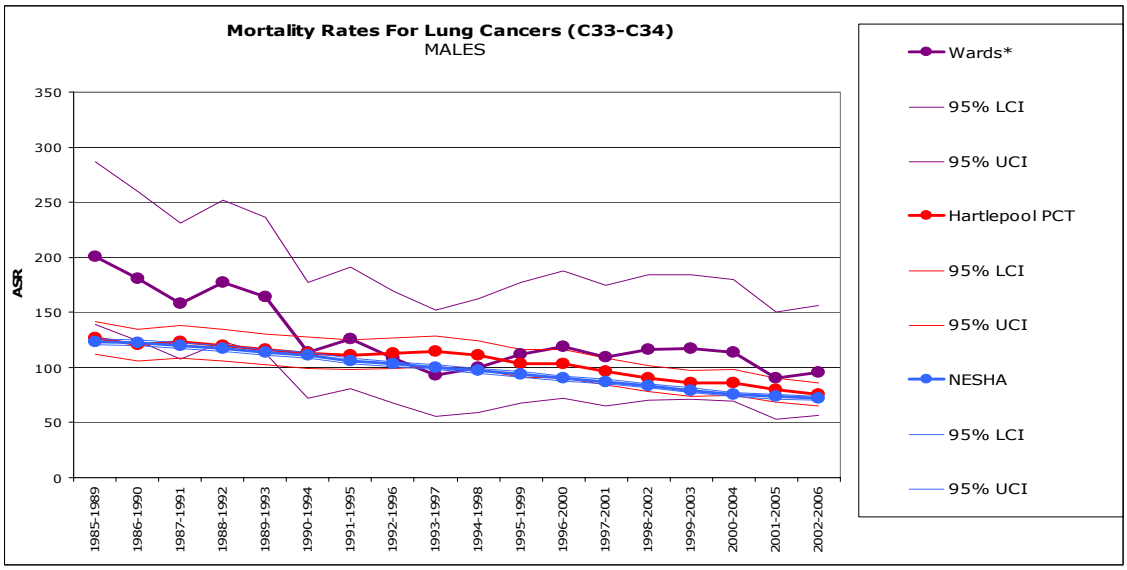
Lung cancer mortality in Hartlepool and the North East has remained the same for women and has declined for men between 1985 and 2006. Lung cancer mortality in St Hilda over the same period appears to have decreased in men and rising and falling in women, but the confidence intervals show no significant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

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



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

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



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

8.

Asbestos related disease

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

Table 9: Mesothelioma mortality: number of deaths and SMR for males by area 1981-2005

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

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

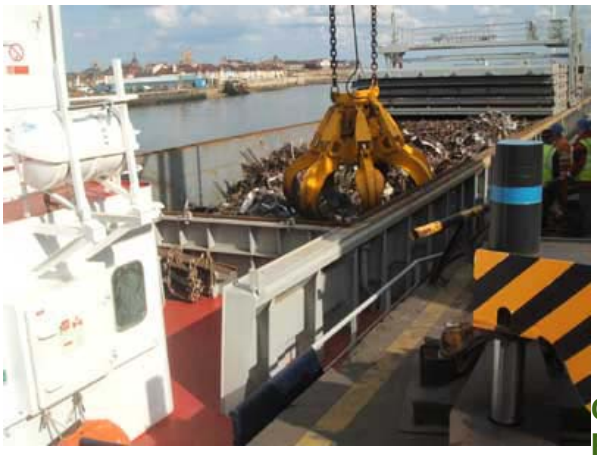
Table 10: Mesothelioma number of deaths and SMR for males and five year time periods 1981-2005

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

8.

5. Appendix

envoy case study



Case study - Environmental Nuisance Particulates

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

What did we offer?

- Air Monitoring, Analysis and Regulator/Public Liaison

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

Envoy developed a monitoring strategy that would seek to directly measure the particulates emitted at the source using pump samplers and multi-fraction particulate cyclone sampling heads. This strategy was reviewed and agreed in the liaison meeting by all parties before implementation. In addition, Envoy agreed to perform analysis on samples collected by residents that had been deposited on surfaces.


envoy report

REPORT NUMBER: 08-1072.02

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

ON BEHALF OF

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

Report Prepared by:

Envoy
12 Cherry Hills, Darton, Barnsley, South Yorkshire, S75 5NZ

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

Lessons Learned

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

8.

5. References

[1] Aluminium Production, IARC vol 34, 1984

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

[3] Titanium Dioxide, monograph, IARC 2006

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

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

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

CABINET REPORT

20 June 2011

Report of: Legal Services Manager

Subject: CALL IN OF DECISION – STRATEGY FOR BRIDGING THE BUDGET DEFICIT 2012/13 – ICT, REVENUES AND BENEFITS

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1. PURPOSE OF REPORT

1.1 To inform Cabinet of receipt of the Scrutiny Co-Ordinating Committee report as attached, under the call in procedures and to advise Cabinet on procedure following consideration of the attached report.

2. BACKGROUND

2.1 The background to the call in is set out in the Scrutiny Co-Ordinating Committee report, paragraph 1. The Scrutiny Co-ordinating Committee met to consider the Call in Notice on 14 June 2011 within the prescribed timescale and in accordance with paragraph 16 of the Call in process. On 16 June 2011, the Committee's report was received by the proper officer and is attached for consideration by the Executive as appendix 1.

3. EXECUTIVE RECONSIDERATION OF THE DECISION

3.1 The Executive are now required to consider the Scrutiny Co-ordinating Committee's comments and either :-

(a) Reaffirm the original decision

Or

(b) Modify the original decision

3.2 The Executive should then forward a response to the Scrutiny Co-Ordinating Committee via the proper officer.

3.3 The response should identify the reasons for reaffirming or modifying the decision in relation to the concerns raised by the Scrutiny Co-Ordinating Committee.

3.4 The decision will take effect the day after the Executive reconsiders the decision.

4. RECOMMENDATIONS

4.1 That Cabinet reconsider the decision as outlined in paragraph 3 above.
4.2 In doing so, provide reasons for the decision made; and
4.3 Forward the response to the Scrutiny Co-ordinating Committee via the proper officer

CABINET

20 June 2011

Report of: Scrutiny Co-ordinating Committee

Subject: CALL-IN OF DECISION - STRATEGY FOR BRIDGING THE BUDGET DEFICIT 2012/13 – ICT, REVENUES AND BENEFIT SERVICES

SUMMARY

1. PURPOSE OF REPORT

2.1 To report the outcome of the Scrutiny Co-ordinating Committee meeting on the 14 June 2011 at which consideration was given to the Call-In of the following decision taken by Cabinet on the 23 May 2011:-

Minute No. 246 – Strategy for Bridging the Budget Deficit 2012/13 - ICT, Revenues and Benefits Services.

'That a procurement exercise be commenced using the OGC Buying Solutions Framework for ICT and Revenues and Benefits services.'

2.2 To refer decision taken in Minute No.246 of Cabinet on 23 May 2011 (as outlined in section 2.1 above) back to Cabinet for further consideration.

2. SUMMARY OF CONTENTS

The report outlines the key concerns of the Scrutiny Co-ordinating Committee in relation to the 'call-in' of the decision taken by Cabinet on the 23 May 2011 in relation to the strategy for bridging the budget deficit 2012/13 in relation to ICT, Revenues and Benefits Services.

3. RELEVANCE TO CABINET

3.1 As per the Authority's Call-In procedure, the Cabinet is required to consider the Scrutiny Co-ordinating Committee's comments and respond to them. In considering comments the Cabinet has two options in terms of a way forward:-

(i) Reaffirm the original decision, or
(ii) Modify the original decision.

4. TYPE OF DECISION

4.1 Non key decision.

5. DECISION MAKING ROUTE

5.1 The decision making route is as follows:

- Cabinet on 23 May 2011;
- Scrutiny Co-ordinating Committee on 14 June 2011; and
- Cabinet on 20 June 2011.

6. DECISION(S) REQUIRED

6.1 To note the views expressed by the Scrutiny Co-ordinating Committee in response to the 'call-in' of the decision taken on the 23 May 2011; and

6.2 To reaffirm or amend the decision taken by Cabinet on the 23 May 2011 (minute no. 246 refers), setting out the reasons for doing so in response to the issues raised by the Scrutiny Co-ordinating Committee.

Report of: Scrutiny Co-ordinating Committee

Subject: CALL-IN OF DECISION - STRATEGY FOR BRIDGING THE BUDGET DEFICIT 2012/13 – ICT, REVENUES AND BENEFIT SERVICES

---

1. BACKGROUND

1.1 At the Cabinet meeting on the 23 May 2011, a report was considered in relation to the strategy for bridging the budget deficit 2012/13 in relation to ICT, Revenues and Benefits Services. Following consideration of the report / information provided Cabinet made the following decision:-

Minute No. 246 – Strategy for Bridging the Budget Deficit 2012/13 - ICT, Revenues and Benefits Services.

'That a procurement exercise be commenced using the OGC Buying Solutions Framework for ICT and Revenues and Benefits services.'

1.2 To assist Cabinet Members, an extract of the minutes from the Cabinet meeting on the 23 May 2011 are attached at **Appendix A**.

1.3 Following the decision of Cabinet, a Call-In Notice was issued by 3 Members of the Scrutiny Co-ordinating Committee on the 2 June 2011. Subject to approval of the notice by the Monitoring Office, the Call-in was received and accepted by the Scrutiny Co-ordinating Committee on the 3 June 2011. Consideration of the notice by the Monitoring Officer, however, resulted in the rejection of the notice on the grounds that 'it did not provide the relevant evidence, or reasons, being relied upon to cite that the decision had not been taken in accordance with the principles of decision making'.

1.4 In light of the rejection of the notice, an expanded Call-In notice in relation to the decision by Cabinet was issued, again by 3 Members of the Scrutiny Co-ordinating Committee, on the 6 June 2011. This notice was accepted by the Monitoring Officer on the 6 June 2011.

1.5 In accordance with the seven working day requirement for completion of Call-In's the replacement notice was accepted and details of the Call-In considered, at the Scrutiny Co-ordinating Committee on the 14 June 2011, on the basis that the decision had been taken in contravention of the principles of decision making as outlined in Article 13 of the Constitution – specifically in respect of parts:-

vi) A presumption in favour of openness; At the time of the referral to SCC it was made clear that we were not to look at the possible IT Solutions nor were we informed that the major outcome required by Cabinet was a budgetary saving of £300,000.

vii) Clarity of aims and desired outcomes; Cabinet failed to inform SCC of the desired budgetary savings or the intention to seek an IT based solution.

xii) Reasonableness; It is not reasonable to place a large number of front facing staff at risk, when there are clear alternatives, especially when the DWP may remove this work form Local Authorities in the next 2 years.

1.6 Those in attendance at the Scrutiny Co-ordinating Committee on the 14 June 2011 included the Mayor, Performance Portfolio Holder and Chief Executive and the outcomes of discussions at this meeting are outlined in Section 2 of this report.

2. KEY ISSUES / CONCERNS

2.1 The Scrutiny Co-ordinating Committee met on the 14 June 2011 to determine whether it agreed with those members who had submitted the call-in notice. The Committee discussed in detail Cabinet's decision on the basis of the grounds for Call In, as detailed in section 1.5 above. The views expressed were as follows:-

vi) A presumption in favour of openness and vii) Clarity of aims and desired outcomes (reasons as detailed in Section 1.5 above)

2.2 The Committee drew attention to the focus of the recent referral from Cabinet, in relation to proposals for the provision of revenues and benefits services and the exclusion from the referral of ICT provisions. Members were of the view that Scrutiny's inability to look at an ICT solution as part of the referral, and its subsequently heavy weighting within Cabinet's decision of the 23 May (as detailed in Section 1.1), represented a lack of openness in the decision making process in relation to this issue.

2.3 It was accepted that in considering the Scrutiny Co-ordinating Committees response to the referral, Cabinet had indicated that the recommendations made would be noted and utilised to inform the process for the development of the strategy for bridging the budget deficit in ICT and Revenues and Benefits services. Concern was, however, expressed that it had not been clear that all aspects of the revenues and benefits service would not be included in the procurement exercise. In light of this, Members were of the view that the implementation of service changes / savings identified by the Scrutiny Co-ordinating Committee in relation to those areas not included in the procurement exercise should be explored immediately, in order to optimise savings.

2.4 Reference was made within the Call-in to a requirement for a specific level of savings. Members were concerned that this figure had not been reported to Scrutiny and Members considered that a significant part of the saving required may have been identified during discussions at Scrutiny meetings. It was, however, noted that there had been concern that the disclosure of this figure

could pre-empt the bids submitted and hamper the generation of the maximum level of savings possible.

2.5 Concern was expressed regarding the apparent absence of a clear business plan. Members also queried the continued provision of financial investment into other areas (i.e. the Contact Centre and Counter-fraud Section) when savings were being sought and requested clarification as to whether investigations into other areas were being considered to identify savings. The Portfolio Holder for Performance commented that to make further savings in this area now would result in more redundancies and it was suggested that securing a contract through the OGC Framework would secure those jobs whilst achieving significant savings. It was noted that not all staff would be included within the contract and it was suggested that these areas be looked at sooner rather than later.

2.6 With reference to the outcomes of the Scrutiny Co-ordinating Committee's recent enquiry into the provision of face to face financial advice and information services in Hartlepool, the Committee was concerned that the impact of its recommendations would be diluted by the removal of an 'in house' revenues and benefits process. These concerns were taken on board by those Cabinet members present and assurances given that the value of the provision of face to face advice services was fully recognised and that the work undertaken by the Committee would be considered in the development of future service provision.

xii) Reasonableness (reasons as detailed in Section 1.5 above)

2.7 Members were concerned that a number of external factors, i.e. the Department of Work and Pensions taking over the provision of the benefits service, the potential to keep the service 'in house' and the potential implications of entering into a new ICT contract outside the current Northgate contract. The Committee welcomed clarification in relation to these issues as follows:-

(i) Department of Work and Pensions taking over the provision of the benefits service and the future. Emphasis was placed upon the impact of changes on staff and the need to protect jobs where possible (whilst recognising the need to make significant savings). Members welcomed indications that TUPE plus arrangements to protect staff would be an integral part of any contract for the revenues and benefits service and highlighted the importance of ensuring that this be clearly detailed in any contract documentation.

(ii) Keeping the service in-house. The Committee noted that this option had been examined; however, it would not achieve the level of service required through this route, without job cuts. It was confirmed that job protection was a primary consideration and that the undertaking of a procurement exercise was seen as the best way of achieving this. It was, however, made clear that whilst the undertaking of a procurement exercise was the preferred option for the way forward, should the process

fail to generate the required savings alternative options would be examined.

(iii) Implications of entering into a new ICT contract outside the current Northgate contract. The Committee welcomed assurances that any new contract would include a full process of due diligence and detailed exit and transition arrangements. In addition to this, regarding a potential extension of the current contract with Northgate it was noted that, given the length of time the contract had been in place, the most appropriate course of action would be to test the market (for a contract with a broadening scope) to ensure that the Council achieves the most beneficial / cost effective outcome for the provision of services.

2.8 The Committee was of the view that it had not been made clear that all elements of the Revenues and Benefits Service would not be included in the OGC Framework procurement exercise and on this basis the decision had contravened the principles of decision making in relation to the provision of clear aims and desired outcomes.

2.9 In recognition of the need to optimise savings without delay, Members concluded that the Scrutiny Co-ordinating Committee's recommendations for potential service changes / savings (as made in response to the recent Cabinet referral) should be explored / implemented immediately in relation to those areas of the Revenues and Benefits Service not included in the OGC procurement exercise.

3. RECOMMENDATIONS

3.1 That the Committee disagreed with Cabinets decision of the 23 May 2011 (Minute 246) as detailed in Section 1.1 above, in that it contravened the principles of decision making in relation to the provision of clear aims and desired outcomes. *(The basis for this decision is outlined in Section 2.8 above)*

3.2 That the decision be referred back to Cabinet for further consideration.

3.3 That in reconsidering its decision the Scrutiny Co-ordinating Committee recommends to Cabinet that in order to optimise savings, the Scrutiny Co-ordinating Committee recommendations for potential service changes / savings (as made in response to the recent Cabinet referral) should be explored / implemented immediately in relation to those areas of the Revenues and Benefits Service not included in the OGC procurement exercise.

MINUTE EXTRACT

CABINET

MINUTES AND DECISION RECORD

23 May 2011

The meeting commenced at 9.15 am in the Civic Centre, Hartlepool

Present:

The Mayor, Stuart Drummond - In the Chair

Councillors: Jonathan Brash (Performance Portfolio Holder)
Robbie Payne (Deputy Mayor) (Finance and Procurement Portfolio Holder),
Gerard Hall (Adult and Public Health Services Portfolio Holder).
Hilary Thompson (Culture, Leisure and Tourism Portfolio Holder),

Also Present: Councillor Jane Shaw, Chair of Adult Services Scrutiny Forum
Councillor Stephen Thomas, Chair of Neighbourhood Services Scrutiny Forum
Councillor Ray Wells
Edwin Jeffries, Hartlepool Joint Trades Union Committee

Officers: Paul Walker, Chief Executive
Andrew Atkin, Assistant Chief Executive,
Chris Little, Chief Finance Officer
Tony MacNab, Solicitor
Joanne Machers, Chief Customer and Workforce Services Officer
Nicola Bailey, Director of Child and Adult Services
Danielle Swainston, Sure Start, Extended Services and Early Years Manager
Dave Stubbs, Director of Regeneration and Neighbourhoods
Damien Wilson, Assistant Director, Planning and Regeneration
Graham Frankland, Assistant Director, Resources

Alistair Rae, Public Relations Manager
Joan Stevens, Scrutiny Manager
Elaine Hind, Scrutiny Support Officer
David Cosgrove, Democratic Services Team

246. Strategy for Bridging the Budget Deficit 2012/13 – ICT, Revenues and Benefits Services (*Chief Executive*)

Type of decision

MINUTE EXTRACT

Non-key.

Purpose of report

To enable Cabinet to make a decision in respect of the proposed options available in respect of ICT and Revenues and Benefits services and their contribution to addressing the budget deficit in the available timescales.

Issue(s) for consideration by Cabinet

The Performance Portfolio Holder reported Cabinet have received three reports (on 24th January 2011, 7th February 2011 and 8th April 2011) which had identified and provided options and proposed recommendations in respect of the potential benefits from and the procurement route for a revised delivery mechanism for ICT and Revenues and Benefits services.

At the meeting in February 2011, Cabinet determined to refer this matter to Scrutiny for consideration with particular reference to the Revenues and Benefits element and the report from Scrutiny Co-ordinating Committee was considered on 8th April 2011.

Cabinet agreed on 8th April that further investigation of the following options be undertaken and reported back to Cabinet at the earliest opportunity taking account of the timescales required for identifying the future of the services in question and the recommendations of the Scrutiny investigation reported earlier in the meeting: -

(i) A procurement exercise is undertaken using the OGC Buying Solutions Framework for ICT and Revenues and Benefits services.
(ii) Scrutiny Co-ordinating Committee's recommendations for Revenues and Benefits Services would be considered as part of whichever delivery option is chosen.
(iii) Other local authorities be approached quickly about what opportunities there are for working together.
(iv) Early stages of testing the market, as part of the procurement process, would be undertaken.
(v) The options and implications of a joint venture vehicle be researched.

Additionally the recommendations of the Scrutiny Coordinating Committee's review of the proposals for the provision of the revenues and benefits service, as referred by Cabinet on 7 February 2011, were noted and utilised to inform the process of the development of the strategy for bridging the budget deficit in the ICT and Revenues and Benefits services for 20112/13.

The Mayor reported that discussions had been held with the other Tees Valley authorities on the potential for working together. These had not proved fruitful as the other authorities were not at the same stage and had differing needs. There had been comment that they would be looking to achieve savings as well from any arrangement.

There was extreme concern expressed by one Cabinet Member that the potential for joint working had not been explored further than the four Tees

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Valley authorities. The proposal also did not contain any projected savings or a business case for the proposed procurement exercise.

The Chief Executive assured Cabinet that no agreement would be entered into unless there were definable savings for the authority. Any contract with an external company would be designed to build upon the high level of transferable skills in the current staff.

The Mayor referred to the letter submitted by the Hartlepool Joint Trades Union Committee and stressed that in his opinion the fundamental driver behind this process was to protect as many jobs in Hartlepool as was possible. These service areas could not be isolated from the budget cuts and outsourcing was not something that we would want to do as a matter of course. However, the Government's changes to benefits and the introduction of the Universal Credit were going to have a major affect in any event. Bringing a contractor in to utilise the skills of the current staff in developing a regional hub for this type of work had to be seen as a positive.

Cabinet discussed the issues surrounding the utilisation of the OGC Buying Solutions Framework. The Assistant Director, Resources stated that advice had been taken from OGC Managers on the utilisation of the ICT framework for Revenues and Benefits. Independent legal advice had also been sought and later in the debate, members requested that a copy of the advice be circulated to Cabinet. Again a Cabinet Member expressed deep concern at using the list proposed which was not a specialised Revenues and Benefits list and didn't contain some of the companies that could be anticipated to undertake this kind of work. The member indicated their opposition to the recommended proposal to enter into a procurement exercise. Legal advice was also sought on the involvement of senior officers of the authority that had been involved in endorsing the service of one of the companies on the list.

The Trades Union representative was invited to comment further on the letter submitted by HJTUC. The representative indicated that the unions shared concerns in relation to the use of the OGC Buying Solutions Framework and that they were minded to challenge the procurement process.

In concluding the debate, the Mayor indicated that the legal advice sought on the process should be shared and revisited to ensure that the proposed procurement exercise route was strong enough to resist challenge. In seeking the views of the Cabinet Members present (Councillor Payne having left the meeting) on the recommendations, there was an unanimous indication of support.

Decision

That a procurement exercise be commenced using the OGC Buying Solutions Framework for ICT and Revenues and Benefits services.

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The meeting concluded at 11.25 a.m.

P J DEVLIN

CHIEF SOLICITOR

PUBLICATION DATE: 31 May 2011