HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL BOROUGH COUNCIL

Thursday 6 October, 2011

at 10.00 a.m.

**in Committee Room B,
Civic Centre, Hartlepool**

MEMBERS: HEALTH SCRUTINY FORUM:

Councillors S Akers-Belcher, Griffin, James, G Lilley, Preece, Robinson, Shields, Sirs and Wells.

Resident Representatives: Maureen Braithwaite, Norma Morrish and Ian Stewart.

1. **APOLOGIES FOR ABSENCE**

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

3. **CONFIRMATION OF THE MINUTES OF THE MEETING HELD ON 8 SEPTEMBER 2011**

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

   4.1 Portfolio Holder's Response to Connected Care - *Joint Report of Child and Adult Services and the Portfolio Holder for Adult's and Public Health*

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

   No items.

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

   No items.

7. **ITEMS FOR DISCUSSION**

Scrutiny Investigation into Cancer Awareness and Early Diagnosis

7.1 Evidence from Member of Parliament for Hartlepool and the Portfolio Holder for Adult's and Public Health

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

(b) Verbal Evidence – *Member of Parliament for Hartlepool and the Portfolio Holder for Adult's and Public Health*

7.2 Setting the Scene:-

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

(b) Presentation – *Assistant Director for Health Improvement and the Specialty Registrar in Public Health, NHS Tees*

North Tees and Hartlepool NHS Foundation Trust

7.3 Governors – *Scrutiny Support Officer*

7.4 Quality Account 2012/13 – Forum Response – *Scrutiny Support Officer*

Health Scrutiny Roadshows

7.5 Scoping Report – *Scrutiny Support Officer*

8. **ISSUES IDENTIFIED FROM FORWARD PLAN**

8.1 The Executive's Forward Plan – *Scrutiny Support Officer*

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

No items.

10. **REGIONAL HEALTH SCRUTINY UPDATE**

No items.

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

ITEMS FOR INFORMATION

Date of Next Meeting: Thursday 17 November 2011 at 10.00 a.m. in the Civic Centre, Hartlepool.

HEALTH SCRUTINY FORUM

MINUTES

8 September 2011

The meeting commenced at 10.00 a.m. in the Civic Centre, Hartlepool

Present:

Councillor Stephen Akers-Belcher (In the Chair);

Councillors: Sheila Griffin, Geoff Lilley, Arthur Preece, Jean Robinson, and Ray Wells.

Resident Representative: Ian Stewart

Also Present: In accordance with Council Procedure Rule 4.2;
Councillor Mick Fenwick as substitute for Councillor Linda Shields
Councillor Carl Richardson as substitute for Councillor Kaylee Sirs
Councillor Marjorie James as substitute for Councillor Chris Simmons
Councillors Brenda Loynes and Edna Wright.
Resident Representative Mary Green

Jan Atkinson, Assistant Director of Public Involvement and Information Governance, North Tees & Hartlepool NHS Foundation Trust,
Sue Smith, Director of Nursing and Patient Safety, North Tees & Hartlepool NHS Foundation Trust,
Carole Langrick, Deputy Chief Executive / Director of Strategic Service Development, North Tees & Hartlepool NHS Trust,
Gill Carton, Associate Director (Emergency Care), North Tees and Hartlepool NHS Foundation Trust,
Joanne Dobson, Assistant Director Health Systems Development at NHS Tees
Dr Nick Timlin, Local General Practitioner

Officers: Louise Wallace, Assistant Director, Health Improvement
James Walsh, Scrutiny Support Officer
David Cosgrove, Democratic Services Officer

16. Apologies for Absence

Councillors Linda Shields, Chris Simmons and Kaylee Sirs.

17. Declarations of Interest by Members

None.

18. Minutes of the meeting held on 11 August 2011

Minute 10 "Determining the Scrutiny Forum's Work Programme for 2011/12" – A Member indicated that the minute included reference to the minutes of the A and E Steering Group being circulated to Members. The Member complained that this had not yet happened and questioned when it would. The Chair indicated that he would endeavour to ensure the minutes were circulated to Members at the earliest opportunity.

Minutes confirmed.

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

No items.

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

No items.

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

No items.

22. North Tees and Hartlepool NHS Foundation Trust – Quality Account 2012/13 (*Scrutiny Support Officer*)

The Scrutiny Support Officer indicated that representatives from North Tees and Hartlepool NHS Foundation Trust had been invited to the meeting to engage with Members in respect of the Trust's Quality Account 2012/13. Sue Smith, Director of Nursing and Patient Safety, gave a presentation to the forum outlining the outcomes of the Quality Accounts for 2011/12 and the development of the key priorities for 2012/13. Areas highlighted for possible key priorities for 2012/13 were Mortality, Effectiveness and Patient Experience. It was highlighted that any suggestions the forum had would be fed into the consultation process for the development of the Quality Accounts. The Trust was looking for feedback from all key stakeholders by the end of October so that the final draft could be completed by the April 2012 deadline. The key issue was that whatever was suggested had to be measurable.

The Chair commented that he welcomed the change in the way the development of the Quality Accounts was being communicated to the forum and key stakeholders as a significant improvement over recent years. The Chair questioned if input into the Quality Accounts was open to staff and

that such input was confidential. Sue Smith commented that this was very much the case and that staff had clear and open channels of communication and nothing to fear from feeding into this process.

The Chair opened the debate to the forum to suggest their priorities to be included in the Quality accounts for 2012/13. Members made the following points during the debate which were responded to by the Trust's representatives where appropriate: -

- Dementia patients – monitoring of feeding when in hospital and also monitoring of falls in hospital and at home following diagnosis.
- Communication within care settings. Several IT systems were in use and the communication of information between the systems needed to be more 'joined up'.
- Assessment Teams and Social Worker Teams needed to have improved links to ensure patients were getting the proper care packages.
- Monitoring of community based provision – was this being undertaken and how? There were recent reports in the press of people being dissatisfied.
- The Director of Nursing and Patient Safety commented that the Trust had very robust assessment processes. The care of over 100 patients was reviewed each month. Patients were questioned on their care each month; did they understand their care package and medication etc. Patients were spoken to independently. It was a proactive process and where there were complaints, the Trust did offer to meet people as their views were important. It had to be stated that not everything that had been reported in the press recently was based on fact. Across the UK, complaints had risen 30%, in Hartlepool the level of complaints was 40% lower than the national average.
- Health Trust Governors and Trust Governance – Members sought details of the governors and attendance statistics at Trust meetings. The Chair considered that it would be useful for the Forum to receive a briefing paper on these points. The Director of Nursing and Patient Safety did consider that the governors' attendance was good and they did regularly go out to speak to patients directly.
- While the complaints statistics quoted appeared encouraging, were they falling due to patients feeling that nothing happened when they did complain so felt that there was little point in making the complaint in the first place.
- Concern was raised at the experiences some patients had reported to Councillors in relation to discharge from hospital at the weekend. Patients were often not approved for discharge until late in the day. If this happened at the weekend, patients had found themselves unable to get ambulance transport home until Monday so were having to stay in hospital over the weekend if they had no family to collect them or they could not afford a taxi. The Trust's representatives indicated that they would discuss these cases with the Councillor and investigate.
- Details of the origins of the suggestions for the key priorities would be useful information for the forum.
- MacMillan had introduced community workers based in a community

setting to work and support the families of cancer sufferers. A similar community based worker for the families of people with dementia could help families through the very challenging time a close relative with dementia could bring to a family.

- Patient experiences – there appeared to be a problem with out-patient appointments being rescheduled, in some cases up to five times, pushing back the date a patient was seen in a specialist's clinic. The Trust's representatives indicated that they would discuss these cases with the Councillor and investigate.
- A resident representative complained that the muscular-skeletal service was based on the second floor of the One Life Centre making it more difficult to access for some patients than the previous service at the hospital which was on the ground floor.

The Chair thanked the Trust's representatives for their presentation and involvement in the forum's debate. It was indicated that a report would be submitted to the October meeting of the forum to allow members to consider further and prioritise their suggested key priorities for the 2012/13 Quality Accounts.

Recommended

1. That the Trust's representatives be thanked for their presentation and involvement in the forum's debate.
2. That a report would be to the October meeting of the forum to allow members to prioritise the forum's suggested key priorities for the 2012/13 Quality Accounts.

23. Emergency Assessment and Minor Injuries in Hartlepool: An Update (*Scrutiny Support Officer*)

The Scrutiny Support Officer introduced the representatives from North Tees and Hartlepool NHS Trust, Carole Langrick, Deputy Chief Executive / Director of Strategic Service Development and Gill Carton, Associate Director (Emergency Care), together with Joanne Dobson, Assistant Director Health Systems Development, NHS Tees and Dr Nick Timlin, a local General Practitioner.

Carole Langrick, Deputy Chief Executive / Director of Strategic Service Development, gave a presentation to the Forum outlining the process of the reconfiguration of the Accident and Emergency services in Hartlepool and the introduction of the Minor Injuries Unit at the One Life Centre on Park Road. It was highlighted that there had been fewer attendances at the A&E Unit at North Tees Hospital than expected since the changes to A&E in Hartlepool were introduced on 2 August. It was considered that this had been due to people seeking treatment at the most appropriate venues. It was also indicated that no out-patient clinics had been cancelled due to the reconfiguration of the A&E services.

The Deputy Chief Executive went onto update the Forum on the development of the new hospital. The Trust was to meet the Department of Health on 14 September to seek final clarification of the proposals with

Ministerial 'sign-off' for the scheme expected in October. The Treasury would then have thirty days to consider the proposals and once approved, the advert in the Official Journal of the European Union was anticipated before the end of November.

In accordance with the recommendation of the External Review of Hartlepool Accident and Emergency Services in March 2011 "There needs to be further wide and transparent dialogue with the public about the future of all services in Hartlepool – and resolution of the urgent care services plan should not stop that dialogue which must continue with sufficient detail for people to understand the 'steps along the way' as well as the end point 'vision'". The Deputy Chief Executive indicated that there would also be engagement with the Forum through the 'Roadshows' and then wider engagement with the public involving discussion groups with the commissioners and clinicians.

In response to some of the issues raised earlier in the meeting, The Deputy Chief Executive indicated that the Trust was facing reductions in its budget of £16.5m this year and the next two financial years. The new hospital plan was as much a response to the financial future of the Trust as it was when originally conceived. As for the recruitment of doctors; the Trust had always found it difficult to bring new doctors to Stockton and Hartlepool. The long term effects of this were those now being felt in A&E services for example. Dr Timlin added that it was essential to the North Tees Area that it got a new hospital. The South Tees Hospital had made a huge difference to services south of the river Tees. Some GP's in Hartlepool were starting to use a computer based diagnosis system that was allowing them to treat more patients within the surgery rather than referring them to hospital. Admission through A&E for example was a very expensive way to be admitted to hospital.

The Chair opened the meeting to debate and questions –

- A Member considered that the assertion that no out-patient clinics had been cancelled was incorrect. The Deputy Chief Executive commented that clinics did get cancelled from time to time because of various reasons, but none had been cancelled due to the move to the OneLife Centre.
- There were reports of trauma patients being moved from Hartlepool to North Tees Hospital. The Trust indicated that this would be the case as the trauma Unit had transferred to North Tees Hospital five years ago.
- How accurate were the Trust's forecasts on the numbers anticipated to use OneLife if they were already more people attending than expected. The Trust indicated that the forecasts were based on use of services to date. The higher end of the forecasts had been used so that the facility was staffed to cope with the number of patients it received. The figures would be evaluated fully after six months of operation of the new facility but daily numbers were also monitored to assess any surges in patient numbers. The Trust also liaised with the North East Ambulance Service (NEAS) weekly on patient numbers and

emergencies etc. The Trust did not see any reason to change the operational staffing levels at the moment based on the use of the OneLife Centre to date

- The stories on the front page of the local press were disturbing and it had to be accepted that it did take a lot for someone to contact the press to make such a complaint. The Chair considered that communication needed to be revisited as it was clear from the stories and peoples own experience that some were not aware of where they should go and often attended the wrong venue. Even seemingly well-informed people in emergency situations were left having to find out where to go first rather than just going. These issues needed to be addressed urgently.
- The Trust recognised that not one communication route would fit all cases and they had tried to use as many information routes as possible to let people know of the changes to service delivery. Communication needed to be ongoing and the Trust would welcome any suggestions for information venues etc that could be put forward.
- A Member commented that the Trust had promised a leaflet to every home but they had not received one. A Trust representative commented that she too had not received a copy of the leaflet that although an 85% delivery rate had been promised this may not have been the case and distribution was being reviewed.
- After being told that the A&E Unit had to close because it was unsafe, people were now relating their own experiences, some through the press, which were that the walk-in wounded clinic at the OneLife Centre was unsafe. The Trust commented that they were satisfied that the OneLife Centre was very safe. The original A&E Unit at the University Hospital of Hartlepool on an evening was staffed with junior doctors without there being sufficient supervision and this therefore made the facility unsafe.
- A Member considered that there was clear concern in the community as to the costs of the new hospital and how much of 'our' health care budget was going to be lost each year through paying PFI debt. The Deputy Chief Executive indicated that she was not going to defend PFI. The Trust would have preferred the previous funding route but that was now no longer open to them. Once people had a detailed understanding of the services that were to be provided through the new hospital and venues like the OneLife Centre they would have a clearer picture as to why the Trust saw the new hospital as part of the solution to the financial situation it had to face in the future. Maintaining two sites was unviable, uneconomic and to the detriment of patients.
- There was concern that by the time the Trust conducted its workshops to inform the public, the new hospital would have been approved and the Trust committed to its implementation.
- Many residents saw the transfer of services out of Hartlepool as unacceptable as it wasn't about patient benefit but simply about costs. The Deputy Chief Executive agreed that some decisions were about costs. The decision on the A&E services at Hartlepool had been purely on safety alone. The Chair commented that many did not want to see the services leave Hartlepool until the new hospital had been

built. The traffic also seemed to be one way; what services could come form North Tees to Hartlepool? If there were to be two hospitals until the new one was built, then the Trust needed to be serious about providing services at Hartlepool. The Deputy Chief Executive indicated that as a Trust they could only provide the services they were commissioned to provide. Where services could be enhanced they would be; urology and cardiac services were two particular cases in point. Services would also be kept in Hartlepool but transferred to the OneLife Centre. It was a building fit for purpose and one GPs were looking at to keep services local. Dr Timlin commented that GPs were glad to see the new OneLife Centre open. It had to be seen as a new form of hospital for the community. Services in general on the north side of the river needed to compete better, particularly against those available at South Tees Hospital.

- The Chair requested a presentation on the changes to service delivery in Hartlepool to be given to the Forum.
- The issue of attracting doctors and other staff to Hartlepool was questioned. The Deputy Chief Executive commented that while she was not a recruitment expert, there had been a long-standing problem in recruiting doctors in this area. The North Tees and Hartlepool hospitals weren't big regional centres or teaching hospitals and therefore the Trust had to fight hard to get doctors to come here. There were certain specialities where there were shortages nationally. The three difficult areas for recruitment were A&E specialists, anaesthetists and paediatricians. The Trust does as much as they can to promote the area and the hospitals but specialist health professionals choose not to come.
- A Member commented that they understood that the Health Scrutiny Forums 'Roadshows' were open to everyone not just Members. The public needed to be able to participate in the roadshows. The Chair gave his commitment to the roadshows being open to the public and considered that they were an opportunity to have meaningful and honest debate on health care in Hartlepool.
- There were serious financial deprivation issues in certain parts of Hartlepool. Many people had found travelling to North Tees Hospital a serious cost burden despite the fact that many could claim the costs of their travel. However the only available venue to collect the forms in Hartlepool was the Job Centre. Why was this the case and couldn't these forms be available through GP surgeries and other venues.
- The Chair considered that front line staff should be asking people how they were getting home and making patients and their families aware of the potential to claim travel costs; the Trust and the PCT needed to take this forward. The hospitals needed to be accessible to the public wherever they were located. The Trust indicated that they would pursue this issue. The use of ambulances to transport patients to and from hospital took them out of service for other users. Where possible staff did encourage family and fiends to collect patients on discharge from hospital so they were going with someone who would see them home safely. The Trust had previously run a shuttle bus service that had been withdrawn through underuse. A Member commented that the bus service had been under-used as people had to book to use it

24 hours in advance. How would most people know they needed it 24 hours in advance?

- There was a view expressed by a Member of the public that Hartlepool had previously had a highly rated hospital with high quality services such as the A&E unit but they had been allowed to deteriorate to the point they were being closed and removed from the town. People believed someone should be held responsible for this and disciplined. The Trust should have the honesty to say they got it wrong and put the services back to the standard they previously were. The people who were complaining in the press were the tip of the iceberg.
- Dr Timlin restated his strong belief that the services at the OneLife Centre were high quality safe services. Ambulatory care meant that people did not need to go to hospital and that was what was provided at OneLife. If people subsequently needed an operation to resolve an injury for example, then they would be transferred to Stockton.
- There was concern expressed at the quality of the staff at the OneLife Centre. When attending an A&E Unit people were seen by expert staff. People did not have confidence that they were being seen by expert staff as they appeared not to have been doing a god job at diagnosing people. There were other concerns expressed at Nurses dispensing medicine at the OneLife Centre rather than doctors. The view was expressed that people would rather see a junior doctor than a nurse. The Trust commented that the OneLife Centre was a 'walk-in' centre and staff wouldn't expect to see major injuries regularly as these would be taken straight to A&E at North Tees. People were appropriately triaged to the right services. The pathways to care were just the same as before just in a different building. Junior doctors needed senior supervision and the simple fact was that there weren't enough of them to provide a safe service. There is a GP on duty at the OneLife Centre and the truth was that the majority of people that attended A&E could have gone to see their own GP. The Emergency Assessment Unit was still in place at Hartlepool Hospital but no one should be self-referring themselves there; referrals would only come from a health care professional such as a GP, Consultant, Ambulance Paramedic or the OneLife Centre.

The Chair thanked the Trust representatives for their involvement in the meeting and their responses to the questions.

Recommended

That the report be noted and the representatives from North Tees and Hartlepool NHS Trust and NHS Tees be thanked for their presentation and response to Member and public questions.

24. Scrutiny Investigation into Cancer Awareness and Early Diagnosis – Scoping Report (*Scrutiny Support Officer*)

The Scrutiny Support Officer reported on the proposals for the Forum's forthcoming investigation into Cancer Awareness and Early Diagnosis. The aim of the investigation was 'to evaluate the effectiveness of the delivery of early detection and awareness raising programmes for cancer, with specific

reference to smoking cessation services'. The following Terms of Reference for the investigation/review were proposed:-

(a) To gain an understanding of the levels of cancer in Hartlepool;
(b) To explore the methods for early detection and screening of cancer;
(c) To assess the impact and delivery of smoking cessation services; and
(d) To examine the impact of cancer awareness raising activities in the Town and what more can be done to improve outcomes for patients.

The report went on to set out the potential areas of enquiry / sources of evidence and the proposed timetable for the investigation which was targeted to conclude by the end of the municipal year.

Members commented that they would wish to see some reflection of the environmental issues raised during the BBC Women's Hour investigation in the Brus Ward and other reports. The Scrutiny Support Officer indicated that the health inequalities issues were being monitored and would be presented at a future meeting of the Forum. The Chair indicated his wish that the forum would look at smoking cessation services and invite charity groups to bring their views to the debate.

Recommended

That the remit and terms of reference for the investigation into Cancer Awareness and Early Diagnosis as detailed above be approved.

25. The Executive's Forward Plan (*Scrutiny Support Officer*)

The Scrutiny Support Officer reported that as members were aware, one of the main duties of Scrutiny is to hold the Executive to account by considering the forthcoming decisions of the Executive (as outlined in the Executive's Forward Plan) and to decide whether value can be added to the decision by the Scrutiny process in advance of the decision being made. This, of course, did not negate Non-Executive Members ability to call-in a decision after it has been made.

The Scrutiny Coordinating Committee had delegated powers to manage the work of Scrutiny, as it thinks fit, and if appropriate can exercise or delegate to individual Scrutiny Forums. Consequently, Scrutiny Coordinating Committee monitors the Executive's Forward Plan and delegates decisions to individual Forums where it feels appropriate.

With reference to the key decisions contained within the Executive's Forward Plan (September – December 2011), those relating to the Health Scrutiny Forum were included in the report for Members information, together with the list of the full Forward Plan items in an appendix to the report. This new format for reporting the Forward Plan issues to Members of the individual Forums had been designed to reduce the need to circulate the full plan but ensure a greater dissemination of information to the scrutiny forums.

Recommended

That the report be noted and the new format for reporting on the forward plane be welcomed.

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

No items.

27. Regional Health Scrutiny Update

No items.

The meeting concluded at 12.50 p.m.

CHAIR

HEALTH SCRUTINY FORUM

6 October 2011

Report of: Joint Report of Director of Child and Adult Services and the Portfolio Holder for Adult and Public Health Services.

Subject: PORTFOLIO HOLDERS RESPONSE TO CONNECTED CARE

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1. PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide Members of the Health Scrutiny Forum with feedback on the recommendations from the investigation into the Connected Care, which was reported to Cabinet on 30 August 2011.

2. BACKGROUND INFORMATION

2.1 The investigation into Connected Care conducted by this Forum falls under the remit of the Child and Adult Services Department and is, under the Executive Delegation Scheme, within the service area covered by the Adult and Public Health Services Portfolio Holder.

2.2 On 30 August 2011, Cabinet considered the Final Report of the Health Scrutiny Forum into Connected Care. This report provides feedback from the Portfolio Holder following the Cabinet's consideration of, and decisions in relation to this Forum's recommendations.

2.3 Following on from this report, progress towards completion of the actions contained within the Action Plan will be monitored through Covalent; the Council's Performance Management System; with standardised six monthly monitoring reports to be presented to the Forum.

3. SCRUTINY RECOMMENDATIONS AND EXECUTIVE DECISION

3.1 Following consideration of the Final Report, Cabinet approved the recommendations in their entirety. Details of each recommendation and proposed actions to be taken following approval by Cabinet are provided in the Action Plan attached at **Appendix A**.

4. RECOMMENDATIONS

4.1 That Members note the proposed actions detailed within the Action Plan, appended to this report **(Appendix A)** and seek clarification on its content where felt appropriate.

Contact Officer:- Jill Harrison – Assistant Director, Adult Social Care
Child and Adult Services Department
Hartlepool Borough Council
Telephone Number: 01429 523911
E-mail – jill.harrison@hartlepool.gov.uk

BACKGROUND PAPERS

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

(i) The Health Scrutiny Forum's Final Report 'Connected Care' considered by Cabinet on 30 August 2011

(ii) Decision Record of Cabinet held on 30 August 2011.

OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN

4.1 Appendix A

NAME OF FORUM: Health Scrutiny Forum

NAME OF SCRUTINY ENQUIRY: Connected Care

DECISION MAKING DATE OF FINAL REPORT: August 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	The external evaluation for the delivery and impact of connected care has been very positive. Ongoing funding is in place via both the council and the PCT for the development of care navigation services (which were originally for the Owton Ward). It is proposed to use this funding for a further two years to enable services to be developed in other communities using the connected care model of community audits and bringing together existing community groups to deliver seamless services.	£100Kp.a. for two years - £50K from HBC and £50K from PCT	J Harrison G Martin J Harrison P Hornsby	March 2013 August 2011 – July 2013
		As part of the reablement plan delivery the PCT and LA have agreed that a range of low level health and social care services can be provided as part of the	£240Kp.a. reablement funding agreed by NHS, for two years.		

OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN

4.1 Appendix A

NAME OF FORUM: Health Scrutiny Forum

NAME OF SCRUTINY ENQUIRY: Connected Care

DECISION MAKING DATE OF FINAL REPORT: August 2011

RECOMMENDATION		EXECUTIVE RESPONSE / PROPOSED ACTION	FINANCIAL IMPLICATIONS	LEAD OFFICER	DELIVERY TIMESCALE
		connected care model of service delivery. It was therefore agreed to commission services across the town that provide low level support and prevention to maintain people within their own communities (including welfare notices, luncheon clubs, handy person service, fuel poverty advice and a home visiting service) for two years from August 2011. It is envisaged that this in the first instance this may involve the Local authority in delivery but will involve all local organisations in coordinating these type of services in the medium term.			
(b)	That once recommendation (a) is completed, connected care is rolled-out to other communities in Hartlepool:-	Discussions to be undertaken with local areas to ascertain if developing the connected care model in their areas would be a positive development. If this is the	As above	J Harrison G Martin	March 2013

OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN

4.1 Appendix A

NAME OF FORUM: Health Scrutiny Forum

NAME OF SCRUTINY ENQUIRY: Connected Care

DECISION MAKING DATE OF FINAL REPORT: August 2011

	RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION	FINANCIAL IMPLICATIONS	LEAD OFFICER	DELIVERY TIMESCALE
		case then agreement on how this will be facilitated in each area and who will be involved is required. This may be different in different areas of the town as per the model of connected care development. It is hoped that the CIC Who Cares (NE) may facilitate this dialogue with residents and community groups in the different areas	Cost neutral Cost neutral	G Martin G Martin	September 2011 September 2012
	(i) Ensuring that the necessary governance structure is in place;	In each area a robust governance structure will be developed that has a local project group to steer and drive the developments and to ensure a truly local focus is developed. Also representatives from the central and north area projects will be part of the development of a town wide Who	Emphasis on rationalising resources to avoid duplication and maximise financial	G Martin	Commenced and ongoing to March 2013

OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN

4.1 Appendix A

NAME OF FORUM: Health Scrutiny Forum

NAME OF SCRUTINY ENQUIRY: Connected Care

DECISION MAKING DATE OF FINAL REPORT: August 2011

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION	FINANCIAL IMPLICATIONS	LEAD OFFICER	DELIVERY TIMESCALE
	Cares (NE) Partnership Group to ensure the CIC develops as a true town wide entity.	efficiencies		
(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;	Each local area will develop and complete its own audit to identify how a connected care approach will inform the development of models that meet local needs. Who Cares (NE) can facilitate audits in other areas if required. At the request of local people in Burbank Who Cares (NE) has already began to work with local residents and organisations to complete a community audit in Burbank.	Cost neutral	J Harrison G Martin	March 2013
(iii) Ensuring that partnership arrangements are in place for current service providers and	The success of the connected care model is based on bringing together existing services and			

OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN

4.1 Appendix A

NAME OF FORUM: Health Scrutiny Forum

NAME OF SCRUTINY ENQUIRY: Connected Care

DECISION MAKING DATE OF FINAL REPORT: August 2011

	RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION	FINANCIAL IMPLICATIONS	LEAD OFFICER	DELIVERY TIMESCALE
	that duplication of work does not occur for those providers already delivering relevant services in that community; and	community organisations within local communities to reduce duplication and encourage partnership approaches. Who Cares (NE) can facilitate this development in other areas to ensure that there is local ownership and that bespoke services are developed tailored to local needs. It would be a requirement within any contract linked to connected care that this approach to partnership is followed.			
	(iv) That a feasibility study is carried out into support for the connected care roll-out through the transfer of staff and / or resources.	Monitoring the development of the model across Hartlepool will determine whether the outcomes justify the transfer of resources in the future.			
(c)	That following the completion of the work being undertaken				

NAME OF FORUM: Health Scrutiny Forum

NAME OF SCRUTINY ENQUIRY: Connected Care

DECISION MAKING DATE OF FINAL REPORT: August 2011

	RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION	FINANCIAL IMPLICATIONS	LEAD OFFICER	DELIVERY TIMESCALE
	by the LSE:-				
	(i) That the findings are shared with the Health Scrutiny Forum; and	Research findings from LSE will be presented to Health Scrutiny Forum.	Cost neutral	G Martin	August 2012
	(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.	Positive outcomes highlighted in the LSE research will be used to encourage all agencies that benefit from the preventative / early intervention approach to contribute to the ongoing delivery of services via a connected care model.	Potential for cost savings by increasing the number of agencies contributing to the funding of the model.	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	Work has already commenced to explore how staff delivering prevention and early intervention services can have access to the Care First system and the Employee Protection Register	Unclear at this time but some cost may be necessary for any additional lines /	T Smith	December 2012

OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN

4.1 Appendix A

NAME OF FORUM: Health Scrutiny Forum

NAME OF SCRUTINY ENQUIRY: Connected Care

DECISION MAKING DATE OF FINAL REPORT: August 2011

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION	FINANCIAL IMPLICATIONS	LEAD OFFICER	DELIVERY TIMESCALE
	study be undertaken into Navigators accessing Care First, Rio, Employee Protection Register and other related systems. (EPR).	equipment.		

HEALTH SCRUTINY FORUM

6 October 2011

Report of: Scrutiny Support Officer

Subject: CANCER AWARENESS AND EARLY DIAGNOSIS – EVIDENCE FROM MEMBER OF PARLIAMENT FOR HARTLEPOOL AND THE PORTFOLIO HOLDER FOR ADULT'S AND PUBLIC HEALTH – COVERING REPORT

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1. PURPOSE OF REPORT

1.1 To inform Members of this Forum that the town's Member of Parliament (MP) has been invited to attend this meeting along with the Portfolio Holder for Adult's and Public Health to provide evidence in relation to this Forum's investigation into Cancer Awareness and Early Diagnosis.

2. BACKGROUND INFORMATION

2.1 Members will recall that at the meeting of this Forum on 8 September 2011, the Terms of Reference and Potential Areas of Inquiry / Sources of Evidence for this Scrutiny investigation were approved by the Forum.

2.2 Consequently, the town's MP and the Portfolio Holder for Adult's and Public Health have agreed to attend this meeting to submit evidence of a local perspective to the Forum.

2.3 During this evidence gathering session with the town's MP and the Portfolio Holder for Adult's and Public Health, it is suggested that responses should be sought to the following key questions:-

(a) Over half of all cases of cancer in Hartlepool are the common cancers; lung, colorectal, breast, prostate and cervical. Cervical (76.6%), breast (75.5%) and bowel cancer (51.6%) can be detected through screening; with the figures in brackets being the take-up levels of screening programmes in 2009-10 in Hartlepool:-

(i) What more could be done in your opinion to raise awareness and increase eligible people from attending screening programmes?

(b) The NHS states that:-

"Lung cancer is one of the few cancers where there is a clear cause in many cases – smoking. Although some people who have never smoked get lung cancer, smoking causes 9 out of 10 cases"[1]

In Hartlepool there are more cases of lung cancer than there are of the other common cancers.

(i) What more, do you feel, could be done in raising awareness about the link between smoking and lung cancer?

(ii) What can we as a Local Authority and our partners in the Healthcare sector do to combat the levels of smoking in the Town?

(c) What other advice / information are you able to provide this Forum, that would assist this scrutiny investigation?

3. RECOMMENDATIONS

3.1 That Members of the Forum consider the views of the Town's MP and the Portfolio Holder for Adult's and Public Health in relation to the questions outlined in section 2.3

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 used in the preparation of this report:-

(i) Minutes of the Health Scrutiny Forum meeting held on 8 September.

(ii) Report of the Scrutiny Support Officer, entitled 'Scrutiny Investigation into Cancer Awareness and Early Diagnosis – Scoping Report' presented at the meeting of the Health Scrutiny Forum on 8 September 2011.

(iii) NHS (2011), *Lung Cancer*, Available from: http://www.beclearoncancer.co.uk/lung-cancer (Accessed 15 August 2011).

[1] NHS, 2011.

HEALTH SCRUTINY FORUM

6 October 2011

Report of: Scrutiny Support Officer

Subject: SCRUTINY INVESTIGATION IN TO CANCER AWARENESS AND EARLY DIAGNOSIS – SETTING THE SCENE PRESENTATION – COVERING REPORT

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1. PURPOSE OF REPORT

1.1 To inform Members that the Assistant Director for Health Improvement and the Specialty Registrar in Public Health, NHS Tees have been invited to attend this meeting to provide a setting the scene presentation in relation to this Forum's investigation into Cancer Awareness and Early Diagnosis.

2. BACKGROUND INFORMATION

2.1 Members will recall that at the meeting of this Forum on 8 September 2011, Members agreed the Scope and Terms of Reference for their forthcoming investigation into the topic of Cancer Awareness and Early Diagnosis.

2.2 Subsequently the Assistant Director for Health Improvement and the Specialty Registrar in Public Health, NHS Tees have agreed to attend this meeting to provide a presentation to outline the following in relation to Cancer Awareness and Early Diagnosis:-

(i) Cancer in Hartlepool: An Overview – Report by the Executive Director for Public Health and the Specialty Registrar in Public Health, NHS Tees (attached as **Appendix A**);

(ii) How cancer is detected; and

(iii) The take-up levels of cancer screening in Hartlepool, in comparison to regional and national statistics.

3. RECOMMENDATION

3.1 It is recommended that the Members of the Health Scrutiny Forum consider the evidence of the Assistant Director for Health Improvement and the Specialty Registrar in Public Health, NHS Tees in attendance at this meeting and seek clarification on any relevant issues where required.

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

BACKGROUND PAPERS

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

(i) Report of the Scrutiny Support Officer entitled 'Scrutiny Investigation into Cancer Awareness and Early Diagnosis – Scoping Report' Presented to the Health Scrutiny Forum on 8 September 2011.

NHS
Tees

Cancer in Hartlepool: An Overview

Dr Victoria Ononeze
Professor Peter Kelly
Public Health Directorate
September 2011

Content

Executive summary

Introduction

Cancer is a major cause of illness and death in Hartlepool. It contributes to about 37% of the gap in life expectancy between Hartlepool and the England average.

The reasons for the higher level of cancer in Hartlepool compared to England are varied and include biological, lifestyle, cultural, economic and environmental factors. Some of these factors are described in the Hartlepool Joint Strategic Needs Assessments available from www.teespublichealth.nhs.uk. How long people live with cancer and their quality of life can also be affected by factors relating to late presentation and service provision.

This report brings together some of the available data on cancer and some aspects of cancer services in Hartlepool. It is compiled from data from the Cancer Registry, Quality and Outcomes Framework (QOF), NHS National Screening Programme and the Department of Health Secondary Uses Service (SUS).

Key points

- Hartlepool has a relatively small population of about 91,865[1] and consequently small numbers of cancer events, making it difficult to interpret and confirm trends
- Hartlepool is a deprived local authority. In 2007 it was ranked 23 most deprived out of 354 local authorities in England. Several common cancers have a close association with level of deprivation. More deprived areas tend to have higher incidence rates of lung cancer but lower incidence rates of prostate and breast cancer.

All cancers

- The number of new cases of all cancers in Hartlepool increased by 34% from 1985 to 2008, with similar number of cases in men and women. The age standardised incidence rate increased by 17% with a higher increase of 22% in women. Rates are higher than the North East and England averages.
- The contribution of the more common cancers (lung, breast, colorectal, prostate and cervical) to new cases of all cancers in Hartlepool increased between 1985 to 2008 from 51% to 54%. This means that just under half of all new cancer cases in 2008 were from less common cancers. The contributions are similar in the other three Tees PCTs, North East and England.
- Deaths from all cancers increased in Hartlepool from 276 in 1985 to 292 in 2008, with more women than men dying. The age standardised mortality rate decreased by 13% but about half that decrease in women. Rates are higher than the North East and England averages.
- The contribution of the more common cancers lung, breast, colorectal, prostate and cervical to death cases from all cancers in Hartlepool decreased between 1985 to 2008 from 55% to 49%. This means that about half the deaths from all cancers in 2008 were from less common cancers. The contributions are similar in the other three Tees PCTs, North East and England.
- 1-year survival rate for all cancers increased by 27% over the 24 year period examined and 5-year survival rate increased by 39%. Although there were similar increases in the North East and England averages, survival rates were higher. 1 and 5-year survival rates in 2008 were 61% and 43% (Hartlepool), 65% and 45% (North East) and 69% and 51% (England). The increase in survival rates was higher in men than women but survival rates were higher in women.

[1] Estimated population in 2009. Tees Valley Unlimited.

Ward level data

- There is a complex picture of incidence and mortality from all cancers in Hartlepool electoral wards, with some less deprived wards with higher rates and more deprived wards with lower rates.

Lung cancer

- Incidence and mortality rates for lung cancer in Hartlepool (1985-2008) follow the North East and England average trend, decreasing in all persons and men but increasing in women. In women in Hartlepool the age standardised incidence rate increased by 5% and mortality rate by 25%.
- 1-year survival rate for lung cancer increased by 66%, from 15% in 1985/89 to 25% in 2003/07, slightly higher than the increase in the North East and England average. The 5-year survival rate increased by 50%, from 4% in 1985/89 to 6% in 2003/07. Survival rates are similar in men and women.

Colorectal cancer

- Incidence rate for colorectal cancer in Hartlepool increased by 70% from 1985-2008, with fewer women than men developing the condition. The mortality rate fluctuated during this period.
- There was a greater percentage increase in 5-year survival rate of 42% compared to 14% in 1-year survival, with more men than women surviving. Survival rates are similar to the North East and England averages.

Breast cancer

- Age standardised incidence rates for breast cancer increased by 62% from 1995-2008, lower than the increase in the North East average but 4 times higher than England average. Mortality rate decreased by 33% and was slightly higher than the North East average but lower than the England average.
- The 5-year survival rate for breast cancer increased by 22% from 67% in 1985/89 to 82% in 1999/03. There was a marginal increase in 1-year survival rate.

Prostate cancer

- The age standardised incidence rate for prostate cancer more than tripled from 1985 to 2008. There were much lower increases in the North East and England. There is a general increasing trend in mortality rate in Hartlepool whilst the North East and England average fluctuated.
- Five-year survival rate increased by 160% (29% to 76%, about double the increases in the North East and England averages. There was also a large increase in the 1-year survival rate of 51% from 63% to 95%.

Cervical cancer

- Age standardised incidence and mortality rates for cervical cancer are decreasing, but are generally higher than the North East and England average.
- 1-and 5-year survival rates for cervical cancer fluctuated during the period examined.

Childhood cancer

- There were 222 childhood cancers diagnosed in Hartlepool in the 0 -19 year age group between 1985 and 2008, but there is no trend in the incidence rate. 75 deaths occurred in this period and there is a general downward trend in mortality rate. Trends in incidence and mortality rates are similar across Tees and the North of England Cancer Network

Staging data

- Smaller proportions of breast, colorectal, cervical and melanoma cancers are diagnosed early at stage 1 when chances of survival are greater, compared with larger proportions in the later stages when prognosis is poorer

General practice cancer profiles

- As expected incidence, prevalence, mortality, conversion (Two Week referrals) and emergency presentation (cancers diagnosed via emergency route) rates for all cancers vary between GP practices, but accurate interpretation is difficult because of the limitations of the data.

Cancer screening uptake

- Over the period 2001/02-2009/10, uptake of screening for breast cancer fluctuated and cervical cancer decreased. There is a general increase in the uptake of bowel cancer over the 4 year period since it started.

Spend on cancer

- Spend on cancer on Hartlepool population increased by 21.5% between 2006/07 and 2009/10, an average of 6.2% of total expenditure but it is lower than comparable areas within Tees, the North East and England. This reflects the small Hartlepool population.

Conclusions

- In Hartlepool, over the 24 year period (1985-2008) examined, the number of new cases of and deaths from all cancers increased. The more common cancers (lung, colorectal, breast, prostate and cervical) contributed to about half of the cases, with lung cancer the single largest contributor. There is therefore the need to raise awareness of the less common cancers which together contribute to the remaining half of the cases.
- The incidence and mortality rates for all cancers in Hartlepool are higher than the North East and England averages, with more women than men developing and dying from cancer.
- The pattern of the variations in incidence and mortality rates of all cancers across Hartlepool electoral wards and general practices is complex, and is likely to be due to population, cultural and personal characteristics and service related factors.
- Increased efforts are needed to address the increasing incidence rates of lung cancer in women, colorectal in men and women and breast and prostate cancer.
- Some of the reasons for the higher incidence and mortality from cancers in Hartlepool are well known and relate to higher levels of deprivation, smoking, drinking and obesity. However, there is increasing evidence that cultural and personal factors (e.g. beliefs and attitudes, lack of awareness of the signs and symptoms of cancer, attitudes to screening and late presentation with symptoms) and service factors (e.g. poor uptake of screening, delays in referrals for investigations and treatment) need to be addressed to increase early detection and improve survival. More initiatives are needed to tackle these issues.

In summary this report provides an overview of the extent of the burden of ill health due to cancer and some of the areas where actions are needed to reduce it.

Glossary

Age standardized rate (ASR) - incidence	Age standardized incidence rate is the number of new cases of cancer that would occur in an area if that area had the same age structure as the standard population (usually European)
Age standardized rate (ASR) - mortality	Age standardized mortality rate is the number of deaths from cancer that would occur in an area if that area had the same age structure as the standard population (usually European)
Cancer Registry	A cancer registry is a systematic collection of information on cancers occurring in the population to enable planning of services, research and education. The Northern and Yorkshire Cancer Registry (NYCRIS) is one of eleven in the UK
Crude rate - incidence	This is the number of new cases of cancer in an area over a specified period and is usually expressed per 100,000 population. It reflects the 'true' proportion of cases in the population
Crude rate - mortality	This is the number of deaths from cancer in an area over a specified period and is usually expressed per 100,000 population. It reflects the 'true' proportion of deaths in the population
Incidence	The number of new cases of cancer in a specified period and in a defined population
Prevalence	The total number of existing cases of cancer in a defined population in a defined period. Point prevalence refers to a specific point in time whilst period prevalence refers to a defined period, for example ten years.
Quality and Outcomes Framework (QOF)	The QOF gives an indication of the overall achievement of a GP surgery through a points system. Practices aim to deliver high quality care across a range of areas for which they score points. The higher the score, the higher the financial reward for the practice. Payment takes into account of factors such as the practice workload and the prevalence of chronic conditions in the practice's local areas.
Secondary Uses Service (SUS)	SUS is the single, comprehensive repository for healthcare data which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services
Survival rate	Cancer survival data show the proportion of people diagnosed with cancer about the same time (cohort), who are alive after 1 and 5 years. The proportions are then adjusted for the number of people expected to die in each age group.

1. Introduction

Cancer is a major cause of illness and death in England. Each year about 200,000 people are diagnosed with cancer and 120,000 die from cancer in England. It is estimated that this equates to 1 in 3 people developing cancer during their lifetime and 1 in 4 deaths from all causes.

There are over 200 different types of cancer, each with its own signs, symptoms and treatments. Early detection of signs and symptoms and diagnosis can often make a difference to how easily cancer is managed and survival.

Improved understanding of the causes of some cancers has been responsible for reductions in deaths from these cancers. Smoking is the cause of about 90% of lung cancer cases. Human Papilloma Virus (HPV) is present in 70% of cervical cancer cases. Nine out of 10 people with prolonged contact with asbestos develop mesothelioma (a rare type of cancer affecting the linings of the lung and abdomen). Cancer screening programmes (breast, cervical and now bowel) and improved treatments have increased early detection and improved survival.

However, variations in the number of new cases of cancer, deaths, survival and cancer screening uptake still remain between areas across England and between communities within a particular area such as Hartlepool.

This report provides an overview of cancer in Hartlepool in relation to incidence, mortality, survival and some aspects of cancer services.

The aim is to promote discussions and realistic reflections on some of the data. It is also intended to help inform decisions about what actions are needed to reduce the burden of cancer in Hartlepool.

Data need to be interpreted with caution because of the small numbers of events and other limitations of the data.

2. Hartlepool at a glance

- Hartlepool has a population of about 91,865
- It is a relatively deprived local authority and in 2007 ranked 23 most deprived out of 354 Local Authorities in England, an improvement from 14 in 2004.
- The health of the people in Hartlepool is generally improving, but is still worse than the England average. Levels of deprivation are higher and life expectancy is lower than the England average
- There are inequalities within Hartlepool. For example, life expectancy for men in the most deprived areas is over 9 years lower than for men living in the least deprived areas. For women it is 7 years lower.
- Over the last ten years, the death rate from all causes has fallen steadily for men, but has fluctuated for women. The early death rate from heart disease and stroke has fallen markedly, but the early death rate from cancer has changed little over the decade
- In Hartlepool, the percentage of mothers smoking in pregnancy is worse than the England average. The percentage of physically active children is better than the England average
- The death rate from smoking is worse than the England average. The rate of road injuries and deaths is better than the England average.
- A 'Healthy Heart Check' initiative has been set up to reduce early deaths from heart disease and help people live longer and healthier lives.
- Initiatives to raise awareness and promote early diagnosis of cancer are being implemented.
- The Local Area Agreement has a number of priorities to address health inequalities. Amongst these are: tackling smoking, tackling alcohol abuse, and improving uptake of cancer screening programmes.
- There are more details available about the health of Hartlepool from www.teespublichealth.nhs.uk

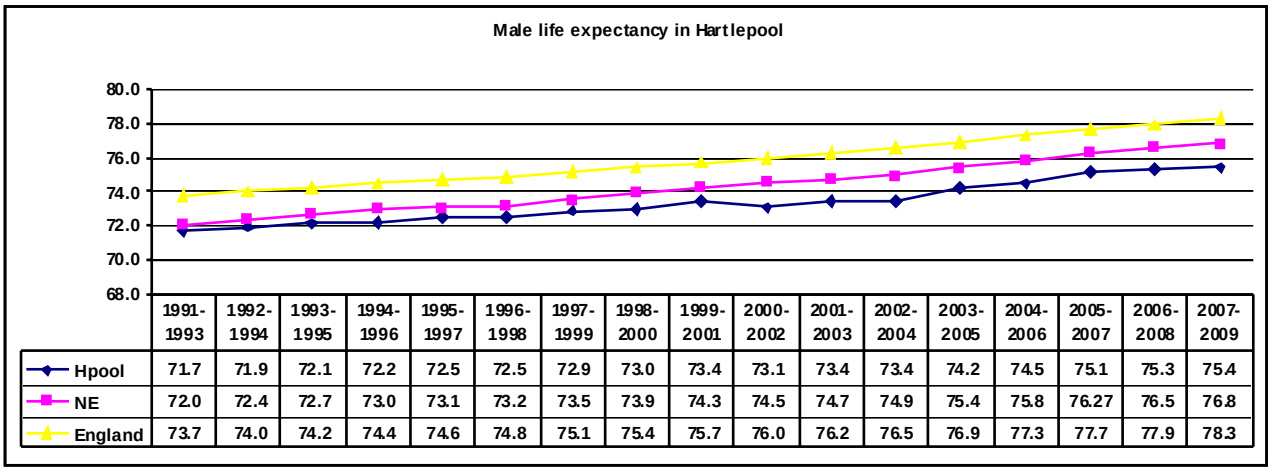
Source: Health Profile 2011

3. Burden of ill health due to cancer

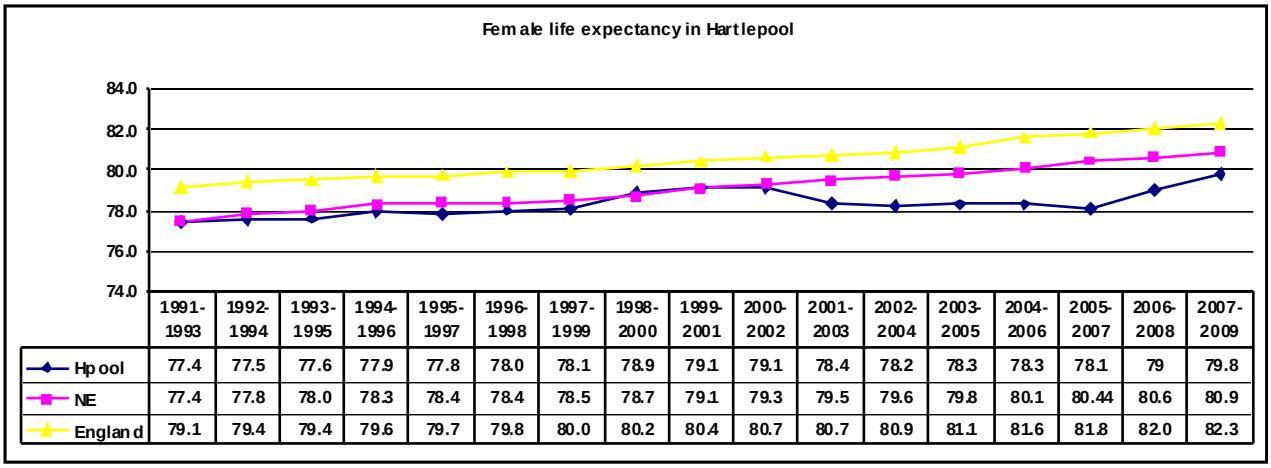
Ill health, poverty, life expectancy and disability in Hartlepool are all much worse compared to England. For example, life expectancy in Hartlepool in the past two decades has been consistently lower than the North East and England averages (Figure 3.1).

In 2006-2008 life expectancy in Hartlepool was 75.3 for males and 79 for females, compared with 77.9 and 82.0, respectively, for England. Life expectancy in males and females in Hartlepool was also lower than the North East average.

Figure 3.1: Life expectancy in Hartlepool 1991/93-2006/08



	1991-1993	1992-1994	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Hpool	71.7	71.9	72.1	72.2	72.5	72.5	72.9	73.0	73.4	73.1	73.4	73.4	74.2	74.5	75.1	75.3	75.4
NE	72.0	72.4	72.7	73.0	73.1	73.2	73.5	73.9	74.3	74.5	74.7	74.9	75.4	75.8	76.27	76.5	76.8
England	73.7	74.0	74.2	74.4	74.6	74.8	75.1	75.4	75.7	76.0	76.2	76.5	76.9	77.3	77.7	77.9	78.3

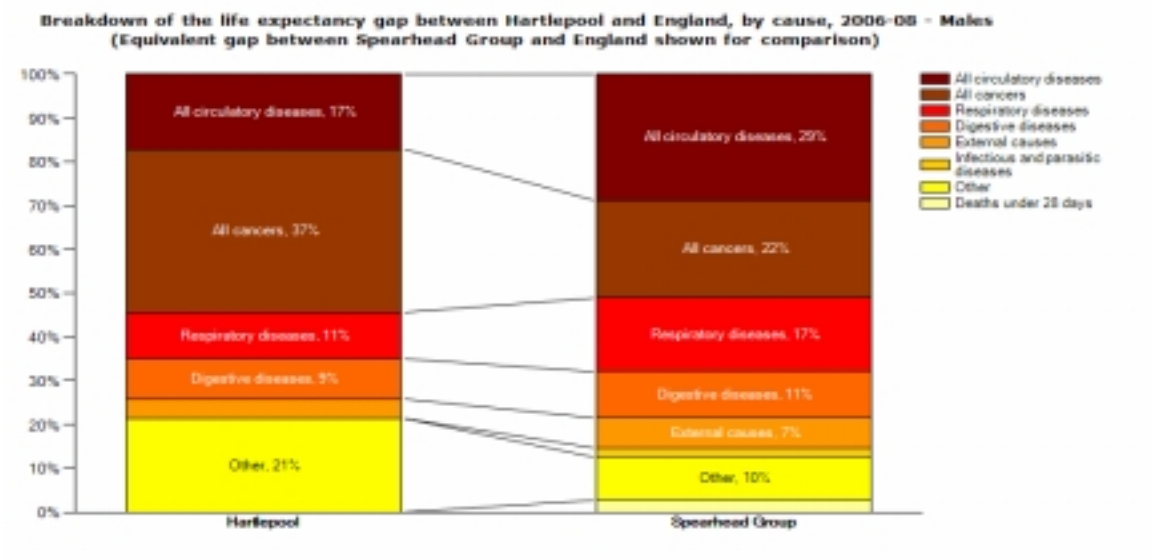


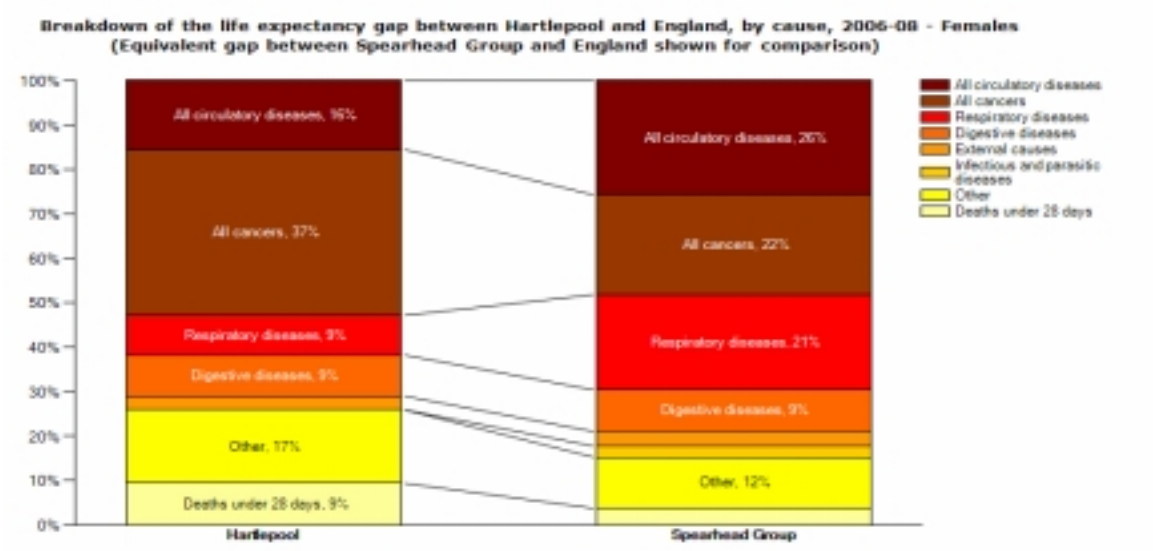
	1991-1993	1992-1994	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Hpool	77.4	77.5	77.6	77.9	77.8	78.0	78.1	78.9	79.1	79.1	78.4	78.2	78.3	78.3	78.1	79	79.8
NE	77.4	77.8	78.0	78.3	78.4	78.4	78.5	78.7	79.1	79.3	79.5	79.6	79.8	80.1	80.44	80.6	80.9
England	79.1	79.4	79.4	79.6	79.7	79.8	80.0	80.2	80.4	80.7	80.7	80.9	81.1	81.6	81.8	82.0	82.3

Source: National Compendium of Health Outcomes and Development 2009

Cancer accounted for about 37% of the shorter life expectancy between Hartlepool and England in both men and women in 2006-08, with lung cancer the largest contributor (Figures 3.2 & 3.3).

Figures 3.2 & 3.3:





Source: Health Inequalities Intervention Tool for all Areas
http://www.lho.org.uk/NHII/Spearhead/LifeExpectancyGap

Risk factor and causes of cancer

Evidence from research on effective interventions for reducing the burden of cancers shows that most of the common cancers are lifestyle related. These factors include smoking, unhealthy diet (and diet rich in red meat), heavy alcohol consumption, prolonged exposure to sunlight and some viral infections.

The knowledge of the prevalence of health related behaviours and their distribution across the different sections of communities in Hartlepool, and actions to reduce unhealthy lifestyle is therefore important. These are detailed in the *Hartlepool Joint Strategic Needs Assessment 2010* available from *www.teespublichealth.nhs.uk*)

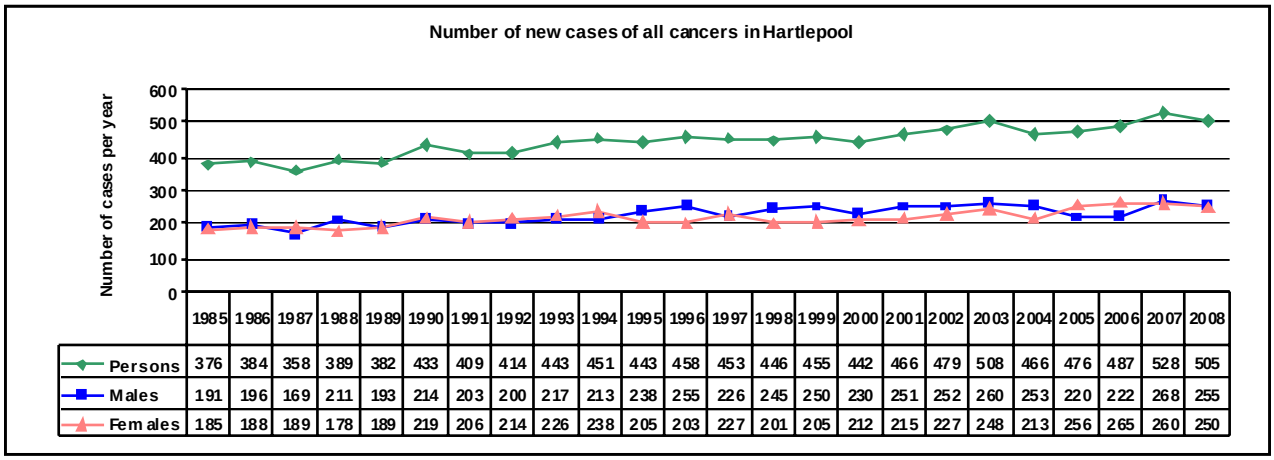
4. All cancers

4.1 Incidence

There is a steady increase in the number of new cases of all cancers in Hartlepool and in both men and women (Figure 4.1):

- Hartlepool 34% increase from 376 cases in 1985 to 505 cases in 2008.
- Males 34% from 191 cases in 1985 to 255 cases in 2008.
- Females 35% from 185 cases in 1985 to 250 cases in 2008.

Figure 4.1: Number of new cases of all cancers (ICD10: C00-C97 excl. C44 non-melanoma skin) in Hartlepool 1985-2008



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Persons	376	384	358	389	382	433	409	414	443	451	443	458	453	446	455	442	466	479	508	466	476	487	528	505
Males	191	196	169	211	193	214	203	200	217	213	238	255	226	245	250	230	251	252	260	253	220	222	268	255
Females	185	188	189	178	189	219	206	214	226	238	205	203	227	201	205	212	215	227	248	213	256	265	260	250

Source: Northern and Yorkshire Cancer Registry Information Service

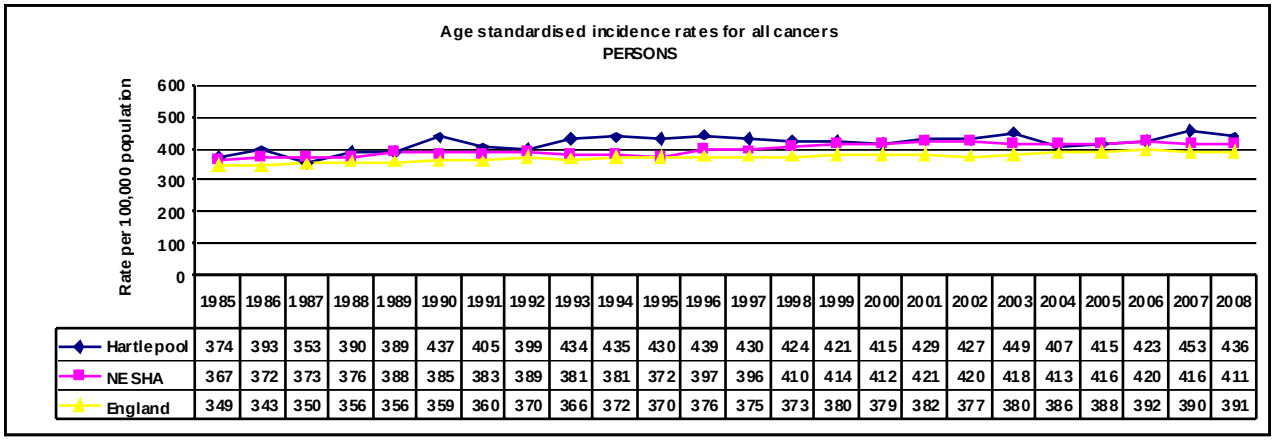
The contribution of the more common cancers lung, breast, colorectal, prostate and cervical to new cases of all cancers in Hartlepool increased between 1985 to 2008 from 51% to 54%. This means that just under half of all new cancer cases in 2008 were from less common cancers. The contributions are similar in the other three NHS Tees PCTs, North East and England (Table 4.1). This means that initiatives to raise the awareness of the less common cancers are also needed.

Table 4.1: Contribution of lung, colorectal, breast, prostate and cervical to new cases of all cancers in 1985 and 2008

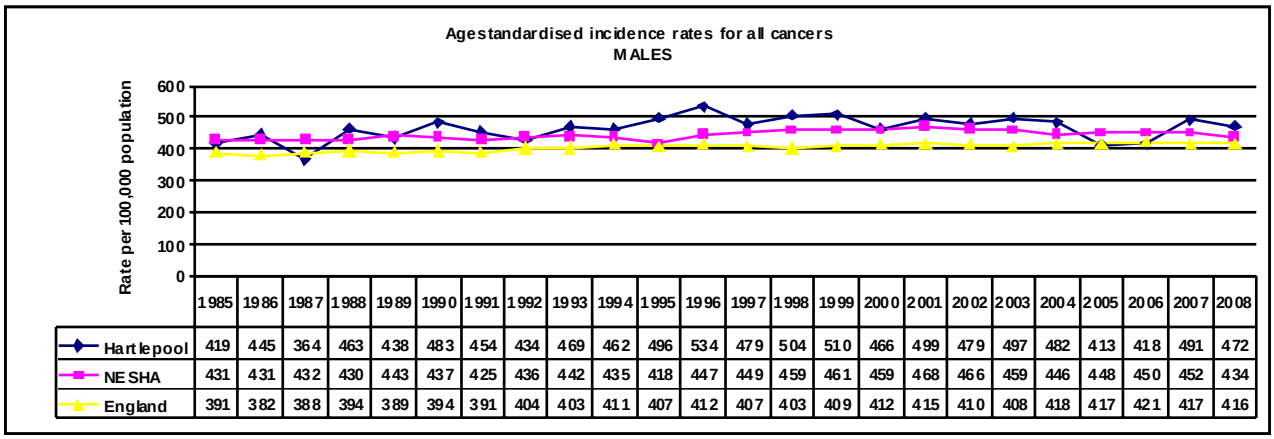
	Hartlepool	Middlesbrough	Redcar & Cleveland	Stockton	NE SHA	England
1985	51%	57%	54%	56%	54%	53%
2008	54%	60%	56%	56%	56%	54%

The age standardised incidence rate for all cancers in Hartlepool show an increase of 17%, from 374 per 100,000 population in 1985 to 436 per 100,000 population in 2008, with a higher increase in rate of 22% in women. Rates are generally higher than the North East and England averages for both men and women (Figure 4.2).

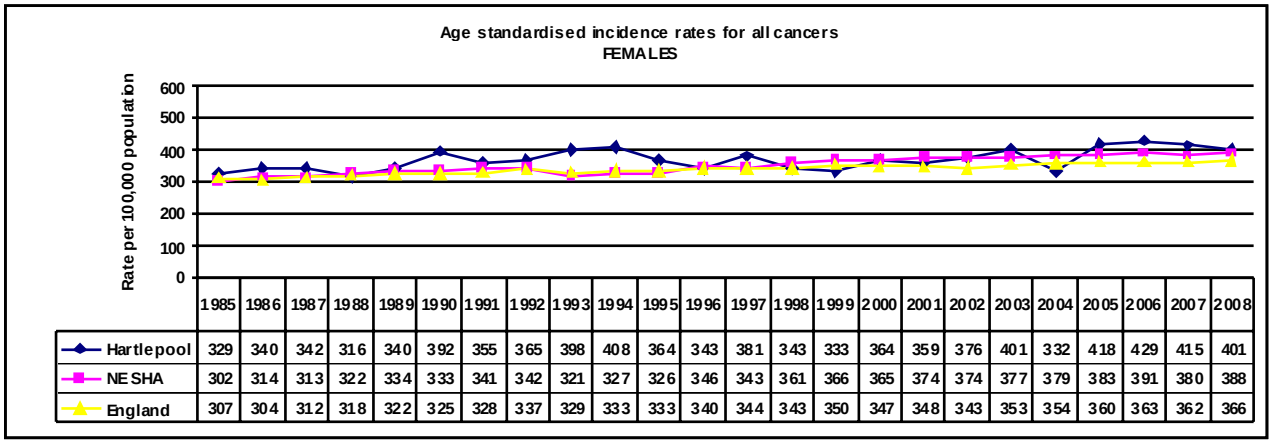
Figure 4.2: Age standardised incidence rates for all cancers (ICD10: C00-C97 excl. C44 non-melanoma skin) for persons, males and females in Hartlepool 1985-2008



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	374	393	353	390	389	437	405	399	434	435	430	439	430	424	421	415	429	427	449	407	415	423	453	436
NESHA	367	372	373	376	388	385	383	389	381	381	372	397	396	410	414	412	421	420	418	413	416	420	416	411
England	349	343	350	356	356	359	360	370	366	372	370	376	375	373	380	379	382	377	380	386	388	392	390	391



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	419	445	364	463	438	483	454	434	469	462	496	534	479	504	510	466	499	479	497	482	413	418	491	472
NESHA	431	431	432	430	443	437	425	436	442	435	418	447	449	459	461	459	468	466	459	446	448	450	452	434
England	391	382	388	394	389	394	391	404	403	411	407	412	407	403	409	412	415	410	408	418	417	421	417	416



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	329	340	342	316	340	392	355	365	398	408	364	343	381	343	333	364	359	376	401	332	418	429	415	401
NESHA	302	314	313	322	334	333	341	342	321	327	326	346	343	361	366	365	374	374	377	379	383	391	380	388
England	307	304	312	318	322	325	328	337	329	333	333	340	344	343	350	347	348	343	353	354	360	363	362	366

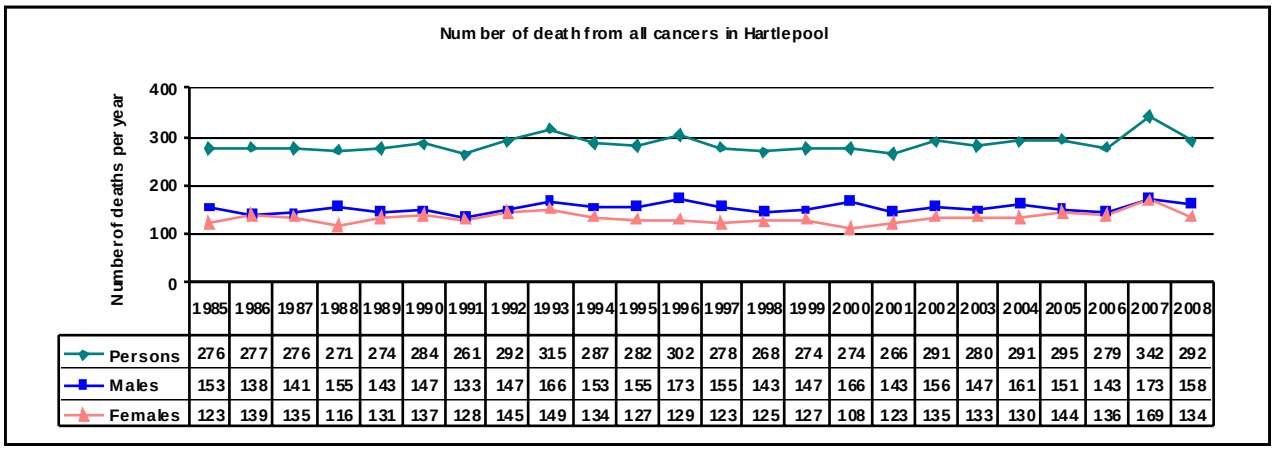
Source: Northern and Yorkshire Cancer Registry Information Service

4.2 Mortality

Generally, the number of deaths from all cancers is increasing in Hartlepool with more women than men dying (Figure 4.3):

- Hartlepool increase from 276 deaths in 1985 to 292 deaths in 2008
- There was a small increase in deaths in men from 153 deaths in 1985 to 158 deaths in 2008
- More women are dying from 123 deaths in 1985 to 134 deaths in 2008

Figure 4.3: Number of deaths from all cancers (ICD10: C00-C97 excl. C44 non-melanoma skin) in Hartlepool 1985 – 2008



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Persons	276	277	276	271	274	284	261	292	315	287	282	302	278	268	274	274	266	291	280	291	295	279	342	292
Males	153	138	141	155	143	147	133	147	166	153	155	173	155	143	147	166	143	156	147	161	151	143	173	158
Females	123	139	135	116	131	137	128	145	149	134	127	129	123	125	127	108	123	135	133	130	144	136	169	134

Source: Northern and Yorkshire Cancer Registry Information Service

The contribution of the more common cancers lung, breast, colorectal, prostate and cervical to death cases from all cancers in Hartlepool decreased between 1985 to 2008 from 55% to 49%. This means that about half the deaths from all cancers in 2008 were from less common cancers. The contributions are similar in the other three NHS Tees PCTs, North East and England (Table 4.2). This means that initiatives to raise the awareness of the less common cancers are also needed.

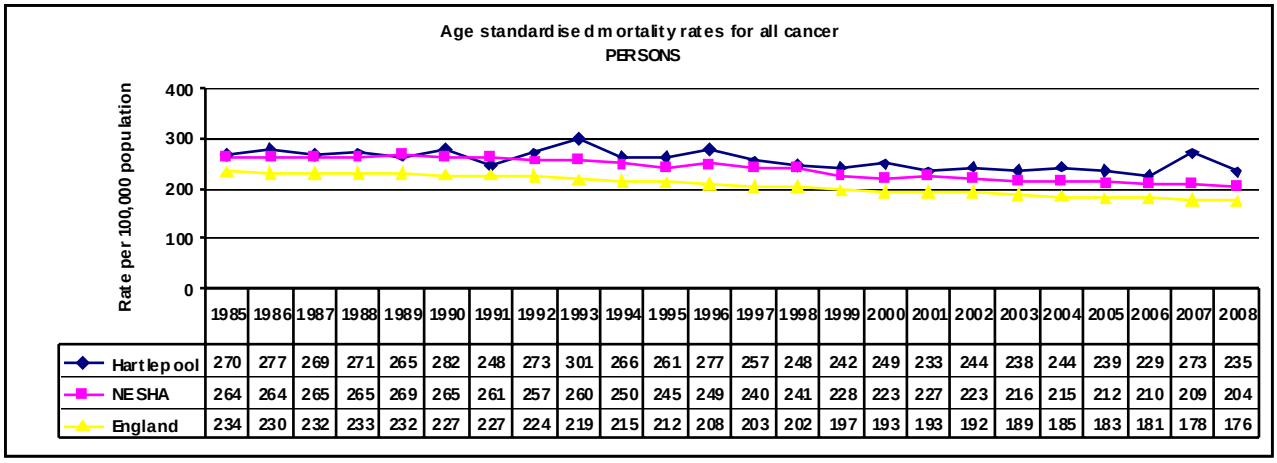
Table 4.2: Contribution of lung, colorectal, breast, prostate and cervical to deaths from all cancers in 1985 and 2008

	Hartlepool	Middlesbrough	Redcar & Cleveland	Stockton	NE SHA	England
1985	55%	60%	57%	56%	55%	54%
2008	49%	51%	50%	52%	50%	47%

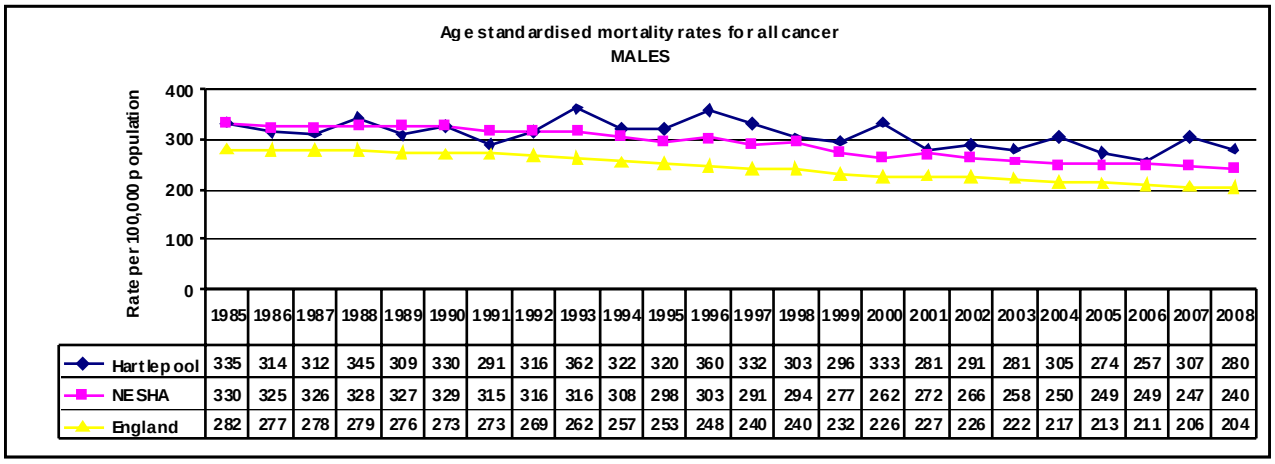
The age standardised mortality rates show a general decrease for all cancers in Hartlepool but lower than the North East and England averages. The decreases in death rates are lower in women than men (Figure 4.4):

- Hartlepool 13% decrease from 270 per 100,000 population in 1985 to 235 per 100,000 population in 2008, about half the decrease in the North East average of 23% (264 per 100,000 population to 204 per 100,000 population) and England average of 25% (234 per 100,000 population to 176 per 100,000 population)
- The decrease in mortality rate for women in Hartlepool was 7% from 204 per 100,000 population in 1985 to 189 per 100,000 population in 2008. This is about half the decrease seen for persons. This gender difference also occurs regionally and to a lesser extent nationally:

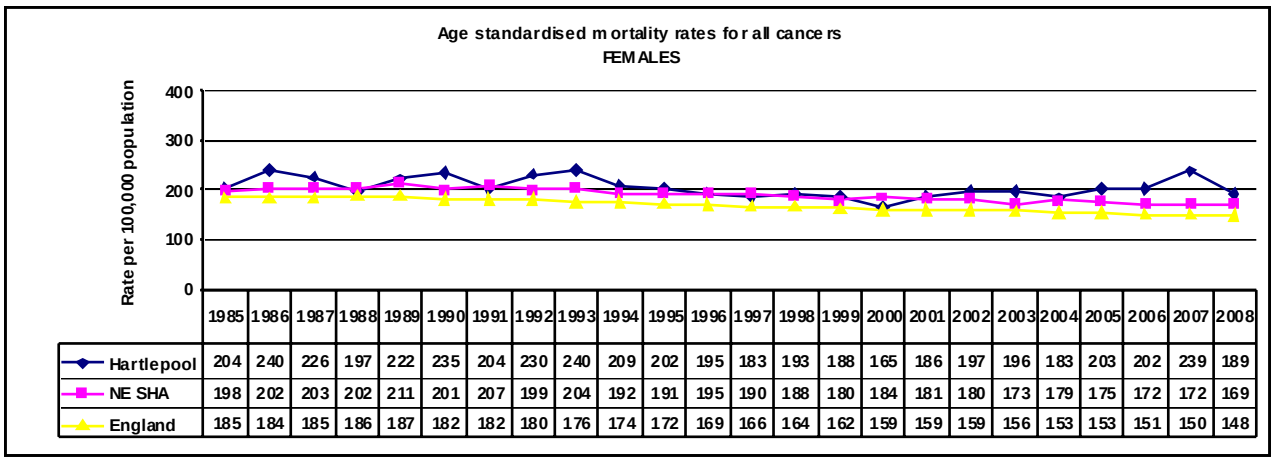
Figure 4.4: Age standardised mortality rates for all cancers (ICD10: C00-C97 excl. C44 non-melanoma skin) for persons, males and females in Hartlepool 1985 - 2008



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	270	277	269	271	265	282	248	273	301	266	261	277	257	248	242	249	233	244	238	244	239	229	273	235
NESHA	264	264	265	265	269	265	261	257	260	250	245	249	240	241	228	223	227	223	216	215	212	210	209	204
England	234	230	232	233	232	227	227	224	219	215	212	208	203	202	197	193	193	192	189	185	183	181	178	176

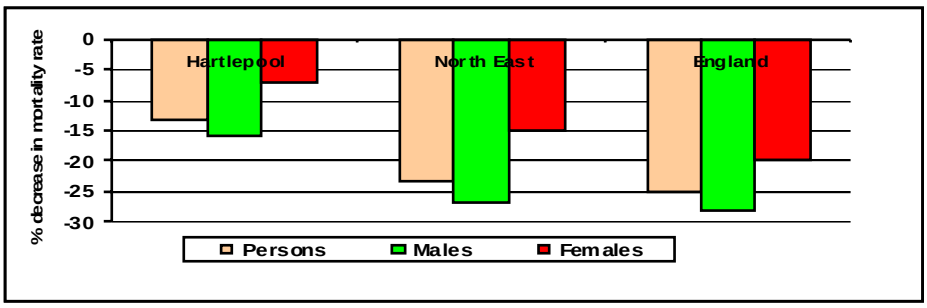


	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	335	314	312	345	309	330	291	316	362	322	320	360	332	303	296	333	281	291	281	305	274	257	307	280
NESHA	330	325	326	328	327	329	315	316	316	308	298	303	291	294	277	262	272	266	258	250	249	249	247	240
England	282	277	278	279	276	273	273	269	262	257	253	248	240	240	232	226	227	226	222	217	213	211	206	204



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	204	240	226	197	222	235	204	230	240	209	202	195	183	193	188	165	186	197	196	183	203	202	239	189
NE SHA	198	202	203	202	211	201	207	199	204	192	191	195	190	188	180	184	181	180	173	179	175	172	172	169
England	185	184	185	186	187	182	182	180	176	174	172	169	166	164	162	159	159	159	156	153	153	151	150	148

Figure 4.4a: Gender difference in decreases in mortality rates for all cancers



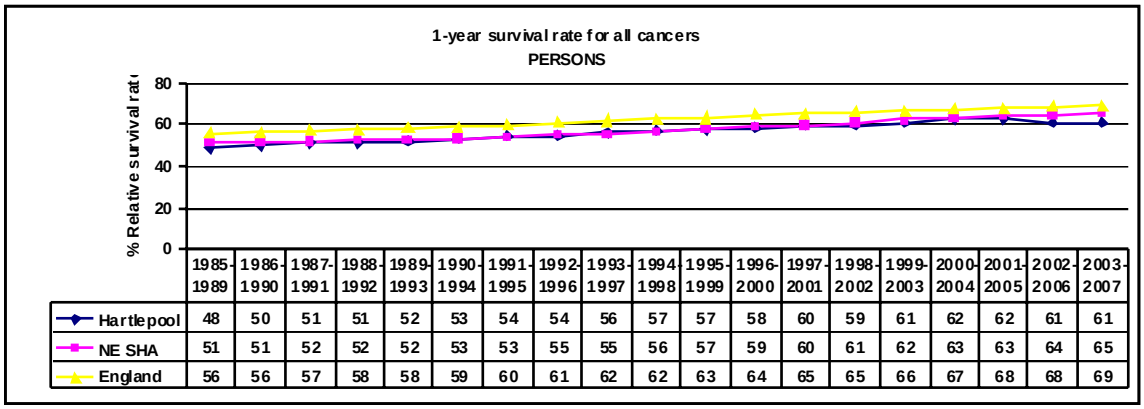
Source: Northern and Yorkshire Cancer Registry Information Service

4.3 Survival

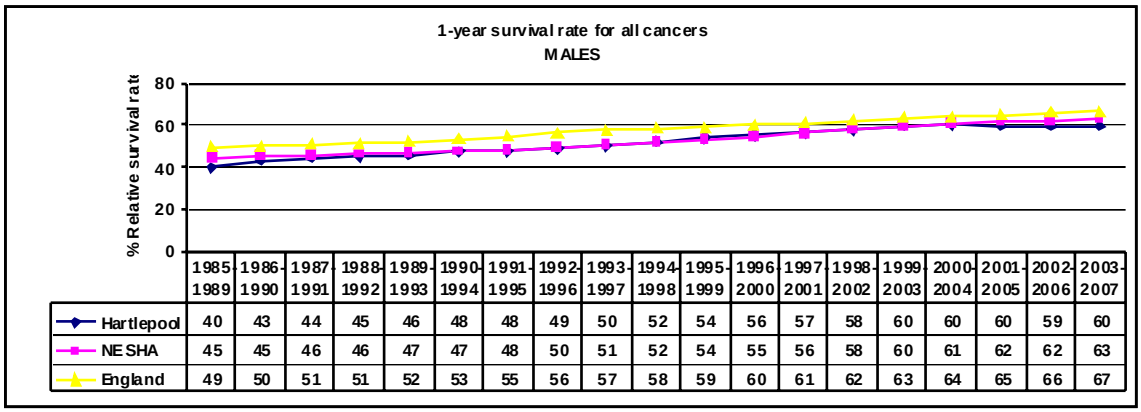
The 1-year survival rate for all cancers increased from 48% in 1985-1989 to 61% in 2003-2007, an increase of 27%. There were similar increases in the North East and England averages.

Survival rates are higher in women than men but there are greater increases in survival rates in men than women in Hartlepool, North East and England (Figure 4.5).

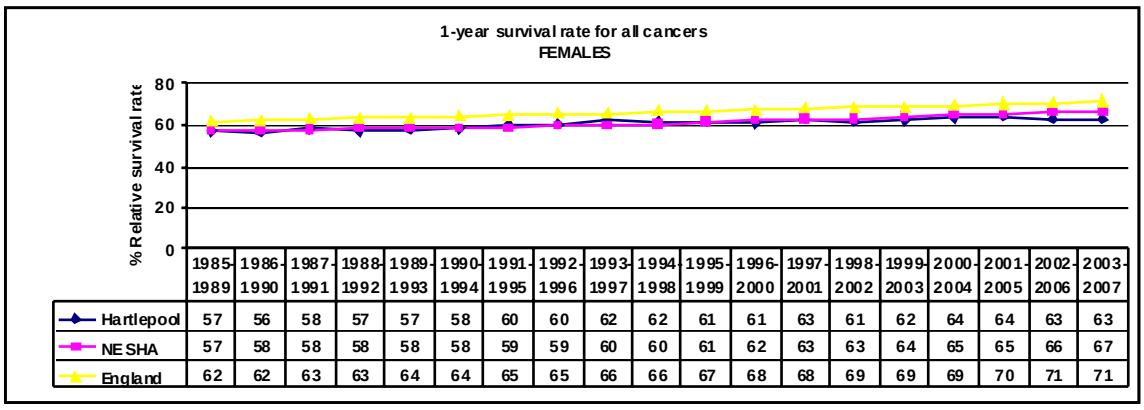
Figure 4.5: 1-Year relative survival rates for all cancers (ICD10: C00-C97 excl. C44 non-melanoma skin) for persons, males and females in Hartlepool 1985/89 – 2003/07



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003	2000-2004	2001-2005	2002-2006	2003-2007
Hartlepool	48	50	51	51	52	53	54	54	56	57	57	58	60	59	61	62	62	61	61
NE SHA	51	51	52	52	52	53	53	55	55	56	57	59	60	61	62	63	63	64	65
England	56	56	57	58	58	59	60	61	62	62	63	64	65	65	66	67	68	68	69



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003	2000-2004	2001-2005	2002-2006	2003-2007
Hartlepool	40	43	44	45	46	48	48	49	50	52	54	56	57	58	60	60	60	59	60
NE SHA	45	45	46	46	47	47	48	50	51	52	54	55	56	58	60	61	62	62	63
England	49	50	51	51	52	53	55	56	57	58	59	60	61	62	63	64	65	66	67



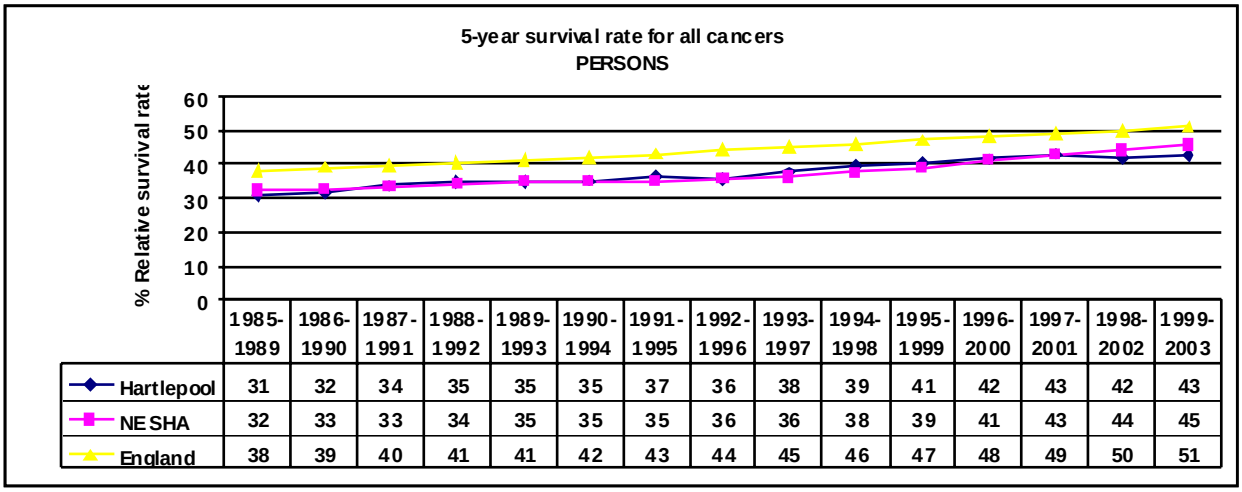
	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003	2000-2004	2001-2005	2002-2006	2003-2007
Hartlepool	57	56	58	57	57	58	60	60	62	62	61	61	63	61	62	64	64	63	63
NE SHA	57	58	58	58	58	58	59	59	60	60	61	62	63	63	64	65	65	66	67
England	62	62	63	63	64	64	65	65	66	66	67	68	68	69	69	69	70	71	71

Source: Northern and Yorkshire Cancer Registry Information Service

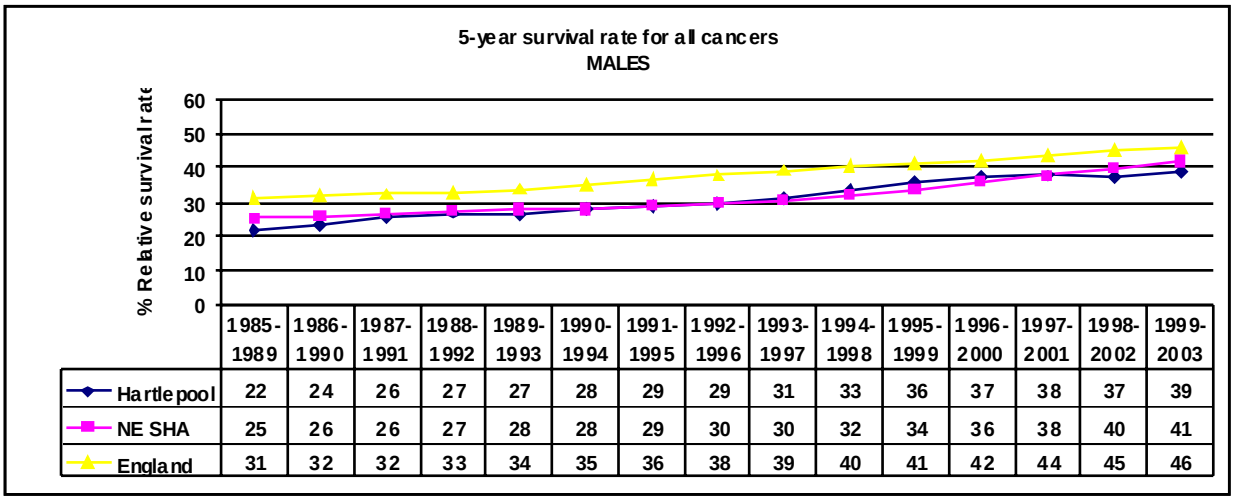
The percentage increase in the 5-year survival rate for all cancers in Hartlepool was 39%, from 31% in 1985/89 to 43% in 1999/03.There were similar increases in the North East and England averages.

As with 1-year survival rate, survival rates are higher in women than men but there are greater increases in rates in men than women in Hartlepool, North East and England (Figure 4.6).

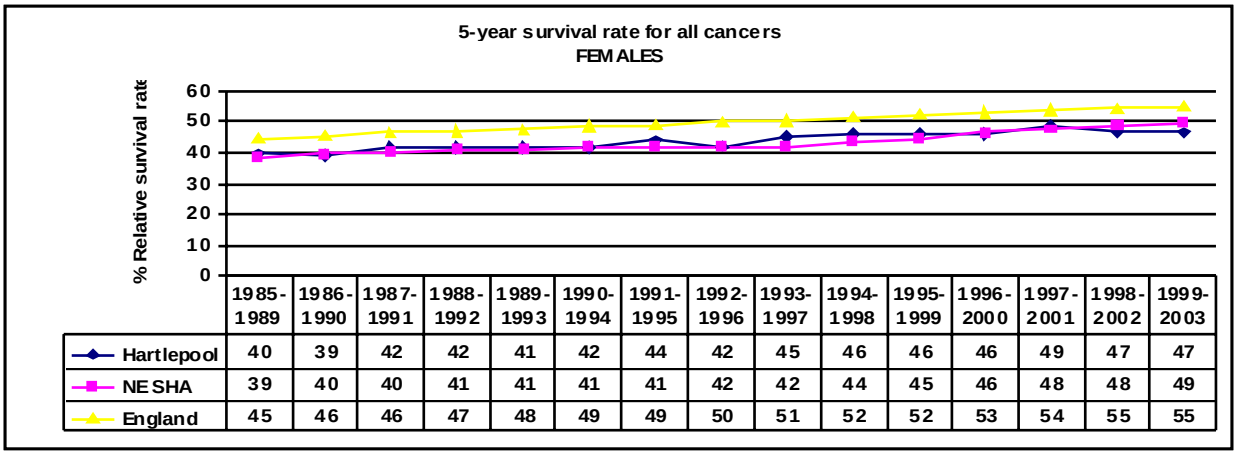
Figure 4.6: 5-Year relative survival rates for all cancers (ICD10: C00-C97 excl. C44 non-melanoma skin) for persons, males and females in Hartlepool 1985/89 – 1999/03



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003
Hartlepool	31	32	34	35	35	35	37	36	38	39	41	42	43	42	43
NE SHA	32	33	33	34	35	35	35	36	36	38	39	41	43	44	45
England	38	39	40	41	41	42	43	44	45	46	47	48	49	50	51



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003
Hartlepool	22	24	26	27	27	28	29	29	31	33	36	37	38	37	39
NE SHA	25	26	26	27	28	28	29	30	30	32	34	36	38	40	41
England	31	32	32	33	34	35	36	38	39	40	41	42	44	45	46

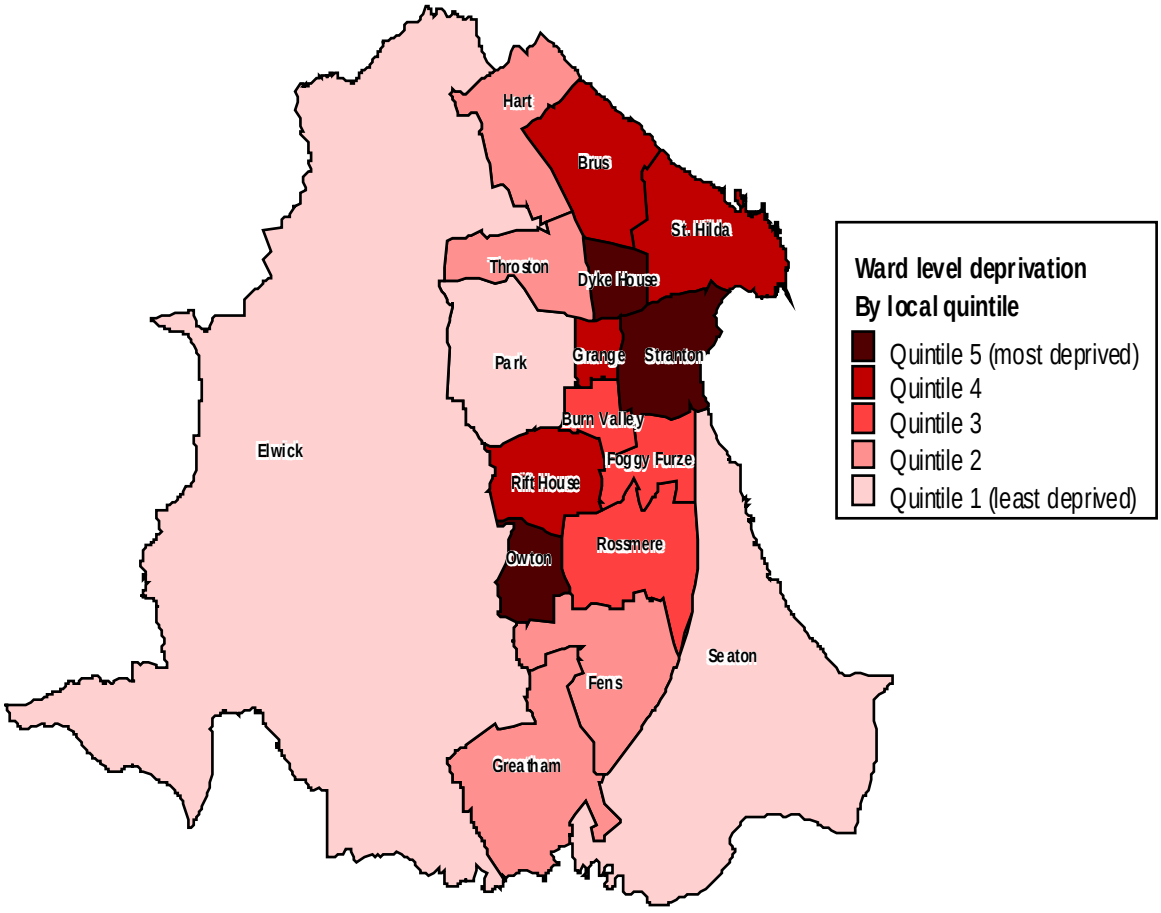


	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003
Hartlepool	40	39	42	42	41	42	44	42	45	46	46	46	49	47	47
NE SHA	39	40	40	41	41	41	41	42	42	44	45	46	48	48	49
England	45	46	46	47	48	49	49	50	51	52	52	53	54	55	55

Source: Northern and Yorkshire Cancer Registry Information Service

5. Ward level data for all cancers

The number of new cases of and deaths from all cancers at electoral wards is usually very small. To facilitate analysis and interpretation annual averages of cases for 5-year groups, between 1994 and 2008, were calculated. The analysis is based on the old electoral wards which were reconfigured in 2003. So caution is needed in interpreting data.



5.1 Incidence

There was a general increase in the annual average number of new cases of all cancers between 1994 and 2008, except in Brinkburn, Dyke House, Rossmere and Stranton where there appears to be a decreasing trend (Table 5.1).

There are higher annual average number of new cases in more deprived wards than the less deprived wards, higher annual average number of 115.2 cases in St Hilda ward (163 out of 7936[2]) and lower number of 27.8 cases in Elwick ward (4777 out of 7936). The exceptions are the Park (6138 out of 7936) and Seaton (3824 out of 7936) wards which are relatively affluent but have high annual average cases of 118.4 and 110.2, respectively. However, average cases need to be standardised to reflect population sizes and age structures.

[2] " 1" means the most deprived ward and 7936 means the least deprived.

Table 5.1: Annual average number of new cases of all cancers (ICD10: C00-C97 excl. C44 non-melanoma skin) in electoral wards for persons, males and females in Hartlepool for 5-year groups 1994-2008

	1994-1998			1999-2003			2004-2008			Total 1994-2008		
Electoral ward	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females
Brinkburn	22.8	11	11.8	25.4	12.6	12.8	22.4	10.6	11.8	70.6	34.2	36.4
Brus	28.6	14.8	13.8	31.6	16.8	14.8	34.2	16	18.2	94.4	47.6	46.8
Dyke House	29.4	15.4	14	29.8	16	13.8	24	12.8	11.2	83.2	44.2	39
Elwick	7.6	3.2	4.4	9.6	5	4.6	10.6	5	5.6	27.8	13.2	14.6
Fens	32.4	16.6	15.8	30	16.2	13.8	34.2	18.8	15.4	96.6	51.6	45
Grange	27.2	11.6	15.6	24.4	11	13.4	30.8	13.8	17	82.4	36.4	46
Greatham	11.4	7	4.4	11.4	7.6	3.8	13.8	7	6.8	36.6	21.6	15
Hart	18.8	10	8.8	22.8	12.8	10	25.2	11.2	14	66.8	34	32.8
Jackson	21	12.6	8.4	24.8	11.2	13.6	22.4	12.2	10.2	68.2	36	32.2
Owton	23.6	12.4	11.2	23.2	12.8	10.4	25	11.4	13.6	71.8	36.6	35.2
Park	36.6	18	18.6	40	23	17	41.8	22.4	19.4	118.4	63.4	55
Rift House	28.2	16.4	11.8	30.6	15.2	15.4	29.8	13.2	16.6	88.6	44.8	43.8
Rossmere	31.6	16.4	15.2	32	16.8	15.2	28.6	13.4	15.2	92.2	46.6	45.6
St Hilda	33.2	18.8	14.4	39	19	20	43	21.4	21.6	115.2	59.2	56
Seaton	32.8	16.2	16.6	33.6	18.4	15.2	43.8	23	20.8	110.2	57.6	52.6
Stranton	36.2	19.4	16.8	28.6	15.8	12.8	29.8	16	13.8	94.6	51.2	43.4
Throston	29	15.8	13.2	33.8	18.6	15.2	36.6	17.4	19.2	99.4	51.8	47.6

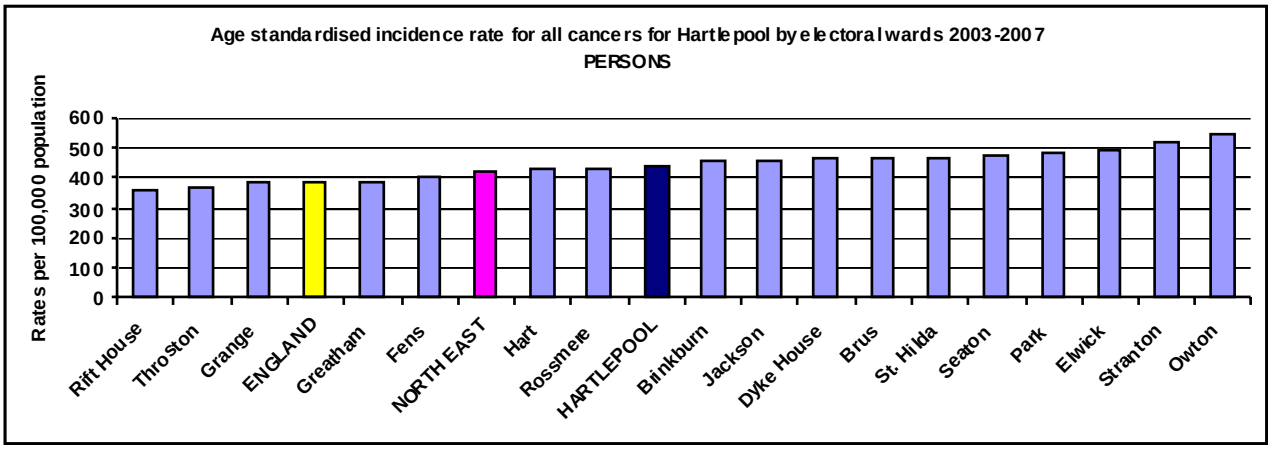
Source: Northern and Yorkshire Cancer Registry Information Service

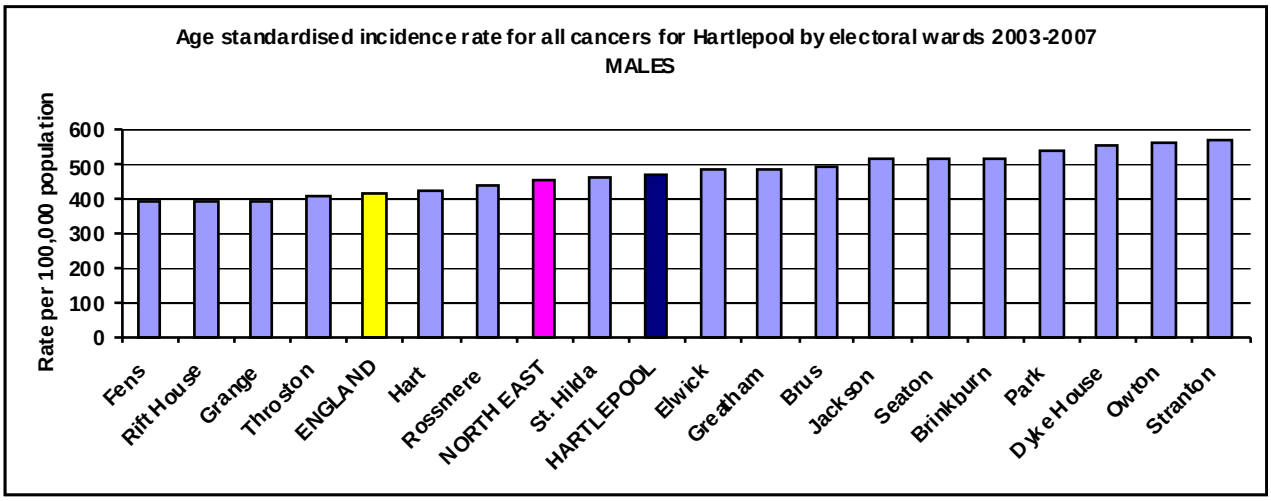
The age standardised incidence rate for all cancers in persons 2003-2007 vary from the lowest 361.4 per 100,000 population in Rift House ward to the highest of 548.4 per 100,000 population in the Owton ward, with Hartlepool average rate at 434.7 per 100, 000 population and England at 387.2 per 100,000 population. Two wards (Rift House and Throston) have incidence rates below the England average for persons, males and females.

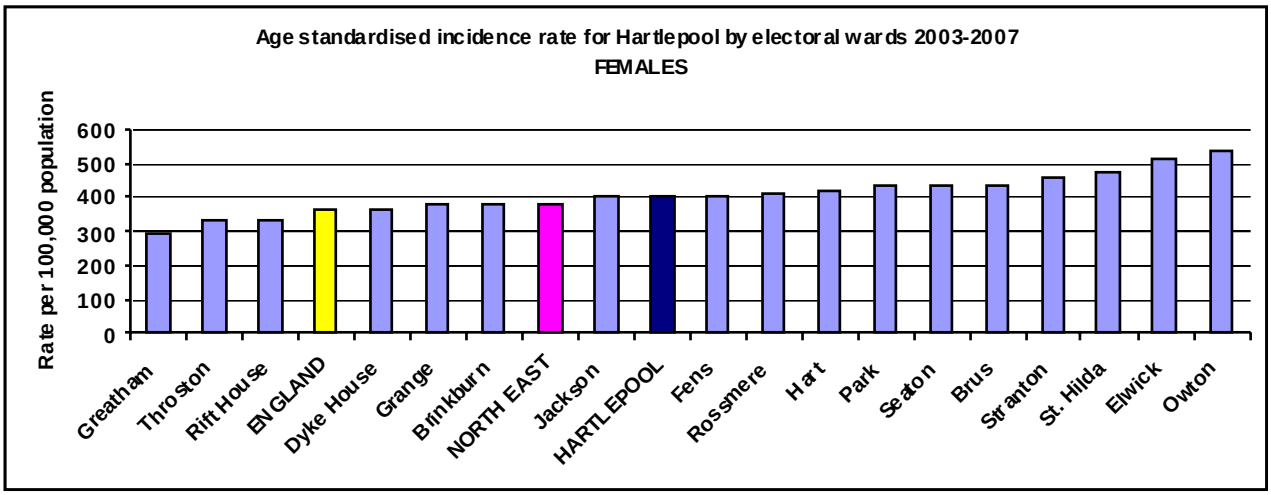
Incidence rates vary across wards and do not necessarily mirror deprivation levels, with deprived wards such as Dyke House (63 out of 7936) with a lower rate of 460.1 per 100,000 population and more affluent ones such as Park (6138 out of 7936) with a higher rate of 483.2 per 100,000 population (Figure 5.1).

Incidence rates are generally higher in men than women.

Figure 5.1: Age standardised incidence rates for all cancers (ICD10: C00-C97 excl. C44 non-melanoma skin) in electoral wards for persons, males and females in Hartlepool 2003-2007







Source: Northern and Yorkshire Cancer Registry Information Service

5.2 Mortality

The annual averages of deaths from all cancers in 1994-2008 vary from 14.4 cases in Elwick ward to 70.2 cases in Park ward (Table 5.2).

Generally, there is an increase in annual averages of cases except in Dyke House, Grange and Stranton wards where there appears to be a decreasing trend.

The annual averages of cases do not appear to mirror deprivation levels across the wards, a higher average number of 70.2 cases in Park ward (6138 out of 7936) and lower average of 48.6 cases in Dyke House (63 out of 7936). However, average deaths need to be standardised to reflect population sizes and structures.

Table 5.2: Annual averages of deaths from all cancers (ICD10: C00-C97 excl. C44 non-melanoma skin) by electoral ward for persons, males and females in Hartlepool for 5-year groups 1994-2008

	1994-1998			1999-2003			2004-2008			Total 1994-2008		
Electoral wards	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females
Brinkburn	12.8	7	5.8	11.4	5	6.4	15.2	7.4	7.8	39.4	19.4	20
Brus	18.8	10.8	8	23.6	12.2	11.4	22.2	11.2	11	64.6	34.2	30.4
Dyke House	17.2	9.8	7.4	16.4	9.6	6.8	15	8.6	6.4	48.6	28	20.6
Elwick	5	2.4	2.6	4.8	3.2	1.6	4.6	2.2	2.4	14.4	7.8	6.6
Fens	18.4	10.2	8.2	16.2	9.6	6.6	20	10.8	9.2	54.6	30.6	24
Grange	19.4	8.4	11	17.4	7.2	10.2	16	7.4	8.6	52.8	23	29.8
Greatham	9.4	5.4	4	5.4	3.8	1.6	7.2	3.2	4	22	12.4	9.6
Hart	9.8	6.4	3.4	11.8	5.4	6.4	13.6	7.4	6.2	35.2	19.2	16
Jackson	13.4	7.4	6	13.6	7.6	6	14.4	9	5.4	41.4	24	17.4
Owton	16.8	9.8	7	14.8	8.2	6.6	16.8	8.2	8.6	48.4	26.2	22.2
Park	19.6	9.6	10	22.6	14	8.6	28	15.8	12.2	70.2	39.4	30.8
Rift House	18.2	9.2	9	21.2	11.2	10	16.4	8.8	7.6	55.8	29.2	26.6
Rossmere	21.2	12.2	9	23.2	13.8	9.4	20.4	10	10.4	64.8	36	28.8
St Hilda	22.4	13.6	8.8	20	10.2	9.8	25.4	12	13.4	67.8	35.8	32
Seaton	21	11.4	9.6	19	10.4	8.6	25	13.2	11.8	65	35	30
Stranton	23.2	13	10.2	16.8	9.4	7.4	20.2	11.8	8.4	60.2	34.2	26
Throston	16.8	9.2	7.6	18.8	11	7.8	20.4	11	9.4	56	31.2	24.8

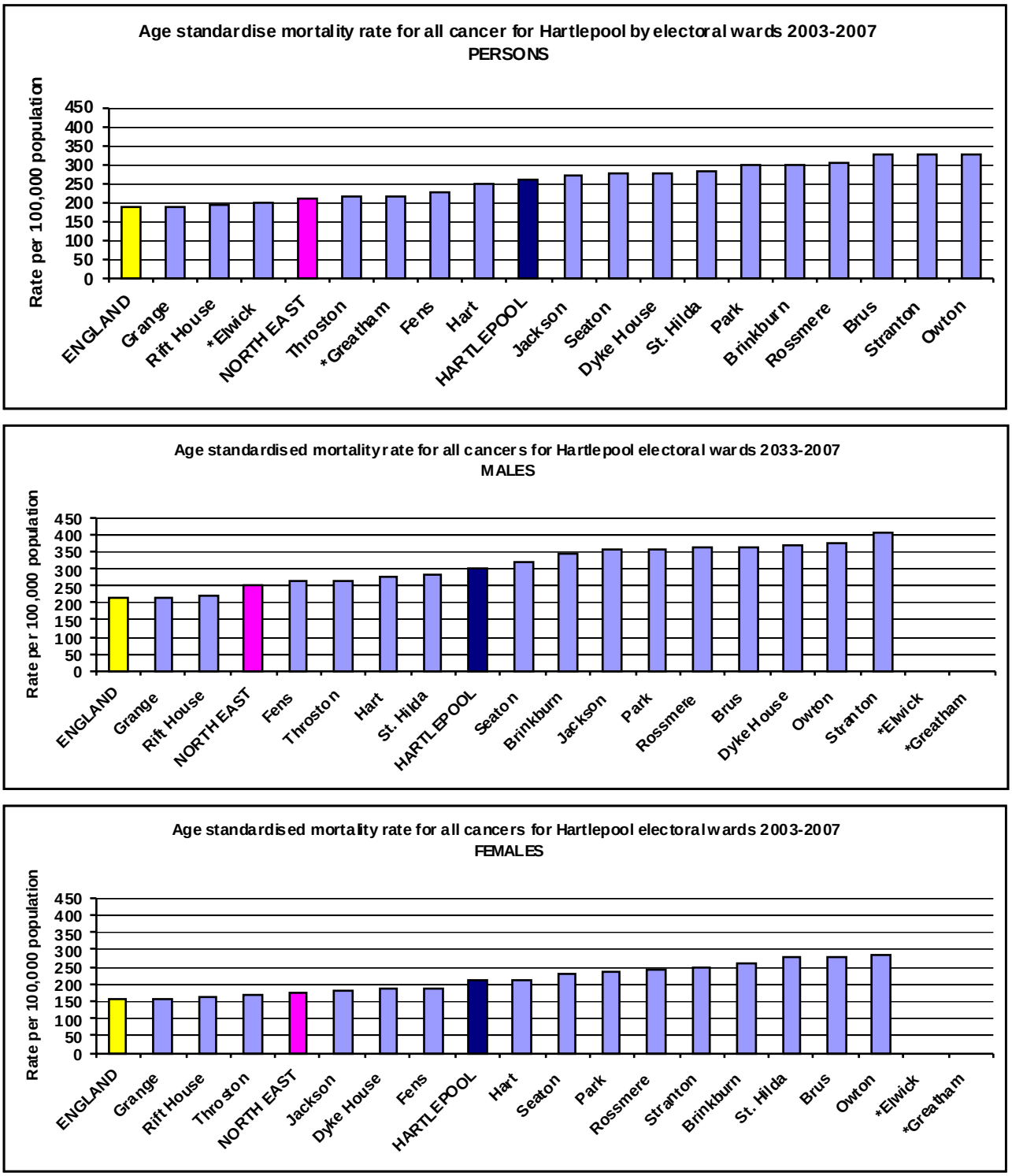
Source: Northern and Yorkshire Cancer Registry Information Service

There is nearly a two-fold difference in mortality rates for all cancers and for persons in electoral wards in Hartlepool in 2003-07, ranging from 186.7 per 100,000 population (Grange ward) to 328.5 per 100,000 population (Owton ward). The average rate for Hartlepool was 256.5 per 100,000 per population which is higher than that of North East (212 per 100,000 population) and England (183 per 100,000 population) averages. The mortality rates in all wards are higher than that the England average (Figure 5.2).

Mortality rates are higher in the more deprived wards of Stranton (49 out of 7936) of 327.1 per 100,000 population) and Brus (222 out of 7936) of 321.5 per 100,000 population. The rate in the less deprived wards of Elwick (4777 out of 7936) of 201.1 per 100,000 population and Greatham (3196 out of 7936) of 216.7 per 100,000 population are lower. However some of the more affluent wards such as Park (6138 out of 7936) and Seaton (3824 out of 7936) have higher rates of 297.8 and 275.0 per 100,000 population, respectively.

Mortality rates are generally higher in men than women.

Figure 5.2: Age standardised mortality rates for all cancers (ICD10: C00-C97 excl. C44 non-melanoma skin) for persons, males and females in electoral wards in Hartlepool 2003-2007



** Data suppressed because less than five events*

Source: Northern and Yorkshire Cancer Registry Information Service

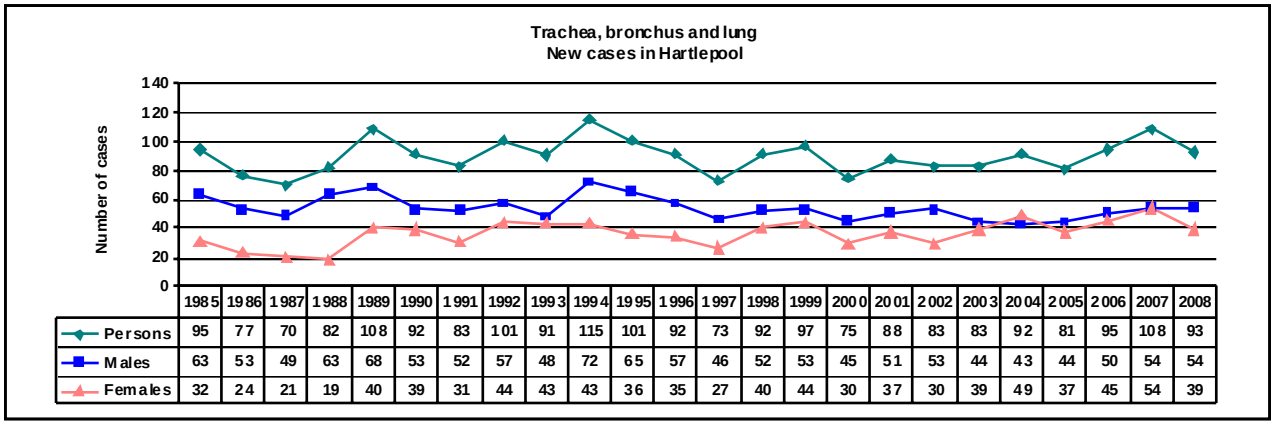
6. Trachea, bronchus and lung cancer

6.1 Incidence

Overall the number of new cases of trachea, bronchus and lung cancer in Hartlepool in 1985 -2008 appears to be decreasing. However, numbers are increasing in females:

- A decrease in cases in males from 63 cases in 1985 to 54 cases in 2008.
- More women are being diagnosed, an increase from 32 cases in 1985 to 39 cases in 2008 (with peaks of 49 cases in 2004, 45 cases in 2006 and 54 cases in 2007) (Figure 6.1).

Figure 6.1: Number of new cases of trachea, bronchus and lung cancer (ICD10: C33-C34) for persons, males and females in Hartlepool 1985-2008



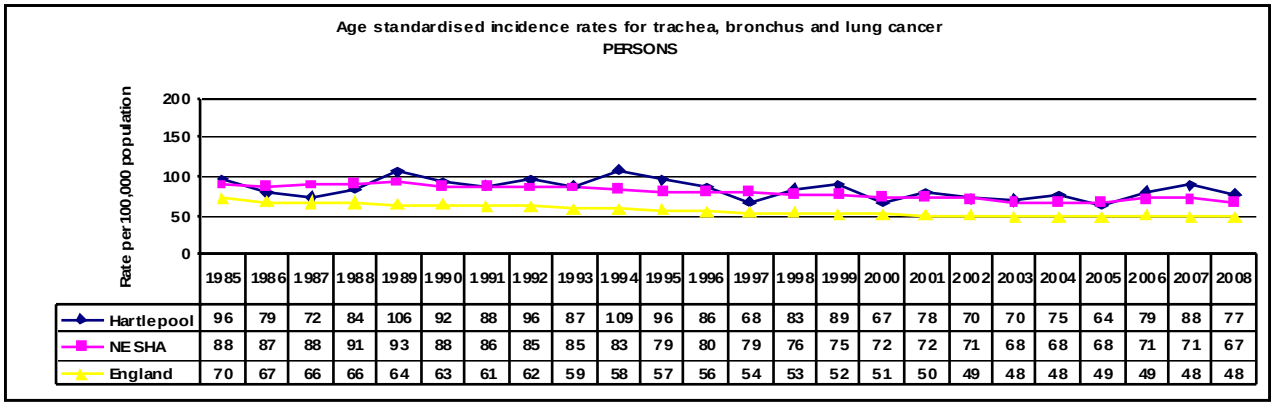
	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Persons	95	77	70	82	108	92	83	101	91	115	101	92	73	92	97	75	88	83	83	92	81	95	108	93
Males	63	53	49	63	68	53	52	57	48	72	65	57	46	52	53	45	51	53	44	43	44	50	54	54
Females	32	24	21	19	40	39	31	44	43	43	36	35	27	40	44	30	37	30	39	49	37	45	54	39

Source: Northern and Yorkshire Cancer Registry Information Service

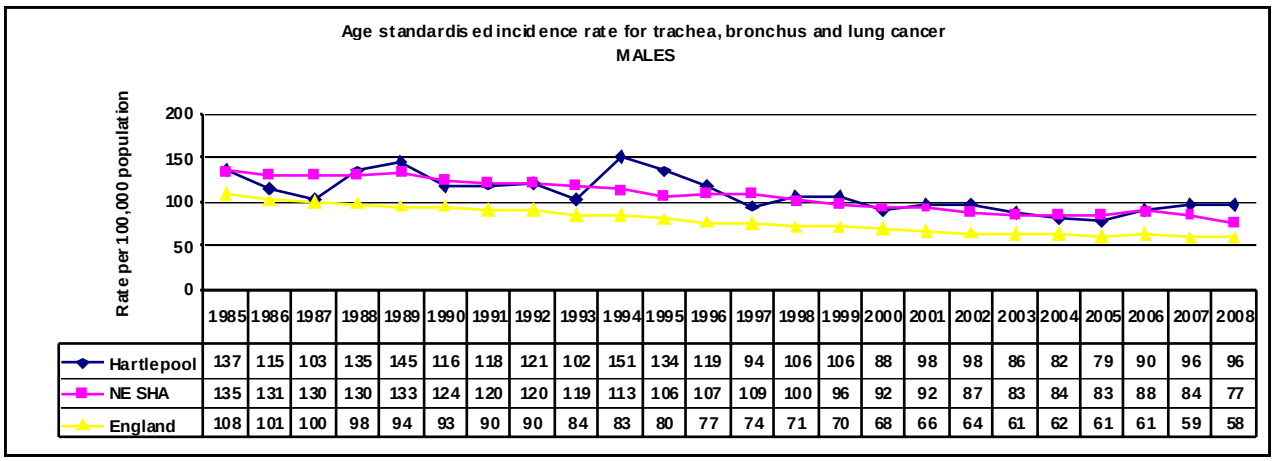
The age standardised incidence rates for trachea, bronchus and lung cancer are also decreasing in Hartlepool overall but increasing in females.

- Hartlepool 25% decrease from 96 per 100,000 population in 1985 to 77 per 100,000 population in 2008, slightly higher than the North East and England averages.
- The decrease in rate is higher in males 43%, from 137 per 100,000 population in 1985 to 96 per 100,000 population in 2008.
- There is a 5% increase in rate in females from 55 per 100,000 population in 1985 to 58 per 100,000 population in 2008. Rates as high as 80 per 100,000 population were seen in 2007. Rates are higher in Hartlepool compared with the North East and England averages (Figure 6.2).

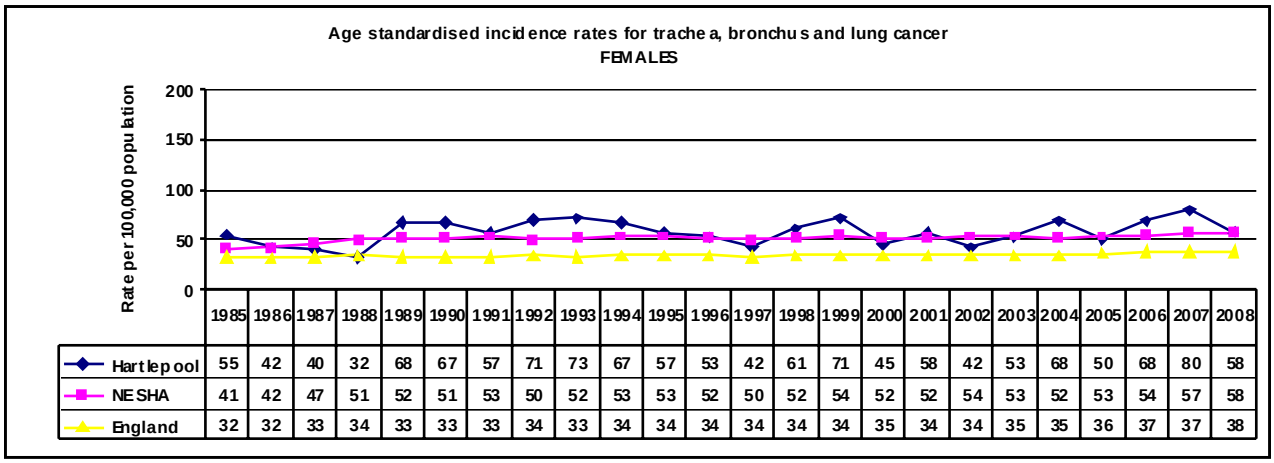
Figure 6.2: Age standardised incidence rates for trachea, bronchus and lung cancer (ICD10: C33-C34) for persons, males and females in Hartlepool 1985-2008



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	96	79	72	84	106	92	88	96	87	109	96	86	68	83	89	67	78	70	70	75	64	79	88	77
NESHA	88	87	88	91	93	88	86	85	85	83	79	80	79	76	75	72	72	71	68	68	68	71	71	67
England	70	67	66	66	64	63	61	62	59	58	57	56	54	53	52	51	50	49	48	48	49	49	48	48



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	137	115	103	135	145	116	118	121	102	151	134	119	94	106	106	88	98	98	86	82	79	90	96	96
NE SHA	135	131	130	130	133	124	120	120	119	113	106	107	109	100	96	92	92	87	83	84	83	88	84	77
England	108	101	100	98	94	93	90	90	84	83	80	77	74	71	70	68	66	64	61	62	61	61	59	58



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	55	42	40	32	68	67	57	71	73	67	57	53	42	61	71	45	58	42	53	68	50	68	80	58
NE SHA	41	42	47	51	52	51	53	50	52	53	53	52	50	52	54	52	52	54	53	52	53	54	57	58
England	32	32	33	34	33	33	33	34	33	34	34	34	34	34	34	35	34	34	35	35	36	37	37	38

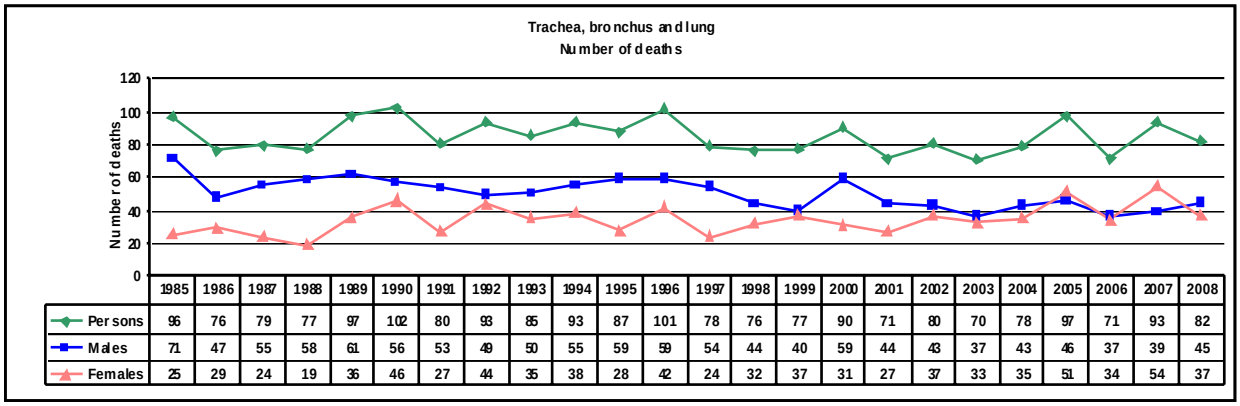
Source: Northern and Yorkshire Cancer Registry Information Service

6.2 Mortality

There is a general decreasing trend in the number of deaths from trachea, bronchus and lung cancer in Hartlepool but an increasing trend in females:

- There were 96 deaths in 1985 compared with 82 deaths in 2008.
- Fewer men died, there were 71 deaths in 1985 and 45 deaths in 2008.
- More women died, increasing from 25 deaths in 1985 to 37 deaths in 2008 (54 died in 2007) (Figure 6.3).

Figure 6.3: Number of deaths from trachea, bronchus and lung cancer (ICD10: C33-C34) for persons, males and females in Hartlepool 1985-2008



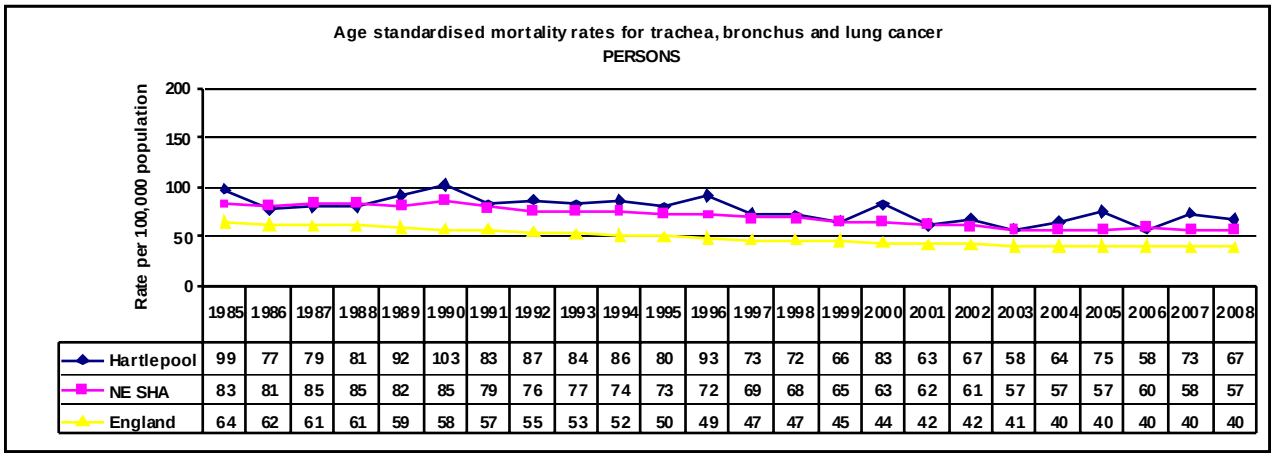
	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Persons	96	76	79	77	97	102	80	93	85	93	87	101	78	76	77	90	71	80	70	78	97	71	93	82
Males	71	47	55	58	61	56	53	49	50	55	59	59	54	44	40	59	44	43	37	43	46	37	39	45
Females	25	29	24	19	36	46	27	44	35	38	28	42	24	32	37	31	27	37	33	35	51	34	54	37

Source: Northern and Yorkshire Cancer Registry Information Service

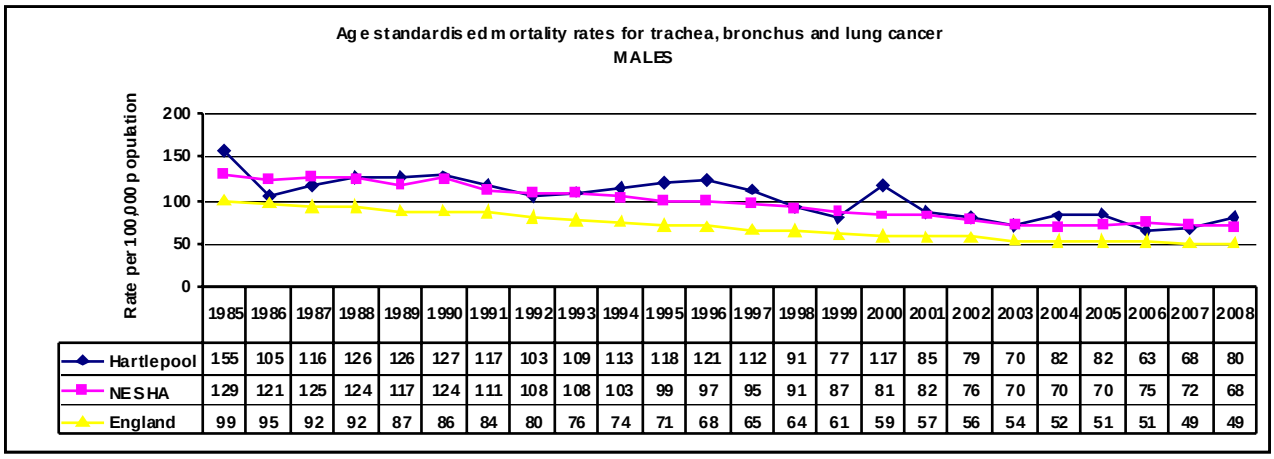
The age standardized mortality rate for trachea, bronchus and lung cancer in Hartlepool show similar trends to incidence rate:

- A decrease in Hartlepool rate of 32%, a fall from 99 per 100,000 population in 1985 to 67 per 100,000 population in 2008, similar to the decrease in the North East average of 31% (83 to 57 per 100,000 population) and slightly lower than the England average decrease of 37% (64 to 40 per 100,000 population.
- A 48% *decrease* in death rate in men from 155 per 100,000 population in 1985 to 80 per 100,000 population in 2008
- A 26% *increase* in rate in women from 43 per 100,000 population in 1985 to 54 per 100,000 population in 2008 (Figure 6.4).

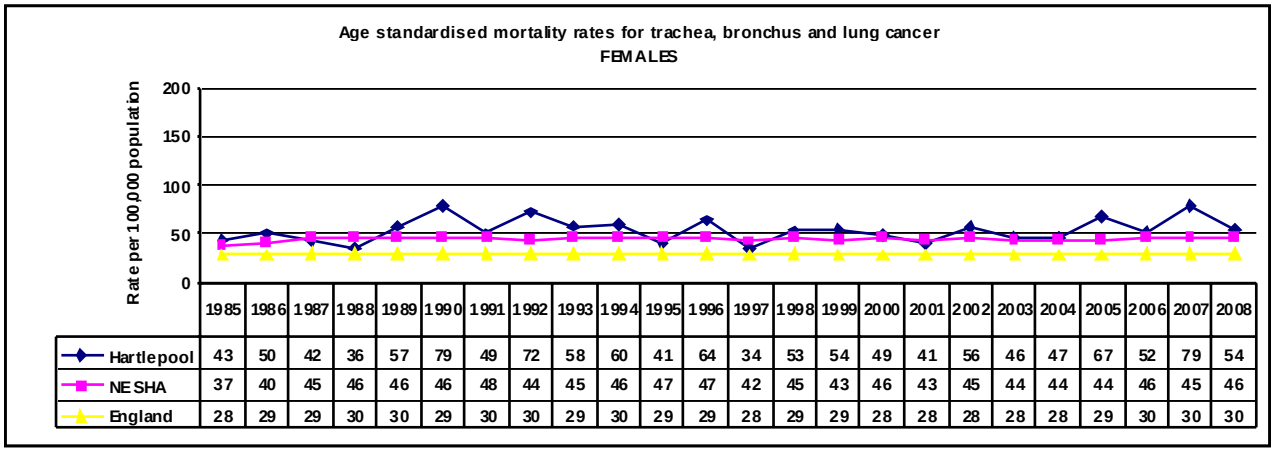
Figure 6.4: Age standardised mortality rates for trachea, bronchus and lung cancer (ICD10: C33-C34) for persons, males and females in Hartlepool 1985-2008



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	99	77	79	81	92	103	83	87	84	86	80	93	73	72	66	83	63	67	58	64	75	58	73	67
NE SHA	83	81	85	85	82	85	79	76	77	74	73	72	69	68	65	63	62	61	57	57	57	60	58	57
England	64	62	61	61	59	58	57	55	53	52	50	49	47	47	45	44	42	42	41	40	40	40	40	40



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	155	105	116	126	126	127	117	103	109	113	118	121	112	91	77	117	85	79	70	82	82	63	68	80
NE SHA	129	121	125	124	117	124	111	108	108	103	99	97	95	91	87	81	82	76	70	70	70	75	72	68
England	99	95	92	92	87	86	84	80	76	74	71	68	65	64	61	59	57	56	54	52	51	51	49	49



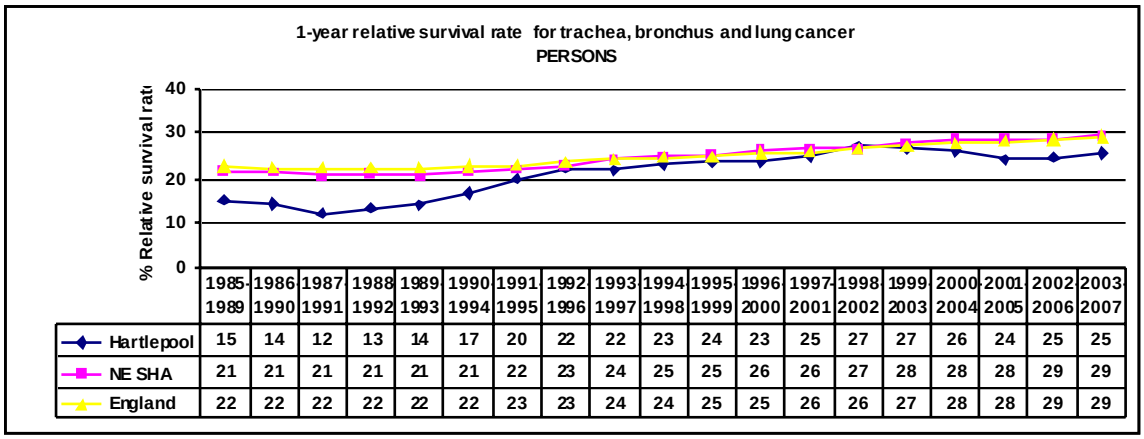
	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	43	50	42	36	57	79	49	72	58	60	41	64	34	53	54	49	41	56	46	47	67	52	79	54
NE SHA	37	40	45	46	46	46	48	44	45	46	47	47	42	45	43	46	43	45	44	44	44	46	45	46
England	28	29	29	30	30	29	30	30	29	30	29	29	28	29	29	28	28	28	28	28	29	30	30	30

Source: Northern and Yorkshire Cancer Registry Information Service

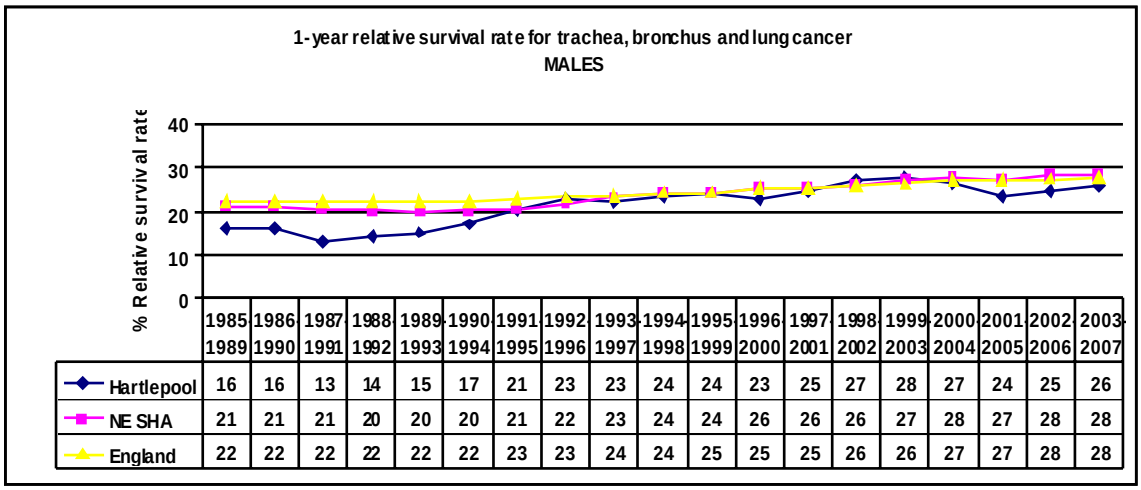
6.3 Survival

One-year survival rate for trachea, bronchus and lung in Hartlepool increased by 67%, from 15% in 1985/89 to 25% in 200307, higher than the North East and England average rate increases of 38% (21% to 29%) and 32% (22% to 29%), respectively.
There were similar increases in rates in men and women (Figure 6.5)

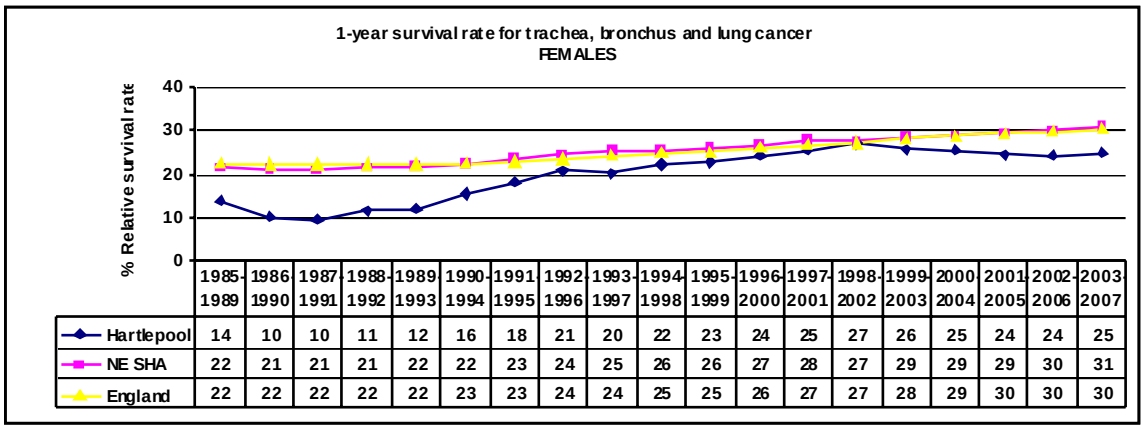
Figure 6.5: 1-year survival rate for trachea, bronchus and lung cancer (ICD10: C33-C34) for persons, males and females in Hartlepool 1985/89-2003/07



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003	2000-2004	2001-2005	2002-2006	2003-2007
Hartlepool	15	14	12	13	14	17	20	22	22	23	24	23	25	27	27	26	24	25	25
NE SHA	21	21	21	21	21	21	22	23	24	25	25	26	26	27	28	28	28	29	29
England	22	22	22	22	22	22	23	23	24	24	25	25	26	26	27	28	28	29	29



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003	2000-2004	2001-2005	2002-2006	2003-2007
Hartlepool	16	16	13	14	15	17	21	23	23	24	24	23	25	27	28	27	24	25	26
NE SHA	21	21	21	20	20	20	21	22	23	24	24	26	26	26	27	28	27	28	28
England	22	22	22	22	22	22	23	23	24	24	25	25	25	26	26	27	27	28	28

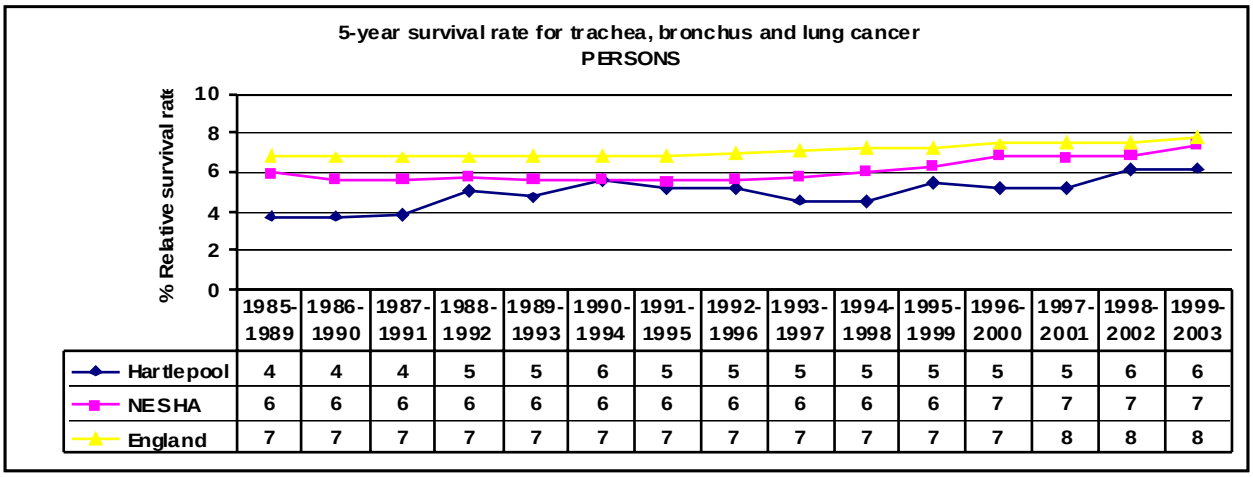


	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003	2000-2004	2001-2005	2002-2006	2003-2007
Hartlepool	14	10	10	11	12	16	18	21	20	22	23	24	25	27	26	25	24	24	25
NE SHA	22	21	21	21	22	22	23	24	25	26	26	27	28	27	29	29	29	30	31
England	22	22	22	22	22	23	23	24	24	25	25	26	27	27	28	29	30	30	30

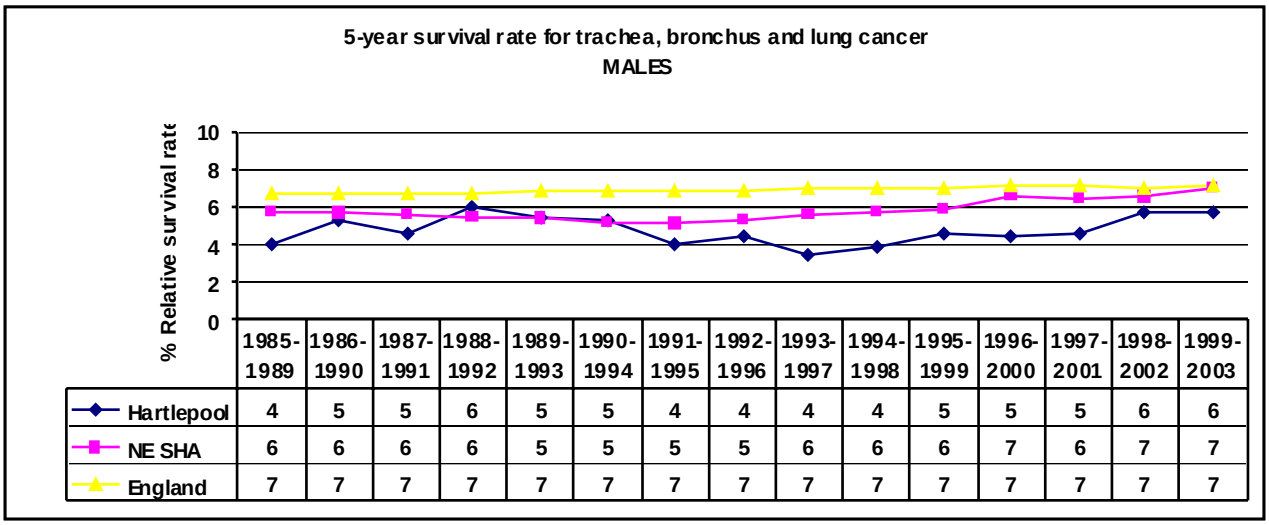
Source: Northern and Yorkshire Cancer Registry Information Service

There was a 50% increase in 5-year survival rate for trachea, bronchus and lung in Hartlepool, from 4% in 1985/89 to 6% in 1999/03. There were also similar increases in the North East and England average rates (Figure 6.6).

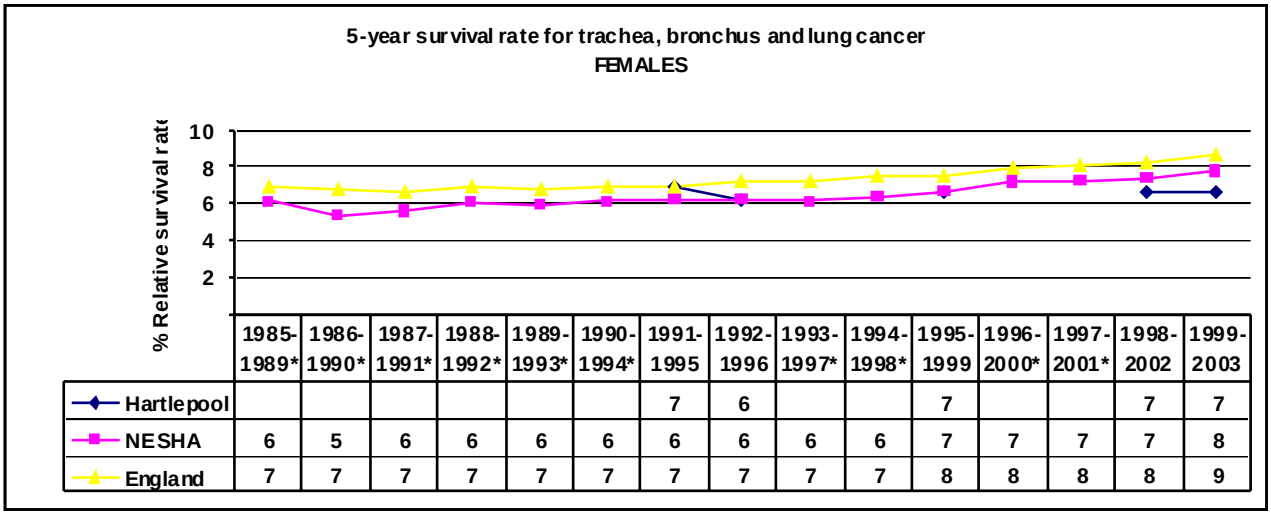
Figure 6.6: 5-year survival rate for trachea, bronchus and lung cancer (ICD10: C33-C34) for persons, males and females in Hartlepool 1985/89-1999/03



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003
Hartlepool	4	4	4	5	5	6	5	5	5	5	5	5	5	6	6
NESHA	6	6	6	6	6	6	6	6	6	6	6	7	7	7	7
England	7	7	7	7	7	7	7	7	7	7	7	7	8	8	8



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003
Hartlepool	4	5	5	6	5	5	4	4	4	4	5	5	5	6	6
NE SHA	6	6	6	6	5	5	5	5	6	6	6	7	6	7	7
England	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7



	1985-1989*	1986-1990*	1987-1991*	1988-1992*	1989-1993*	1990-1994*	1991-1995	1992-1996	1993-1997*	1994-1998*	1995-1999	1996-2000*	1997-2001*	1998-2002	1999-2003
Hartlepool							7	6			7			7	7
NESHA	6	5	6	6	6	6	6	6	6	6	7	7	7	7	8
England	7	7	7	7	7	7	7	7	7	7	8	8	8	8	9

** Missing due to small numbers*
Source: Northern and Yorkshire Cancer Registry Information Service

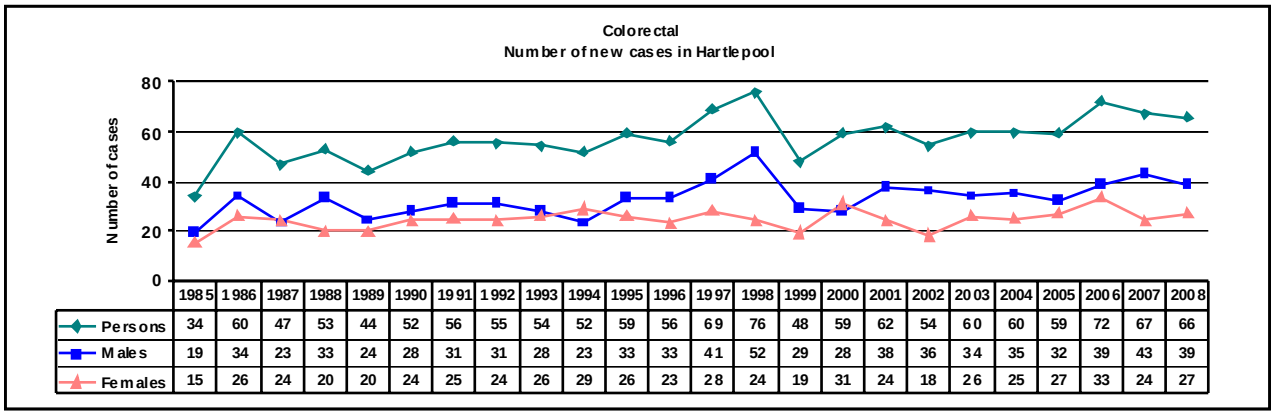
7. Colorectal cancer

7.1 Incidence

The number of new cases of colorectal cancer in Hartlepool has almost doubled between 1985 and 2008, from 34 cases in 1985 to 66 cases in 2008. The annual average of cases in the first six years (1985 – 1990) was 48 cases and 64 cases in the last six years (2003-2008).

- In men the number of cases increased from 19 cases in 1985 to 39 cases in 2008
- There were fewer cases in women, from 15 cases in 1985 to 27 cases in 2008 (Figure 7.1).

Figure 7.1: Number of new cases of colorectal cancer (ICD10: C18-C20) for persons, males and females in Hartlepool 1985-2008



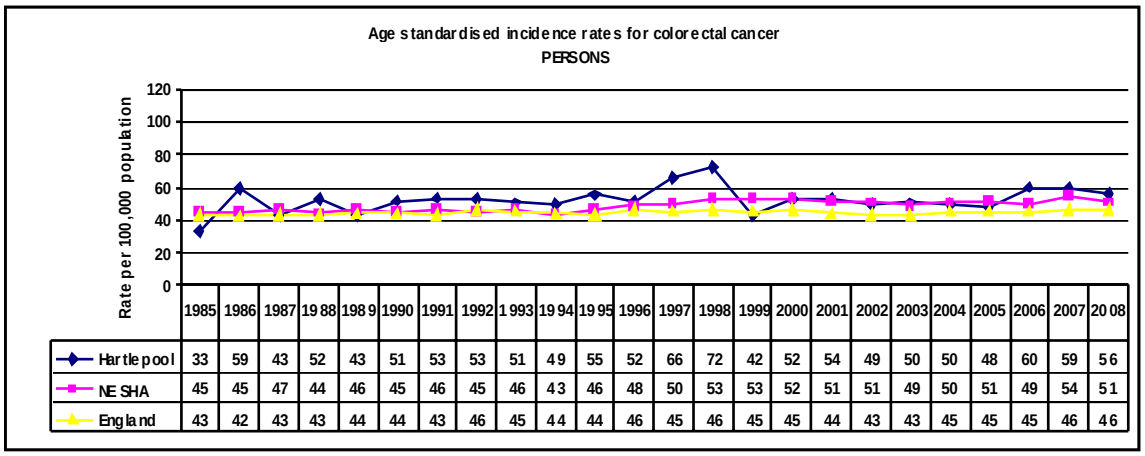
	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Persons	34	60	47	53	44	52	56	55	54	52	59	56	69	76	48	59	62	54	60	60	59	72	67	66
Males	19	34	23	33	24	28	31	31	28	23	33	33	41	52	29	28	38	36	34	35	32	39	43	39
Females	15	26	24	20	20	24	25	24	26	29	26	23	28	24	19	31	24	18	26	25	27	33	24	27

Source: Northern and Yorkshire Cancer Registry Information Service

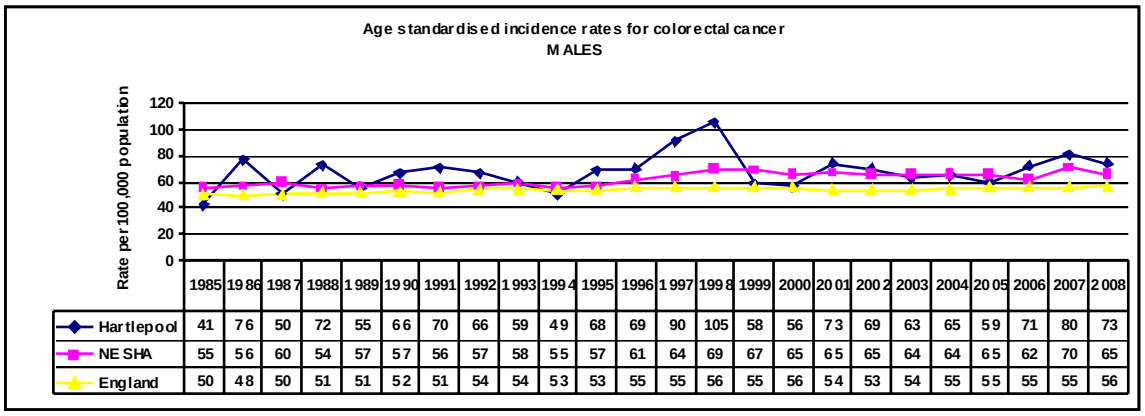
There was an increase in age standardised incidence rate for colorectal cancer in Hartlepool of about 70%, from 33 per 100,000 population in 1985 to 56 per 100,000 population in 2008. This was over 5 times higher than 13% increase in the North East average (45 to 51 per 100,000 population) and 10 times the England average of 7% (43 to 46 per 100,000 population). However, the rate in Hartlepool was exceptionally low in 1985 compared to the North East and England averages (Figure 7.2).

There was a greater increase in incidence rate in men 78%, from 41 per 100,000 population in 1985 to 73 per 100,000 population in 2008, and a lower increase in rate in females of 56%, from 25 per 100,000 population in 1985 to 39 per 100,000 population in 2008.

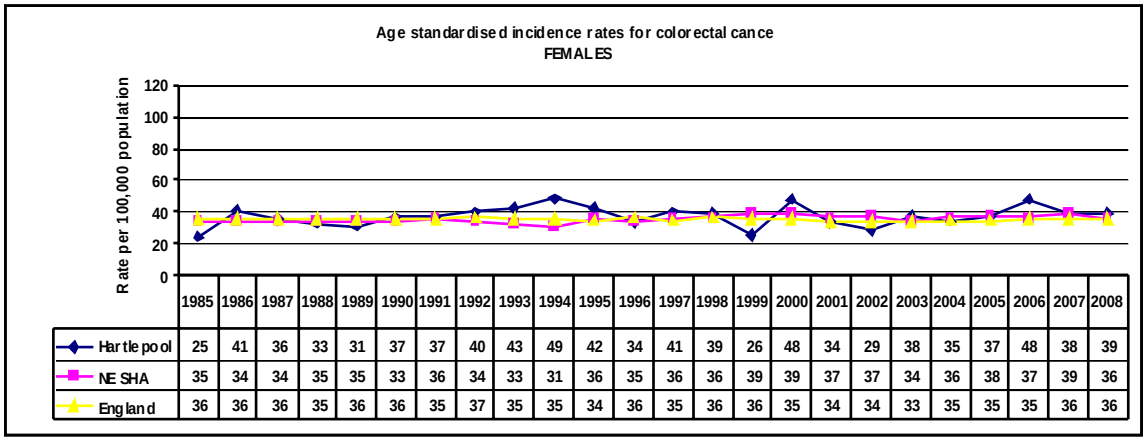
Figure 7.2; Age standardised incidence rates for colorectal cancer (ICD10: C18-C20) for persons, males and females in Hartlepool 1985-2008



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	33	59	43	52	43	51	53	53	51	49	55	52	66	72	42	52	54	49	50	50	48	60	59	56
NESHA	45	45	47	44	46	45	46	45	46	43	46	48	50	53	53	52	51	51	49	50	51	49	54	51
England	43	42	43	43	44	44	43	46	45	44	44	46	45	46	45	45	44	43	43	45	45	45	46	46



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	41	76	50	72	55	66	70	66	59	49	68	69	90	105	58	56	73	69	63	65	59	71	80	73
NESHA	55	56	60	54	57	57	56	57	58	55	57	61	64	69	67	65	65	65	64	64	65	62	70	65
England	50	48	50	51	51	52	51	54	54	53	53	55	55	56	55	56	54	53	54	55	55	55	55	56



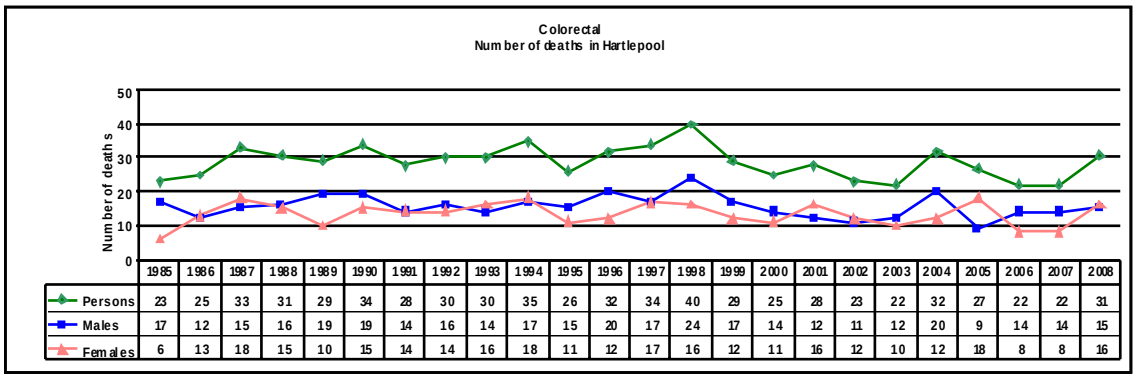
	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	25	41	36	33	31	37	37	40	43	49	42	34	41	39	26	48	34	29	38	35	37	48	38	39
NESHA	35	34	34	35	35	33	36	34	33	31	36	35	36	36	39	39	37	37	34	36	38	37	39	36
England	36	36	36	35	36	36	35	37	35	35	34	36	35	36	36	35	34	34	33	35	35	35	36	36

Source: Northern and Yorkshire Cancer Registry Information Service

7.2 Mortality

There is an increasing trend in the number of deaths from colorectal cancer in Hartlepool from 23 cases in 1985, which peaked at 40 cases in 1998. Since then there has been a steady decline in incidence rates to 22 cases in 2007. In 2008 the number of cases rose again to 31 cases. Generally, more men than women are dying from colorectal cancer (Figure 7.3)

Figure 7.3: Number of deaths from colorectal cancer (ICD10: C18-C20) in Hartlepool 1985-2008

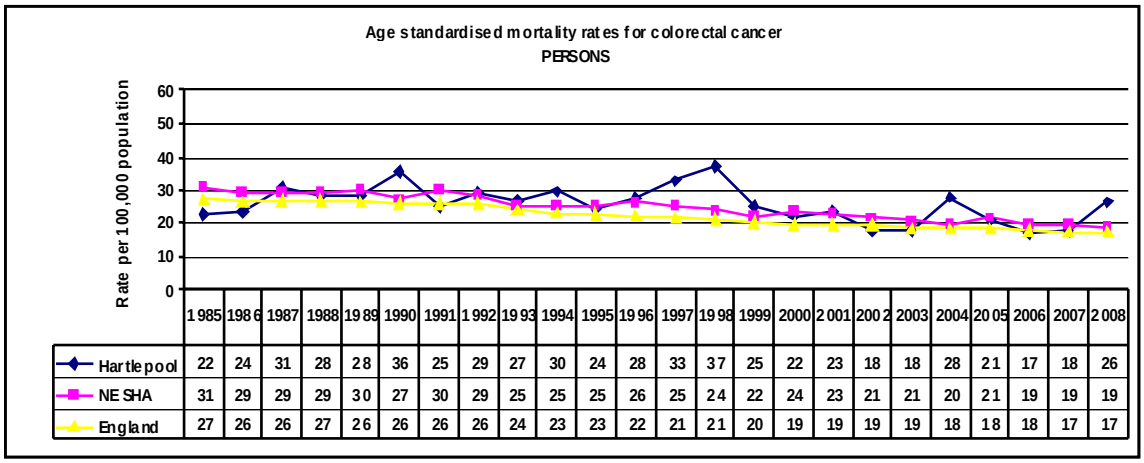


	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Persons	23	25	33	31	29	34	28	30	30	35	26	32	34	40	29	25	28	23	22	32	27	22	22	31
Males	17	12	15	16	19	19	14	16	14	17	15	20	17	24	17	14	12	11	12	20	9	14	14	15
Females	6	13	18	15	10	15	14	14	16	18	11	12	17	16	12	11	16	12	10	12	18	8	8	16

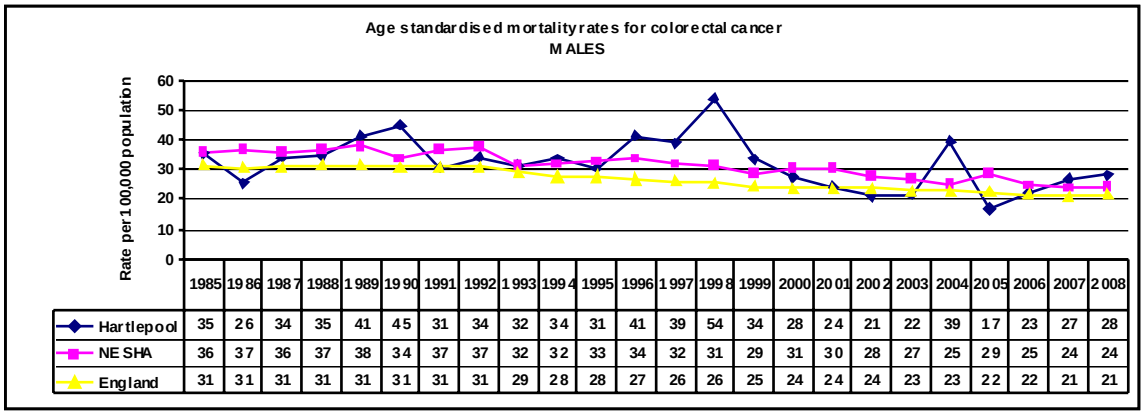
Source: Northern and Yorkshire Cancer Registry Information Service

In the last ten years there appears to be a decreasing trend in the age standardized incidence rates for colorectal cancer in Hartlepool following an increasing trend which peaked at 37 per 100,000 population in 1998. There is a similar trend in incidence rates in the North East and England. Rates are generally higher in men than women (Figure 7.4).

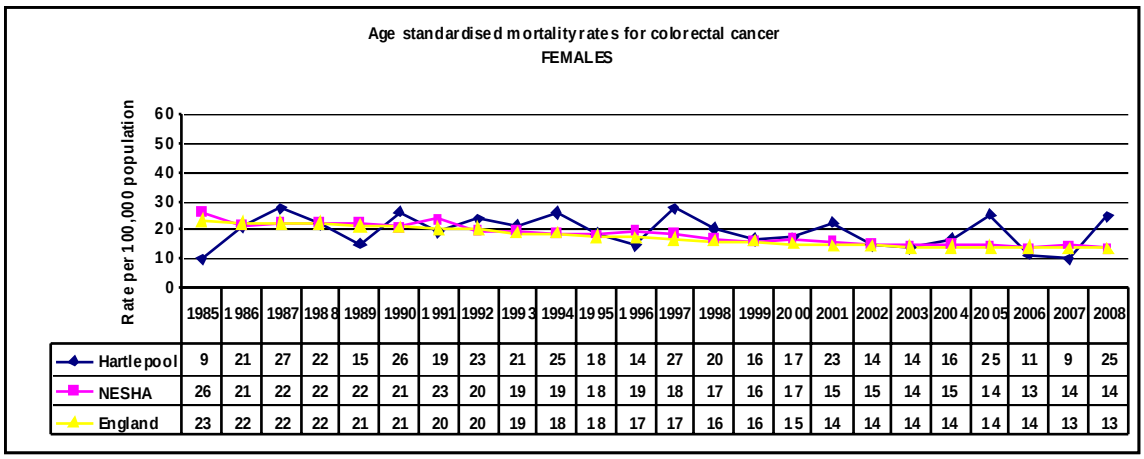
Figure 7.4: Age standardised mortality rate for colorectal cancer (ICD10: C18-C20) for persons, males and females in Hartlepool 1985-2008



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	22	24	31	28	28	36	25	29	27	30	24	28	33	37	25	22	23	18	18	28	21	17	18	26
NESHA	31	29	29	29	30	27	30	29	25	25	25	26	25	24	22	24	23	21	21	20	21	19	19	19
England	27	26	26	27	26	26	26	26	24	23	23	22	21	21	20	19	19	19	19	18	18	18	17	17



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	35	26	34	35	41	45	31	34	32	34	31	41	39	54	34	28	24	21	22	39	17	23	27	28
NESHA	36	37	36	37	38	34	37	37	32	32	33	34	32	31	29	31	30	28	27	25	29	25	24	24
England	31	31	31	31	31	31	31	31	29	28	28	27	26	26	25	24	24	24	23	23	22	22	21	21



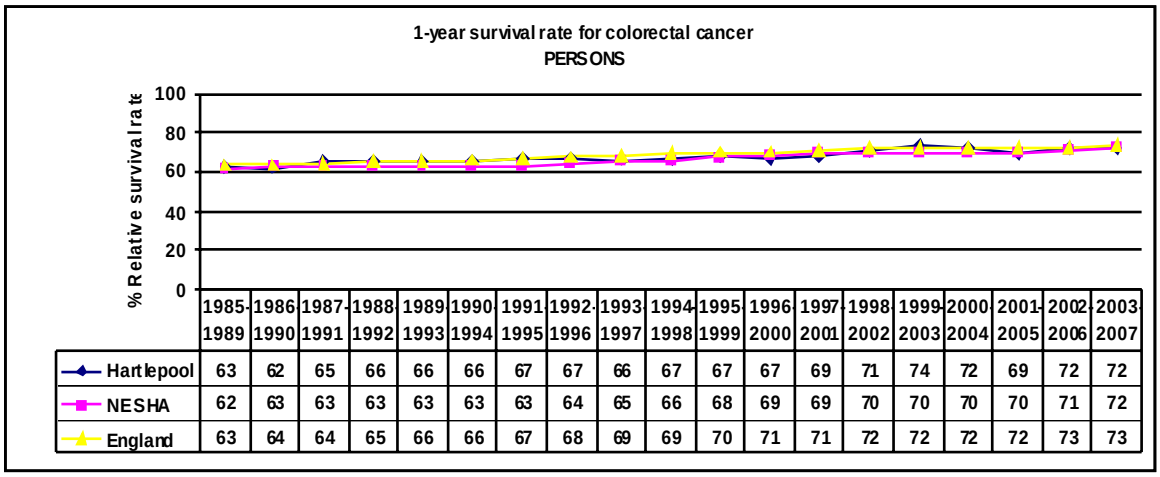
	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	9	21	27	22	15	26	19	23	21	25	18	14	27	20	16	17	23	14	14	16	25	11	9	25
NESHA	26	21	22	22	22	21	23	20	19	19	18	19	18	17	16	17	15	15	14	15	14	13	14	14
England	23	22	22	22	21	21	20	20	19	18	18	17	17	16	16	15	14	14	14	14	14	14	13	13

Source: Northern and Yorkshire Cancer Registry Information Service

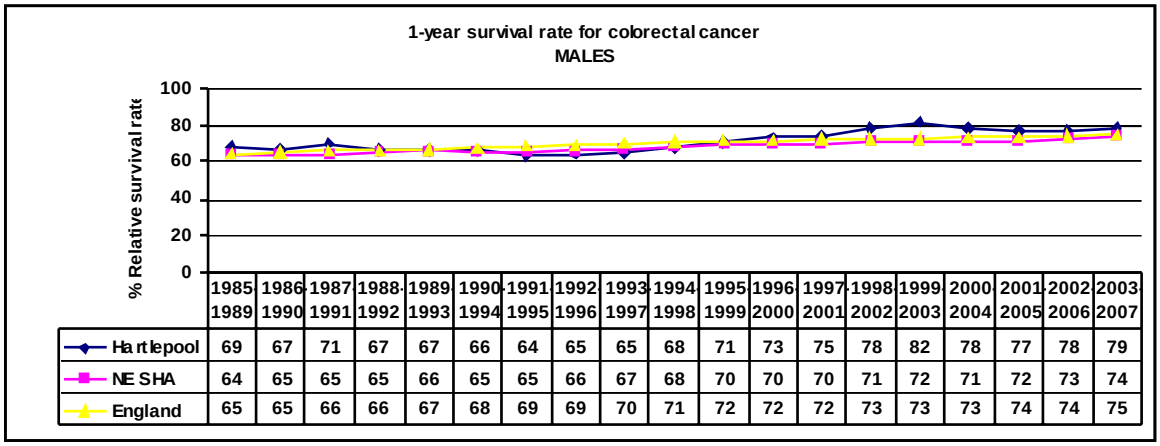
7.3 Survival

One-year survival rate for colorectal cancer in Hartlepool increased from 63% in 1985-1989 to 72% in 2003-2007, similar to the increases in the North East and England. Survival rates are higher in men than women (Figure 7.5).

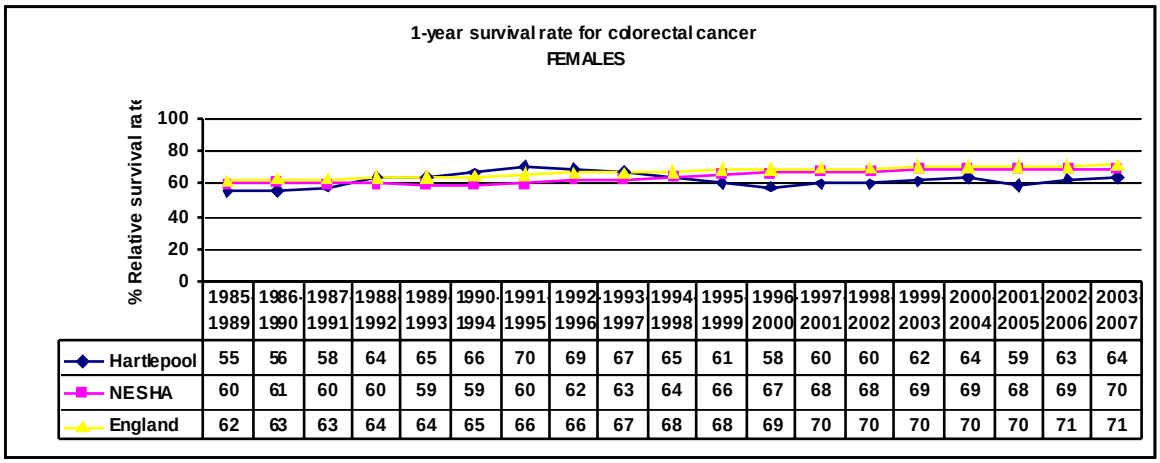
Figure 7.5: 1-year survival rate for colorectal cancer (ICD10: C18-C20) for persons, males and females in Hartlepool 1985/89 -2003/07



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003	2000-2004	2001-2005	2002-2006	2003-2007
Hartlepool	63	62	65	66	66	66	67	67	66	67	67	67	69	71	74	72	69	72	72
NESHA	62	63	63	63	63	63	63	64	65	66	68	69	69	70	70	70	70	71	72
England	63	64	64	65	66	66	67	68	69	69	70	71	71	72	72	72	72	73	73



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003	2000-2004	2001-2005	2002-2006	2003-2007
Hartlepool	69	67	71	67	67	66	64	65	65	68	71	73	75	78	82	78	77	78	79
NESHA	64	65	65	65	66	65	65	66	67	68	70	70	70	71	72	71	72	73	74
England	65	65	66	66	67	68	69	69	70	71	72	72	72	73	73	73	74	74	75

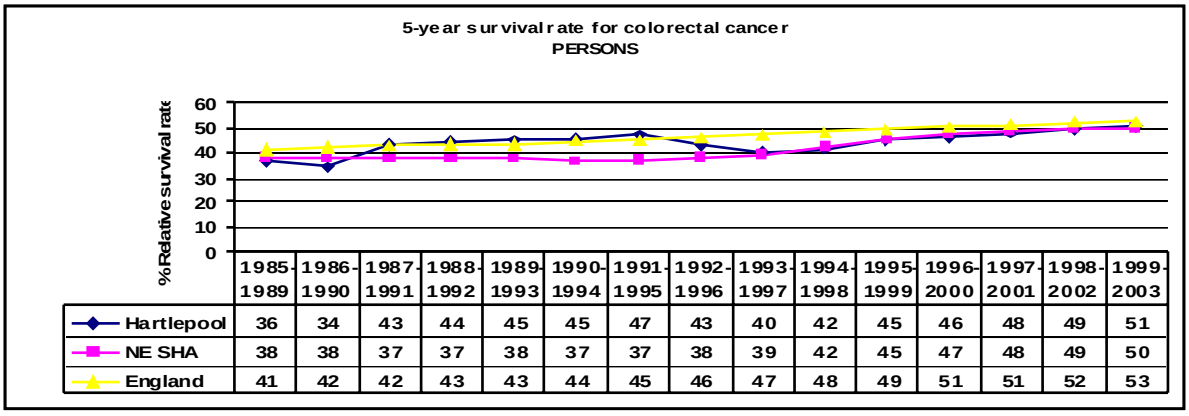


	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003	2000-2004	2001-2005	2002-2006	2003-2007
Hartlepool	55	56	58	64	65	66	70	69	67	65	61	58	60	60	62	64	59	63	64
NESHA	60	61	60	60	59	59	60	62	63	64	66	67	68	68	69	69	68	69	70
England	62	63	63	64	64	65	66	66	67	68	68	69	70	70	70	70	70	71	71

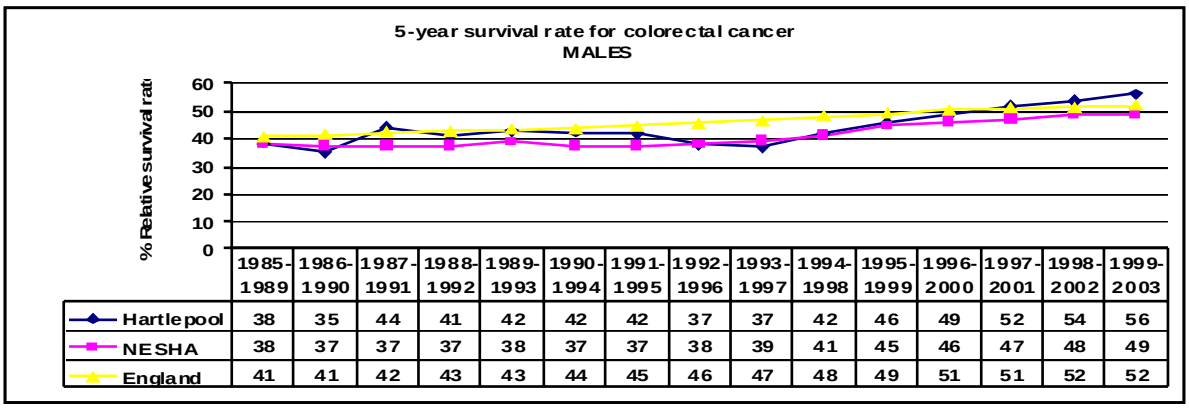
Source: Northern and Yorkshire Cancer Registry Information Service

The 5-year survival rate for colorectal cancer in Hartlepool increased from 36% in 1985 to 51% in 2008, higher than the North East and England averages. Higher percentages of men than women are surviving with colorectal cancer in Hartlepool. Survival rates have also fallen for women in the last ten years (Figure 7.6).

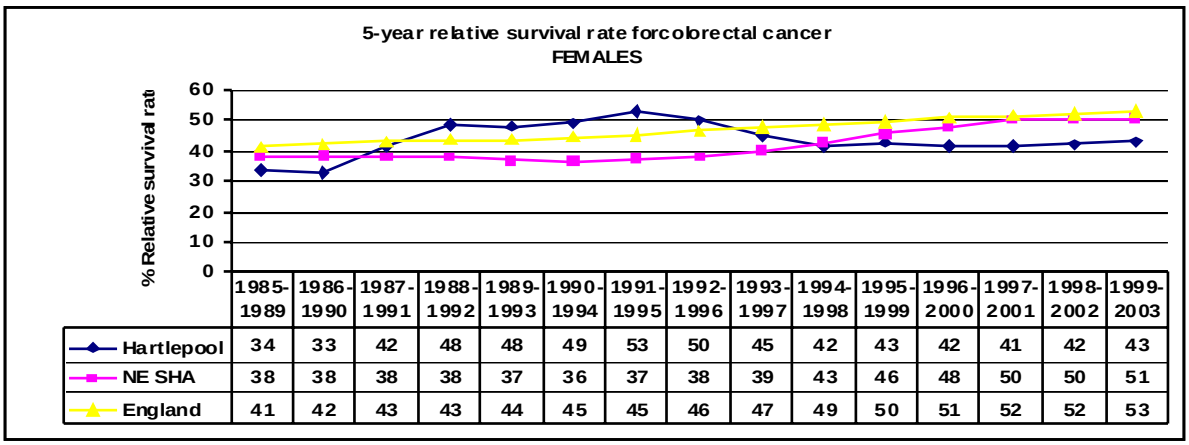
Figure 7.6: 5-year survival rate for colorectal cancer (ICD10: C18-C20) for persons, males and females in Hartlepool 1985/89- 1999/03



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003
Hartlepool	36	34	43	44	45	45	47	43	40	42	45	46	48	49	51
NESHA	38	38	37	37	38	37	37	38	39	42	45	47	48	49	50
England	41	42	42	43	43	44	45	46	47	48	49	51	51	52	53



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003
Hartlepool	38	35	44	41	42	42	42	37	37	42	46	49	52	54	56
NESHA	38	37	37	37	38	37	37	38	39	41	45	46	47	48	49
England	41	41	42	43	43	44	45	46	47	48	49	51	51	52	52



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003
Hartlepool	34	33	42	48	48	49	53	50	45	42	43	42	41	42	43
NE SHA	38	38	38	38	37	36	37	38	39	43	46	48	50	50	51
England	41	42	43	43	44	45	45	46	47	49	50	51	52	52	53

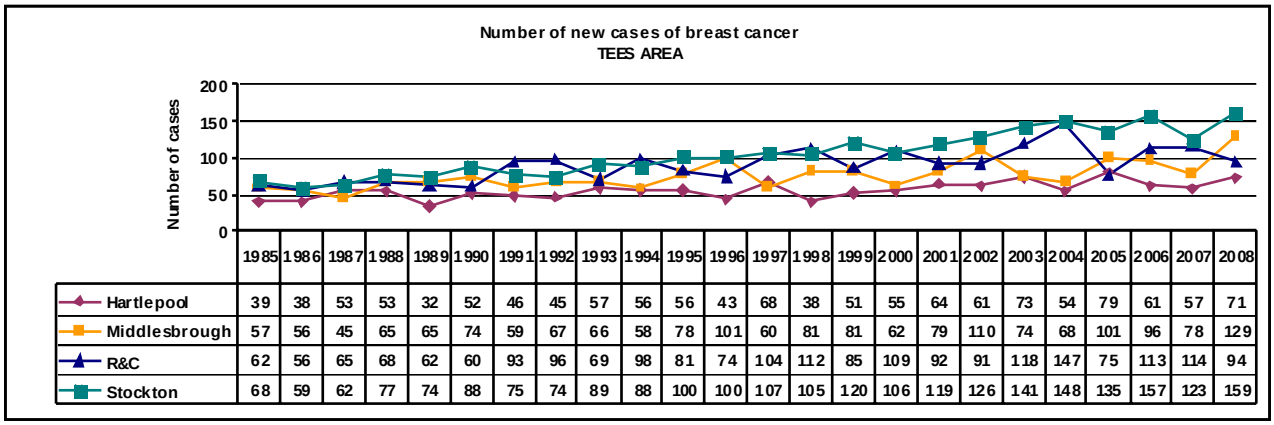
Source: Northern and Yorkshire Cancer Registry Information Service

8. Breast cancer

8.1 Incidence

The number of new cases of breast cancer in Hartlepool almost doubled from 39 cases in 1985 to 71 cases in 2008. There were similar increases in the number cases in the three other NHS Tees PCTs (Figure 8.1).

Figure 8.1: Number of new cases of breast cancer (ICD10: C50) in Tees 1985-2008

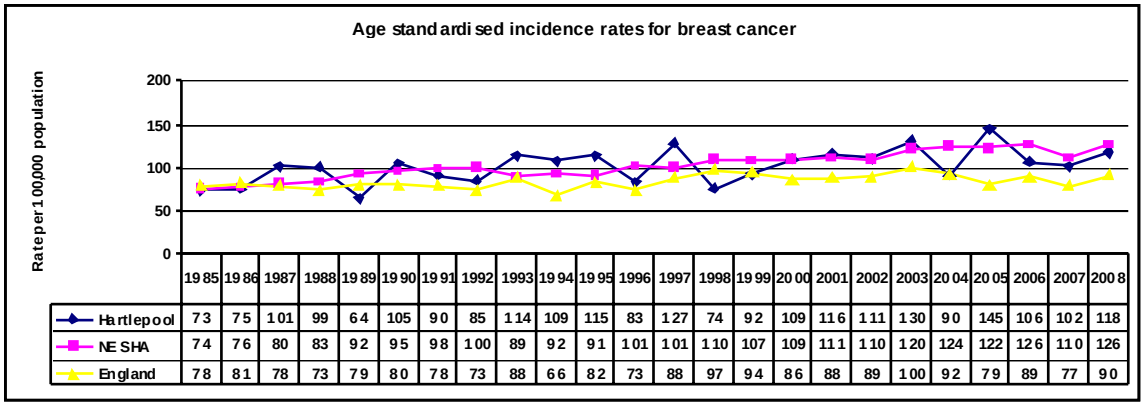


	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	39	38	53	53	32	52	46	45	57	56	56	43	68	38	51	55	64	61	73	54	79	61	57	71
Middlesbrough	57	56	45	65	65	74	59	67	66	58	78	101	60	81	81	62	79	110	74	68	101	96	78	129
R&C	62	56	65	68	62	60	93	96	69	98	81	74	104	112	85	109	92	91	118	147	75	113	114	94
Stockton	68	59	62	77	74	88	75	74	89	88	100	100	107	105	120	106	119	126	141	148	135	157	123	159

Source: Northern and Yorkshire Cancer Registry Information Service

There was a 62% increase in the age standardised incidence rate for breast cancer in Hartlepool, from 73 per 100,000 population to 118 per 100,000 population, lower than the 70% (74 to 126 per 100,000 population) increase in the North East average but 4 times (78 to 90 per 100,000 population) higher than the England average (Figure 8.2).

Figure 8.2: Age standardised incidence rate for breast cancer (ICD10: C50) in Hartlepool 1985-2008



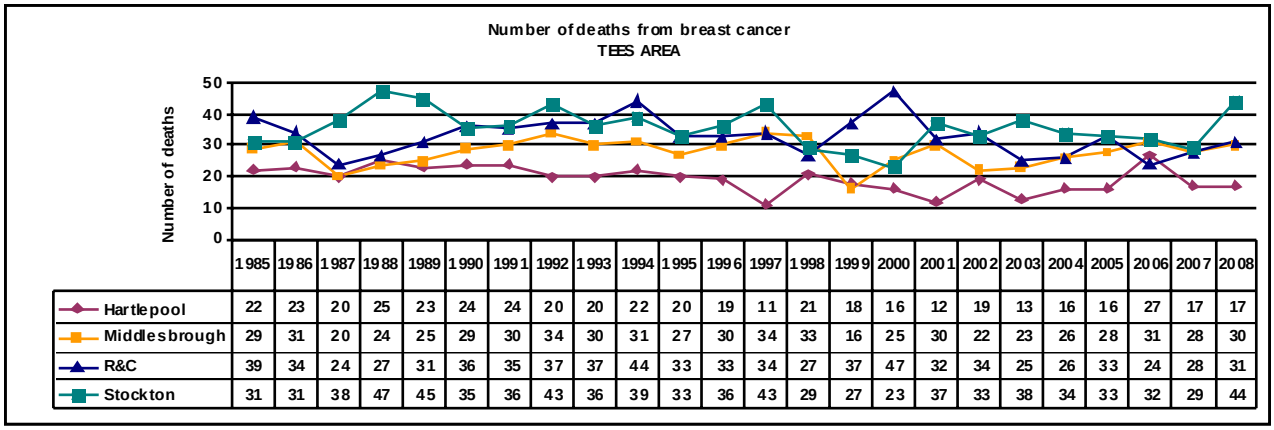
	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	73	75	101	99	64	105	90	85	114	109	115	83	127	74	92	109	116	111	130	90	145	106	102	118
NESHA	74	76	80	83	92	95	98	100	89	92	91	101	101	110	107	109	111	110	120	124	122	126	110	126
England	78	81	78	73	79	80	78	73	88	66	82	73	88	97	94	86	88	89	100	92	79	89	77	90

Source: Northern and Yorkshire Cancer Registry Information Service

8.2 Mortality

The number of deaths from breast cancer shows a decreasing trend from 22 cases in 1985 to 17 cases in 2008 (Figure 8.3).

Figure 8.3: Number of deaths from breast cancer (ICD10: C50) in Tees 1985-2008

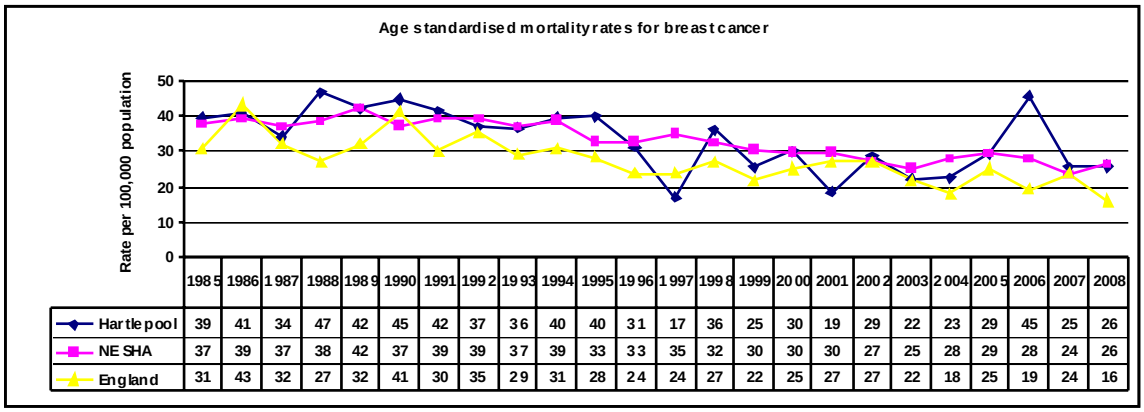


	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	22	23	20	25	23	24	24	20	20	22	20	19	11	21	18	16	12	19	13	16	16	27	17	17
Middlesbrough	29	31	20	24	25	29	30	34	30	31	27	30	34	33	16	25	30	22	23	26	28	31	28	30
R&C	39	34	24	27	31	36	35	37	37	44	33	33	34	27	37	47	32	34	25	26	33	24	28	31
Stockton	31	31	38	47	45	35	36	43	36	39	33	36	43	29	27	23	37	33	38	34	33	32	29	44

Source: Northern and Yorkshire Cancer Registry Information Service

The age standardised mortality rate decreased by 33%, from 39 per 100,000 population in 1985 to 26 per 100,000 population in 2008, slightly higher decrease than the North East average of 30% (37 to 26 per 100,000 population) and lower than England average of 48% (31 to 16 per 100,000 population) (Figure 8.4).

Figure 8.4: Age standardised mortality rate for breast cancer (ICD10: C50) in Hartlepool 1985-2008



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	39	41	34	47	42	45	42	37	36	40	40	31	17	36	25	30	19	29	22	23	29	45	25	26
NESHA	37	39	37	38	42	37	39	39	37	39	33	33	35	32	30	30	30	27	25	28	29	28	24	26
England	31	43	32	27	32	41	30	35	29	31	28	24	24	27	22	25	27	27	22	18	25	19	24	16

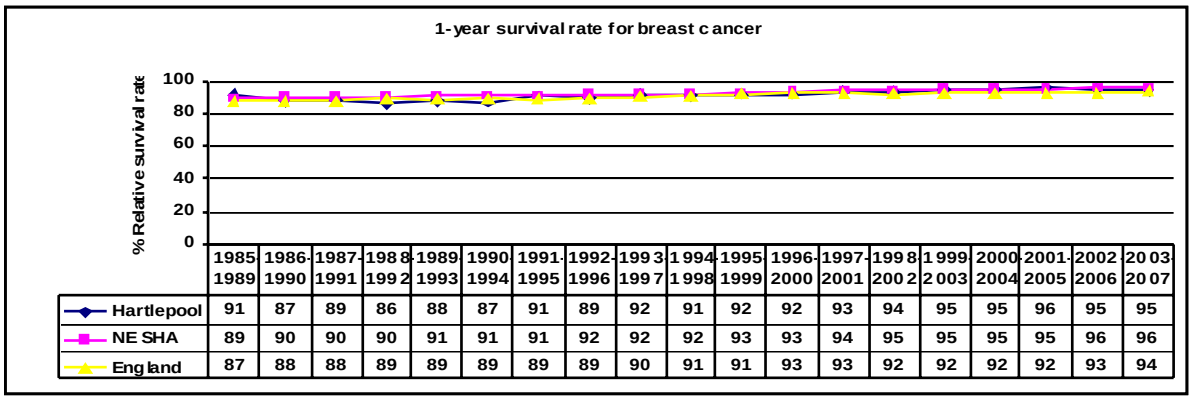
Source: Northern and Yorkshire Cancer Registry Information Service

8.4 Survival

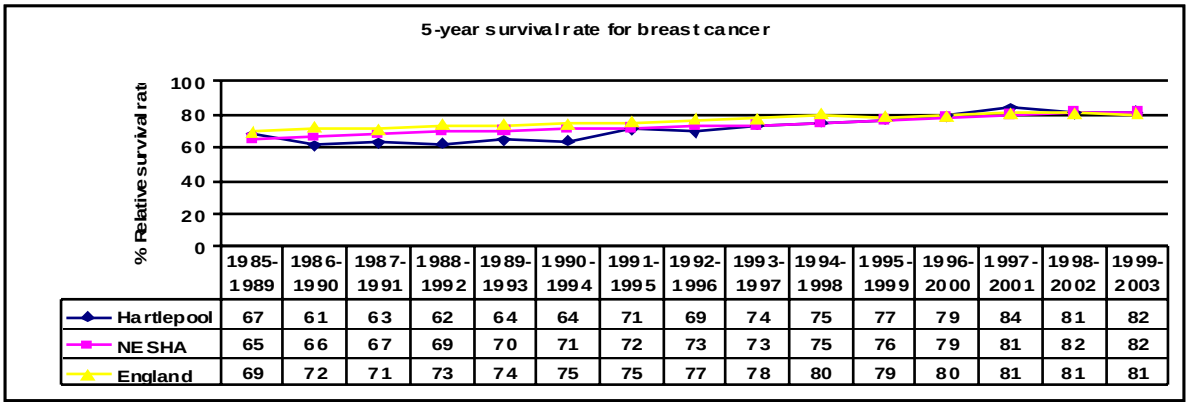
There was an increase in 1-year survival rate for breast cancer in Hartlepool from 91% in 1985/89 to 95% in 2003/07, similar to the increase in the North East average (89% to 96%) and England average (87% to 94%).

The 5-year survival rate for breast cancer increased by 22%, from 67% in 1985/89 to 82% in 1999/03, lower than the increases of 26% (65% to 82%) and 19% (68-81%) in the North East and England averages, respectively (Figure 8.5).

Figure 8.5: 1-& 5-year survival rates for breast cancer (ICD10: C50) in Hartlepool 1985/89-2003/07 and 19985/89-1999/03



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003	2000-2004	2001-2005	2002-2006	2003-2007
Hartlepool	91	87	89	86	88	87	91	89	92	91	92	92	93	94	95	95	96	95	95
NE SHA	89	90	90	90	91	91	91	92	92	92	93	93	94	95	95	95	95	96	96
England	87	88	88	89	89	89	89	89	90	91	91	93	93	92	92	92	92	93	94



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003
Hartlepool	67	61	63	62	64	64	71	69	74	75	77	79	84	81	82
NE SHA	65	66	67	69	70	71	72	73	73	75	76	79	81	82	82
England	69	72	71	73	74	75	75	77	78	80	79	80	81	81	81

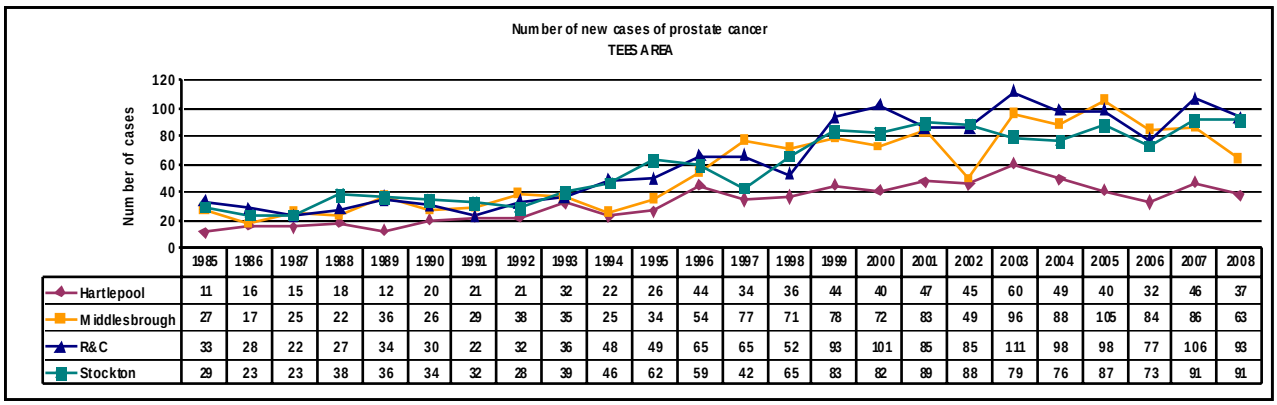
Source: Northern and Yorkshire Cancer Registry Information Service

9. Prostate cancer

9.1 Incidence

The number of new cases of prostate cancer rose from 11 cases in 1985 to a peak of 60 cases in 2003, with a downward trend in the last five years (Figure 9.1).

Figure 9.1: Number of new cases of prostate cancer (ICD10: C61) in Tees 1985-2008

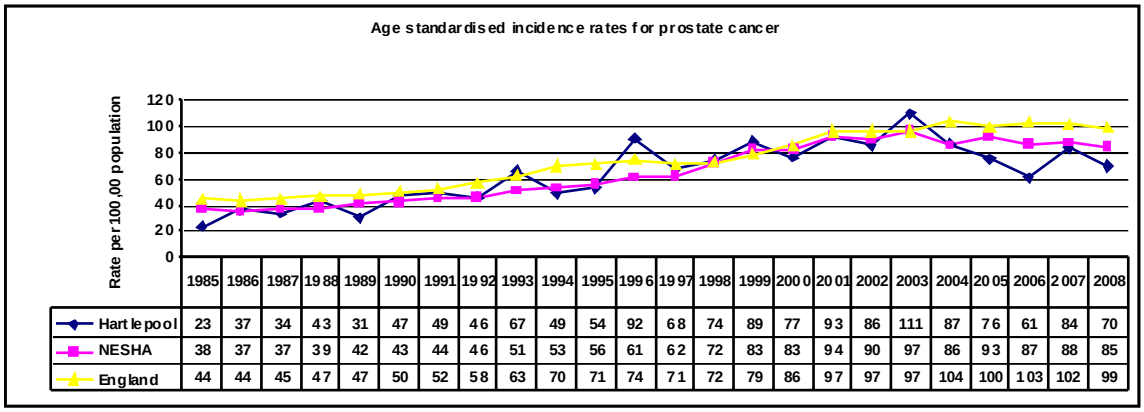


	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	11	16	15	18	12	20	21	21	32	22	26	44	34	36	44	40	47	45	60	49	40	32	46	37
Middlesbrough	27	17	25	22	36	26	29	38	35	25	34	54	77	71	78	72	83	49	96	88	105	84	86	63
R&C	33	28	22	27	34	30	22	32	36	48	49	65	65	52	93	101	85	85	111	98	98	77	106	93
Stockton	29	23	23	38	36	34	32	28	39	46	62	59	42	65	83	82	89	88	79	76	87	73	91	91

Source: Northern and Yorkshire Cancer Registry Information Service

The age standardised incidence rate for prostate cancer rose from 23 per 100,000 population in 1985 to 111 per 100,000 population in 2003. It has since fallen to 70 per 100,000 population in 2008. There was a steady rise in the average rates for the North East and England (Figure 9.2).

Figure 9.2: Age standardised incidence rate for prostate cancer (ICD10: C61) in Hartlepool 1985-2008



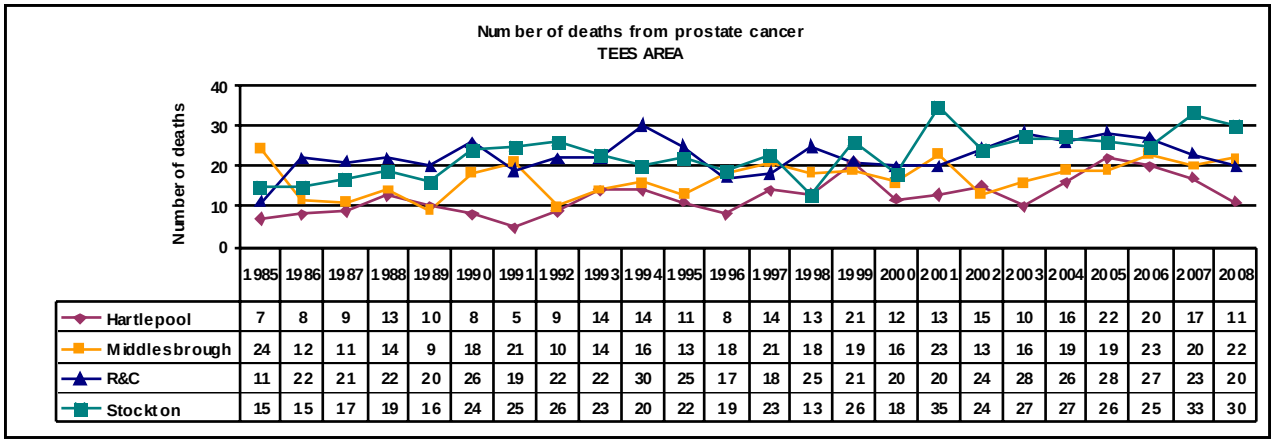
	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	23	37	34	43	31	47	49	46	67	49	54	92	68	74	89	77	93	86	111	87	76	61	84	70
NESHA	38	37	37	39	42	43	44	46	51	53	56	61	62	72	83	83	94	90	97	86	93	87	88	85
England	44	44	45	47	47	50	52	58	63	70	71	74	71	72	79	86	97	97	97	104	100	103	102	99

Source: Northern and Yorkshire Cancer Registry Information Service

9.2 Mortality

There is a general increasing trend in the number of deaths from prostate cancer in Hartlepool, similar to the trend across Tees (Figure 9.3).

Figure 9.3: Number of deaths from prostate cancer (ICD10: C61) in Tees 1985-2008

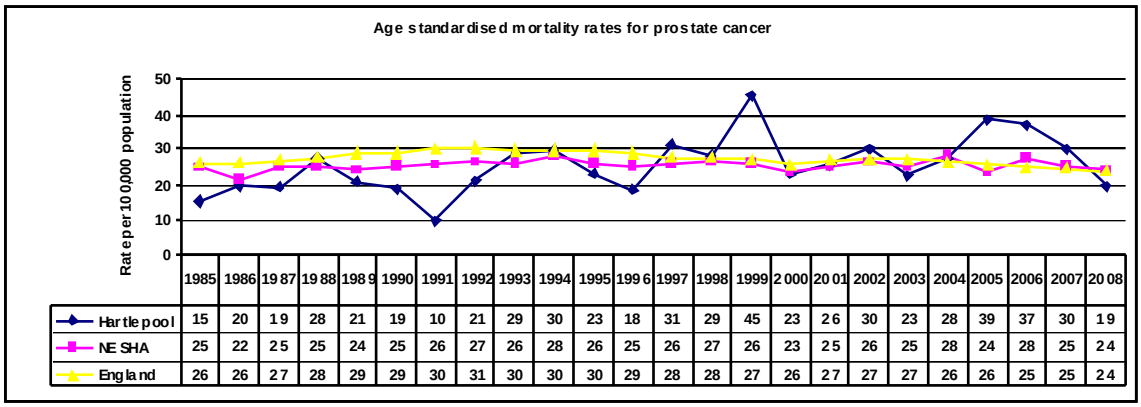


	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	7	8	9	13	10	8	5	9	14	14	11	8	14	13	21	12	13	15	10	16	22	20	17	11
Middlesbrough	24	12	11	14	9	18	21	10	14	16	13	18	21	18	19	16	23	13	16	19	19	23	20	22
R&C	11	22	21	22	20	26	19	22	22	30	25	17	18	25	21	20	20	24	28	26	28	27	23	20
Stockton	15	15	17	19	16	24	25	26	23	20	22	19	23	13	26	18	35	24	27	27	26	25	33	30

Source: Northern and Yorkshire Cancer Registry Information Service

The age standardised mortality rate for prostate cancer shows a slightly increasing trend from 15 per 100,000 population in 1985 to 19 per 100,000 population in 2008, with higher rates of up to 45 per 100,000 population in between this period (Figure 9.4).

Figure 9.4: Age standardised mortality rate for prostate cancer (ICD10: C61) in Hartlepool 1985-2008



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	15	20	19	28	21	19	10	21	29	30	23	18	31	29	45	23	26	30	23	28	39	37	30	19
NESHA	25	22	25	25	24	25	26	27	26	28	26	25	26	27	26	23	25	26	25	28	24	28	25	24
England	26	26	27	28	29	29	30	31	30	30	30	29	28	28	27	26	27	27	27	26	26	25	25	24

Source: Northern and Yorkshire Cancer Registry Information Service

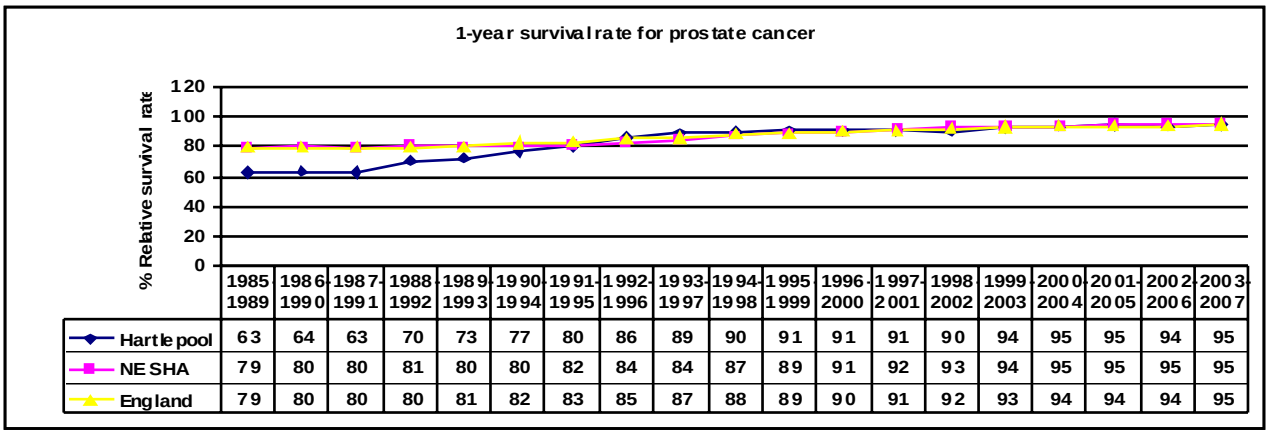
9.3 Survival

One-year survival rate for prostate cancer in Hartlepool increased from 63% in 1985/89 to 95% in 2003/07, about double the increase in the North East and England averages from 79% to 95%.

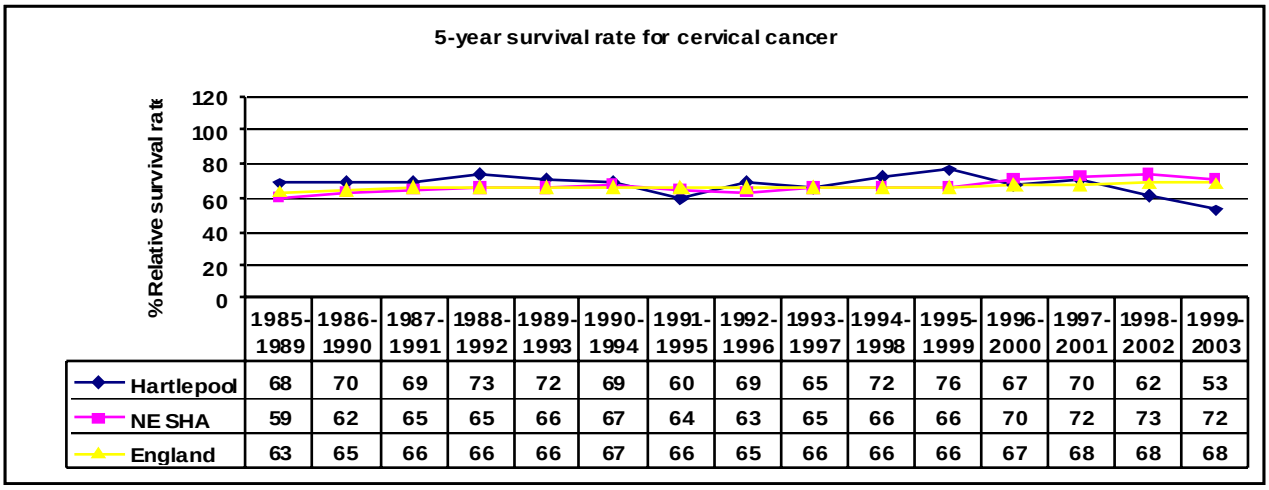
There was an increase in the 5-year survival rate for prostate cancer in Hartlepool from 29% in 1985 to 76% in 2008, about double the increase in the North East average (43% to 79%) and England average (46% to 80%) (Figure 9.5).

The 5-year survival gap between Hartlepool and England in 1985/89 had closed by the mid 1990s. Since then Hartlepool has experienced survival rates similar to the England average.

Figure 9.5: 1-& 5-year survival rates for prostate cancer (ICD10: C61) in Hartlepool 1985/89-2003/07 and 1985/89-1999/03



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003	2000-2004	2001-2005	2002-2006	2003-2007
Hartlepool	63	64	63	70	73	77	80	86	89	90	91	91	91	90	94	95	95	94	95
NE SHA	79	80	80	81	80	80	82	84	84	87	89	91	92	93	94	95	95	95	95
England	79	80	80	80	81	82	83	85	87	88	89	90	91	92	93	94	94	94	95



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003
Hartlepool	68	70	69	73	72	69	60	69	65	72	76	67	70	62	53
NE SHA	59	62	65	65	66	67	64	63	65	66	66	70	72	73	72
England	63	65	66	66	66	67	66	65	66	66	66	67	68	68	68

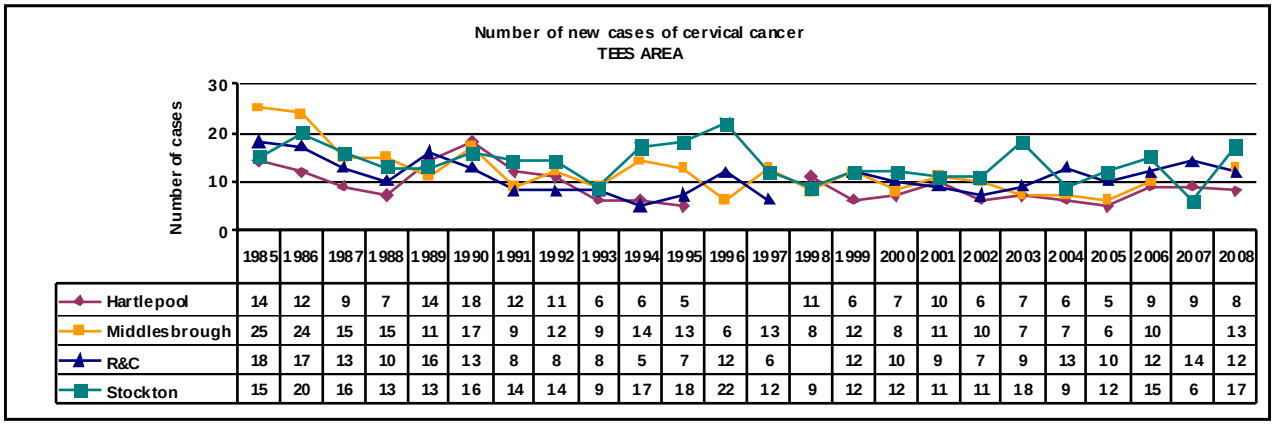
Source: Northern and Yorkshire Cancer Registry Information Service

10. Cervical cancer

10.1 Incidence

The number of new cases of cervical cancer in Hartlepool decreased by nearly a half from 14 cases in 1985 to 8 cases in 2008. Decreasing trends were also seen in the rest of Tees (Figure 10.1).

Figure 10.1: Number of new cases of cervical cancer (ICD10: C53) in Tees 1985-2008



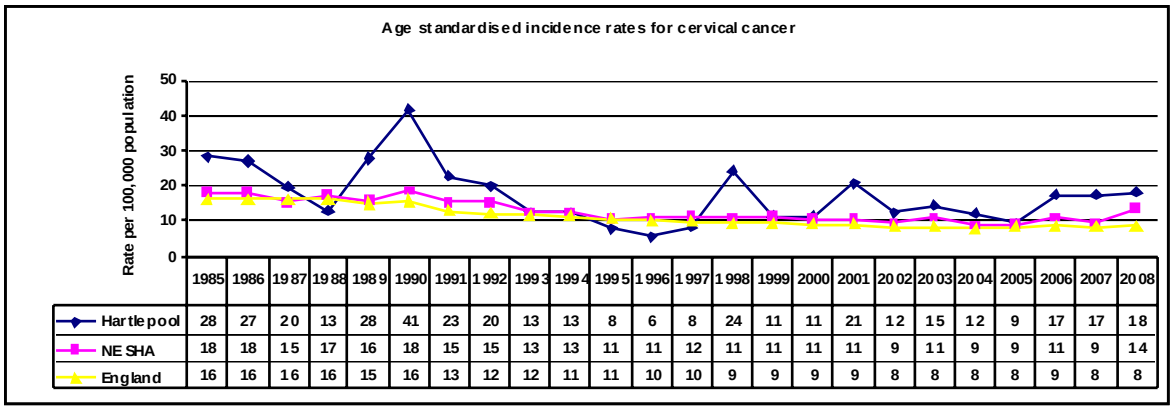
	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	14	12	9	7	14	18	12	11	6	6	5			11	6	7	10	6	7	6	5	9	9	8
Middlesbrough	25	24	15	15	11	17	9	12	9	14	13	6	13	8	12	8	11	10	7	7	6	10		13
R&C	18	17	13	10	16	13	8	8	8	5	7	12	6		12	10	9	7	9	13	10	12	14	12
Stockton	15	20	16	13	13	16	14	14	9	17	18	22	12	9	12	12	11	11	18	9	12	15	6	17

Source: Northern and Yorkshire Cancer Registry Information Service

In Hartlepool, there is a general decreasing trend in age standardised incidence rate. Overall rates are higher compared with North East and England averages (Figure 10.2).

There is some evidence that the gap between Hartlepool and England is narrowing in absolute terms. In 1985-1989 the absolute gap was 7.4[3] compared with 6.4 in 2004-2008. However, the relative gap is worsening from 48%[4] in 1985-1989 to 78% in 2004-2008.

Figure 10.2: Age standardised incidence rate for cervical cancer (ICD10: C53) in Hartlepool 1985-2008



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	28	27	20	13	28	41	23	20	13	13	8	6	8	24	11	11	21	12	15	12	9	17	17	18
NESHA	18	18	15	17	16	18	15	15	13	13	11	11	12	11	11	11	11	9	11	9	9	11	9	14
England	16	16	16	16	15	16	13	12	12	11	11	10	10	9	9	9	9	8	8	8	8	9	8	8

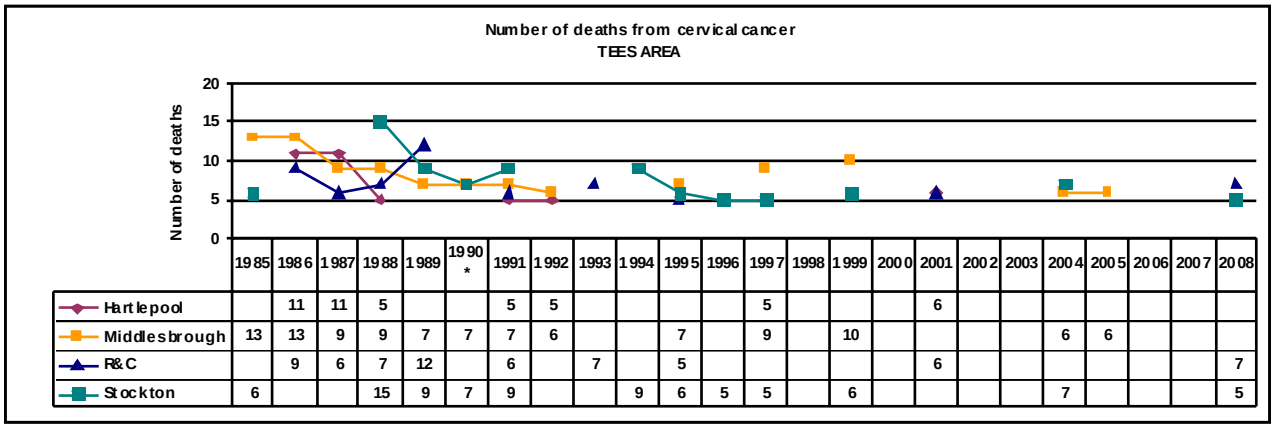
Source: Northern and Yorkshire Cancer Registry Information Service

[3] The difference between the average incidence rates in Hartlepool and England between 1985-1989.
[4] Absolute gap as a percentage of the England average incidence rate between 1985-1989.

10.2 Mortality

Generally, there is a decreasing trend in the number of deaths from cervical cancer across NHS Tees (Figure 10.3). There is also a decreasing trend in age standardised mortality rate from cervical cancer in Hartlepool, with similar trends in the North East and England averages (Figure 10.4).

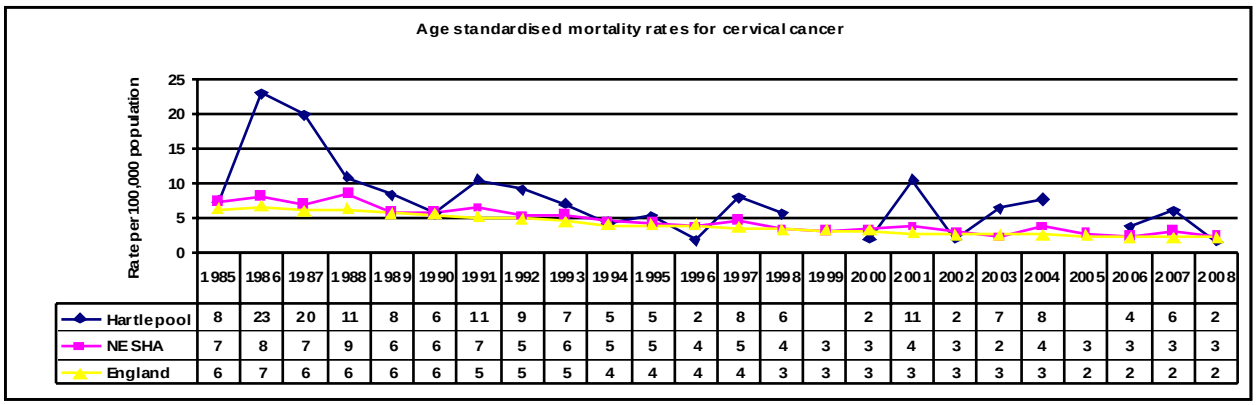
Figure 10.3: Number of deaths from cervical cancer (ICD10: C53) in Tees 1985-2008



	1985	1986	1987	1988	1989	1990 *	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool		11	11	5			5	5					5				6							
Middlesbrough	13	13	9	9	7	7	7	6			7		9		10					6	6			
R&C		9	6	7	12		6		7		5						6							7
Stockton	6			15	9	7	9			9	6	5	5		6					7				5

Empty cells contain numbers less than 5
Source: Northern and Yorkshire Cancer Registry Information Service

Figure 10.4: Age standardised mortality rate for cervical cancer (ICD10: C53) in Hartlepool 1985-2008



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	8	23	20	11	8	6	11	9	7	5	5	2	8	6		2	11	2	7	8		4	6	2
NESHA	7	8	7	9	6	6	7	5	6	5	5	4	5	4	3	3	4	3	2	4	3	3	3	3
England	6	7	6	6	6	6	5	5	5	4	4	4	4	3	3	3	3	3	3	3	2	2	2	2

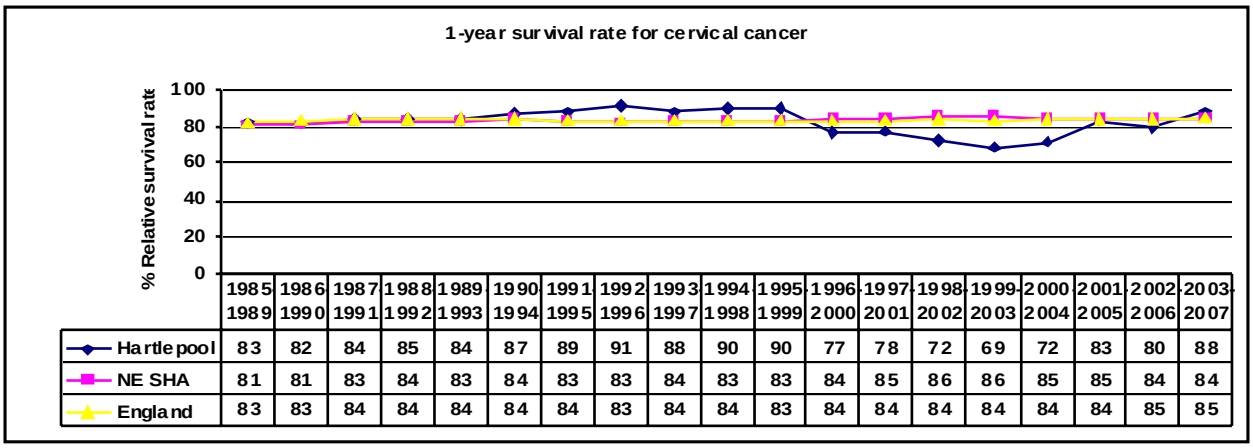
Empty cells contain numbers less than 5
Source: Northern and Yorkshire Cancer Registry Information Service

10.3 Survival

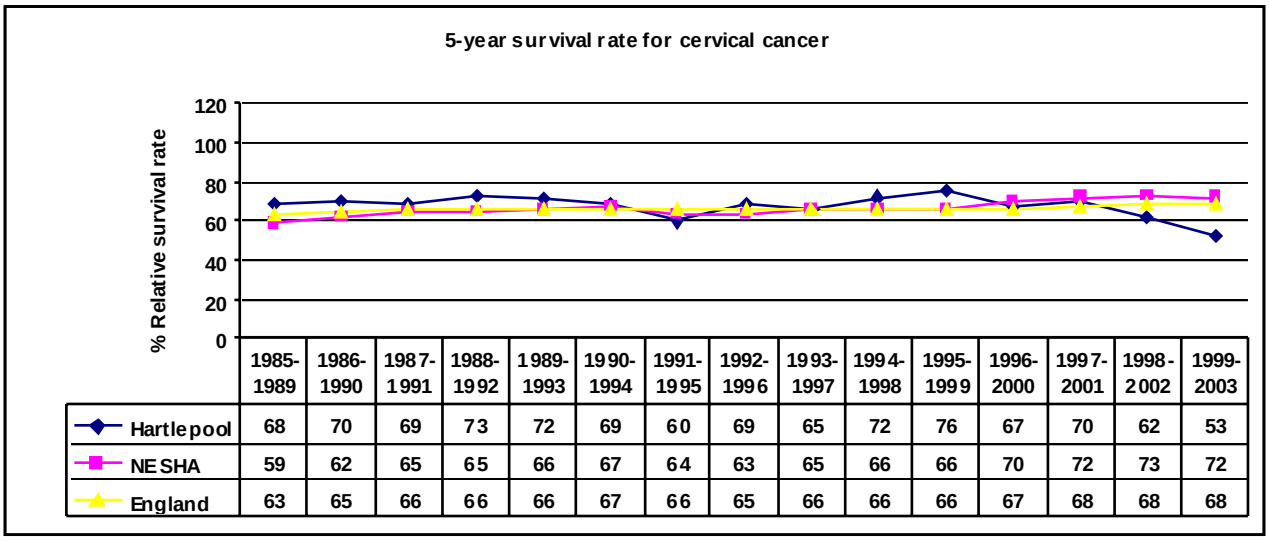
The 1-year survival rate for cervical cancer in Hartlepool rose from 83% in 1985/89 to 90% in1995/99, followed by a decline to 69% in 1999/03 and rising again to 88% in 2003/07. On average, survival rates in Hartlepool are slightly lower than the North East and England averages (Figure 10.5).

The 5-year survival rate has been falling since the mid 1990s in Hartlepool but rising in North East and England.

Figure 10.5: 1-& 5-year survival rates for cervical cancer (ICD10: C53) in Hartlepool 1985/89 -2003/07 and 1985/89-1999/03



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003	2000-2004	2001-2005	2002-2006	2003-2007
Hartlepool	83	82	84	85	84	87	89	91	88	90	90	77	78	72	69	72	83	80	88
NE SHA	81	81	83	84	83	84	83	83	84	83	83	84	85	86	86	85	85	84	84
England	83	83	84	84	84	84	84	83	84	84	83	84	84	84	84	84	84	85	85



	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003
Hartlepool	68	70	69	73	72	69	60	69	65	72	76	67	70	62	53
NE SHA	59	62	65	65	66	67	64	63	65	66	66	70	72	73	72
England	63	65	66	66	66	67	66	65	66	66	66	67	68	68	68

Source: Northern and Yorkshire Cancer Registry Information Service

11. Childhood cancer

Childhood cancer is not one disease but many, and children tend to develop different kinds of cancer compared with adults. Leukaemias are the most commonly diagnosed cancer in children, accounting for around a third (31%) of all cases[5].

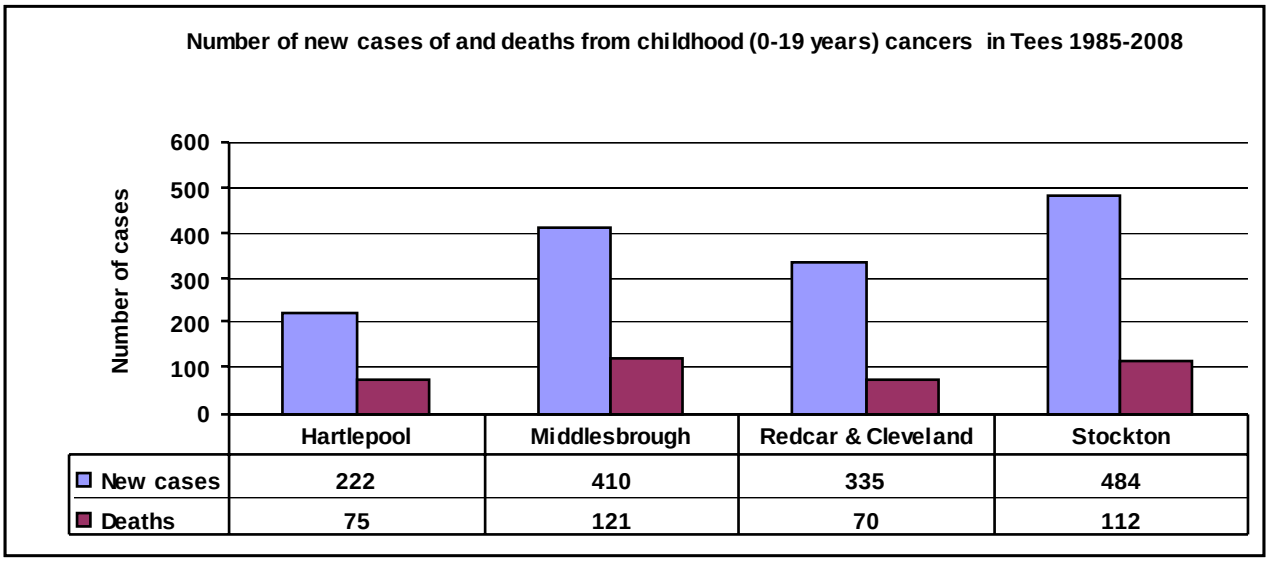
11.1 Incidence

In children aged 0-19 years between 1985 and 2008, there were:

- 222 cases of childhood cancers and 75 deaths in Hartlepool
- 410 cases of childhood cancer and 121 deaths in Middlesbrough
- 335 cases of childhood cancer and 70 deaths in Redcar and Cleveland
- 484 cases of childhood cancer and 112 deaths in Stockton (Figure 11.1)

The data show higher crude mortality rate in Hartlepool. Thirty-four percent (1 in 3) of children who developed cancer in Hartlepool died from it compared to 21% (1 in 5) in Redcar and Cleveland, 23% (1 in 5) in Stockton and 30% (1 in 3) in Middlesbrough.

Figure 11.1: Number of cases and deaths from childhood (0 – 19 years) cancers ICD10:C00-C97 excl. C44 non-melanoma skin) in Tees 1985 – 2008

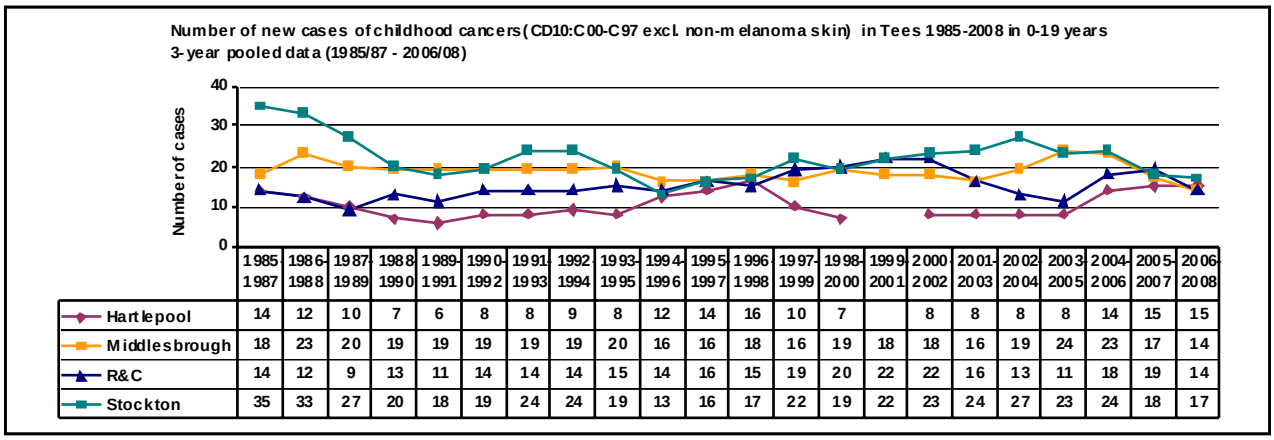


Source: Northern and Yorkshire Cancer Registry Information Service

The numbers of new cases of childhood cancer in the 0-19 year age group fluctuated in Hartlepool and across Tees between 1985 and 2008 (Figure 11.2).

[5] National Registry of Childhood Tumors/Childhood Cancer Research Group

Figure 11.2; Number of new cases of childhood (0 – 19 years) cancers (ICD10:C00-C97 excl. C44 non-melanoma skin) in Tees 1985 - 2008

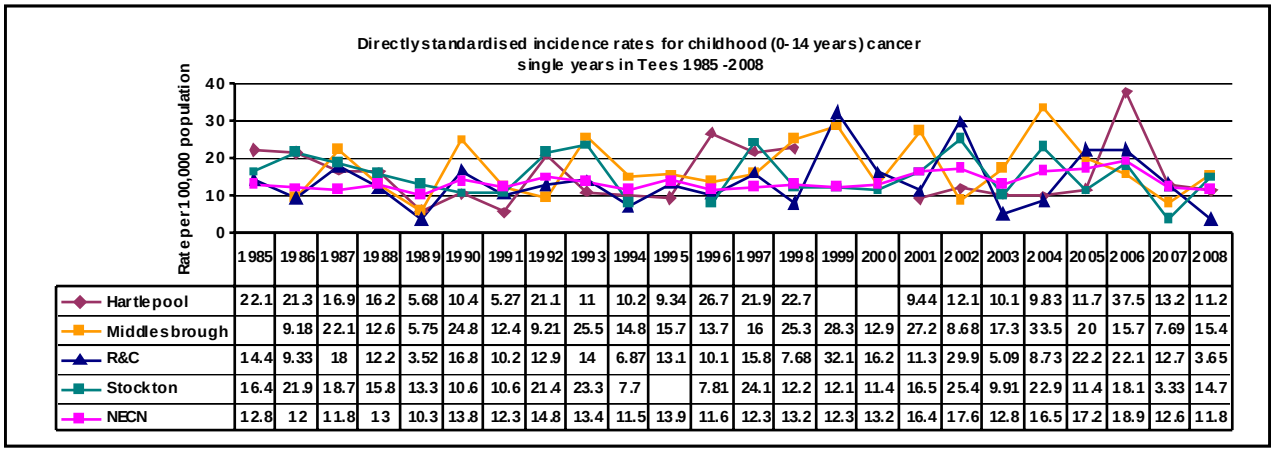


	1985-1987	1986-1988	1987-1989	1988-1990	1989-1991	1990-1992	1991-1993	1992-1994	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Hartlepool	14	12	10	7	6	8	8	9	8	12	14	16	10	7		8	8	8	8	14	15	15
Middlesbrough	18	23	20	19	19	19	19	19	20	16	16	18	16	19	18	18	16	19	24	23	17	14
R&C	14	12	9	13	11	14	14	14	15	14	16	15	19	20	22	22	16	13	11	18	19	14
Stockton	35	33	27	20	18	19	24	24	19	13	16	17	22	19	22	23	24	27	23	24	18	17

Blank cells denote where data is not available or suppressed (< 5 cases)
Source: Northern and Yorkshire Cancer Registry Information Service

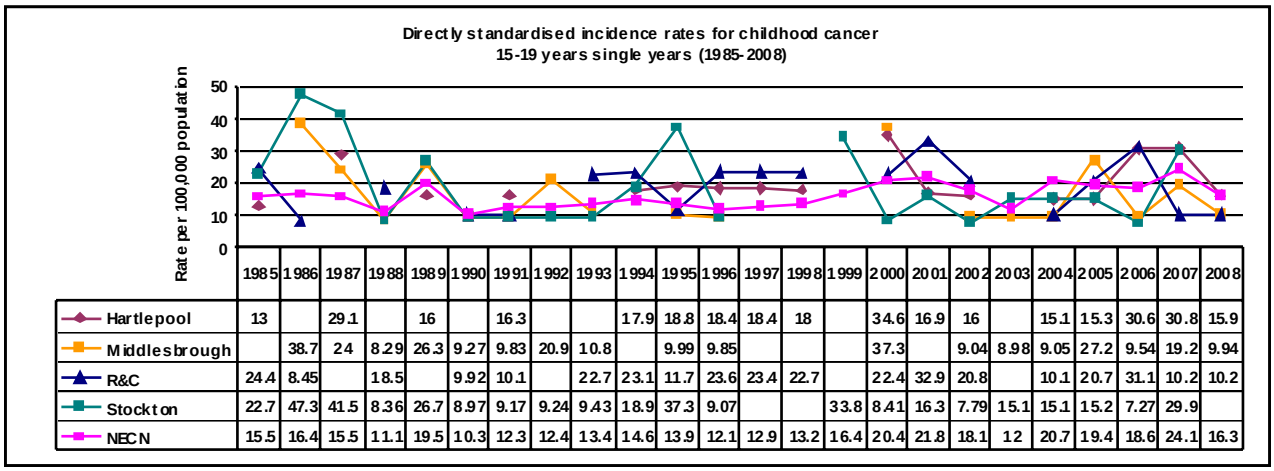
There is no clear trend in the directly standardised incidence rate in childhood cancers in those aged 0-14 years and 15-19 year age group across Tees (Figures 11.3 & 11.4).

Figure 11.3: Directly standardised incidence rates of childhood (0 – 14 years) cancers (ICD10:C00-C97 excl. C44 non-melanoma skin) in Tees 1985 – 2008



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	22.1	21.3	16.9	16.2	5.68	10.4	5.27	21.1	11	10.2	9.34	26.7	21.9	22.7			9.44	12.1	10.1	9.83	11.7	37.5	13.2	11.2
Middlesbrough		9.18	22.1	12.6	5.75	24.8	12.4	9.21	25.5	14.8	15.7	13.7	16	25.3	28.3	12.9	27.2	8.68	17.3	33.5	20	15.7	7.69	15.4
R&C	14.4	9.33	18	12.2	3.52	16.8	10.2	12.9	14	6.87	13.1	10.1	15.8	7.68	32.1	16.2	11.3	29.9	5.09	8.73	22.2	22.1	12.7	3.65
Stockton	16.4	21.9	18.7	15.8	13.3	10.6	10.6	21.4	23.3	7.7		7.81	24.1	12.2	12.1	11.4	16.5	25.4	9.91	22.9	11.4	18.1	3.33	14.7
NECN	12.8	12	11.8	13	10.3	13.8	12.3	14.8	13.4	11.5	13.9	11.6	12.3	13.2	12.3	13.2	16.4	17.6	12.8	16.5	17.2	18.9	12.6	11.8

Figure 11.4: Directly standardised incidence rates for Childhood (15- 19 yrs) cancers (ICD10:C00-C97 excl. C44 non-melanoma skin) in Tees 1985 - 2008



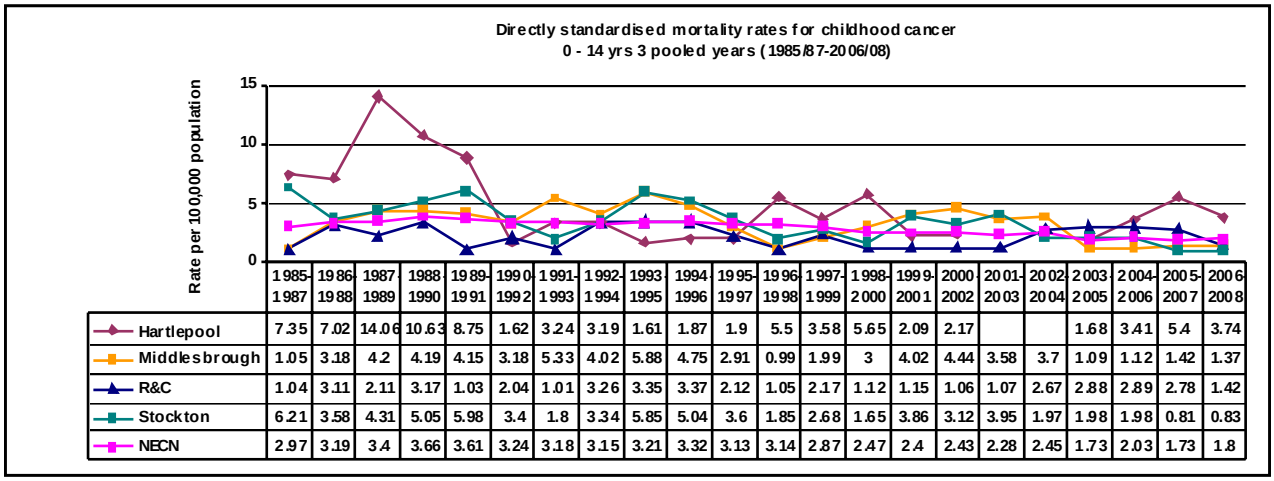
	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hartlepool	13		29.1		16		16.3			17.9	18.8	18.4	18.4	18		34.6	16.9	16		15.1	15.3	30.6	30.8	15.9
Middlesbrough		38.7	24	8.29	26.3	9.27	9.83	20.9	10.8		9.99	9.85				37.3		9.04	8.98	9.05	27.2	9.54	19.2	9.94
R&C	24.4	8.45		18.5		9.92	10.1		22.7	23.1	11.7	23.6	23.4	22.7		22.4	32.9	20.8		10.1	20.7	31.1	10.2	10.2
Stockton	22.7	47.3	41.5	8.36	26.7	8.97	9.17	9.24	9.43	18.9	37.3	9.07			33.8	8.41	16.3	7.79	15.1	15.1	15.2	7.27	29.9	
NECN	15.5	16.4	15.5	11.1	19.5	10.3	12.3	12.4	13.4	14.6	13.9	12.1	12.9	13.2	16.4	20.4	21.8	18.1	12	20.7	19.4	18.6	24.1	16.3

Blank cells denote where data is not available or suppressed (< 5 cases)
Source: Northern and Yorkshire Cancer Registry Information Service

11.2 Mortality

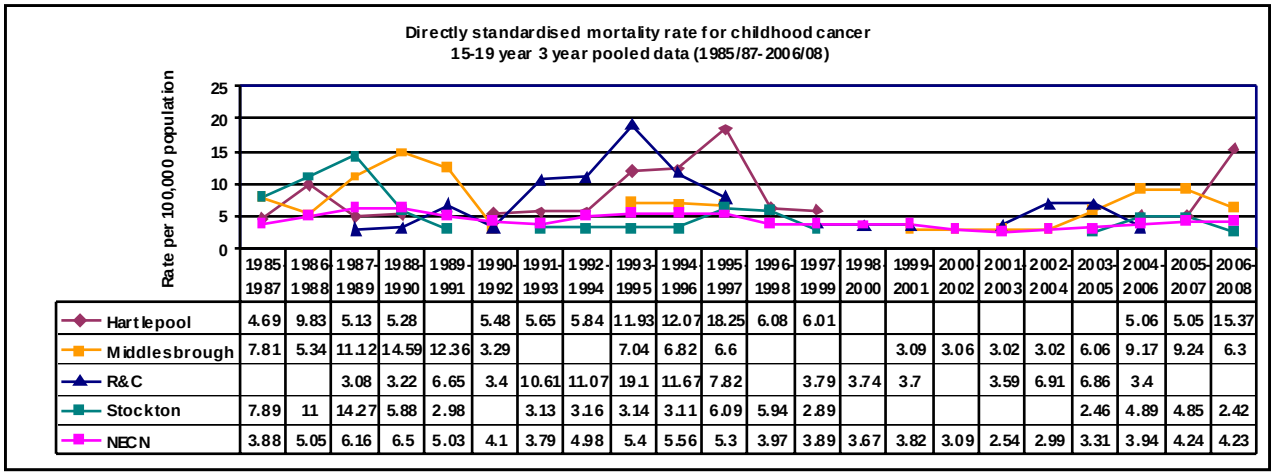
The number of death from childhood cancer is not presented due to missing and numbers less than 5, but directly standardised mortality rates in the 0-14 & 15-19 year age groups across Tees fluctuated (Figures 11.5 & 11.6).

Figure 11.5: Directly standardised mortality rates for Childhood (0- 14 yrs) cancers (ICD10:C00-C97 excl. C44 non-melanoma skin) in Tees 1985 - 2008



	1985-1987	1986-1988	1987-1989	1988-1990	1989-1991	1990-1992	1991-1993	1992-1994	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Hartlepool	7.35	7.02	14.06	10.63	8.75	1.62	3.24	3.19	1.61	1.87	1.9	5.5	3.58	5.65	2.09	2.17			1.68	3.41	5.4	3.74
Middlesbrough	1.05	3.18	4.2	4.19	4.15	3.18	5.33	4.02	5.88	4.75	2.91	0.99	1.99	3	4.02	4.44	3.58	3.7	1.09	1.12	1.42	1.37
R&C	1.04	3.11	2.11	3.17	1.03	2.04	1.01	3.26	3.35	3.37	2.12	1.05	2.17	1.12	1.15	1.06	1.07	2.67	2.88	2.89	2.78	1.42
Stockton	6.21	3.58	4.31	5.05	5.98	3.4	1.8	3.34	5.85	5.04	3.6	1.85	2.68	1.65	3.86	3.12	3.95	1.97	1.98	1.98	0.81	0.83
NECN	2.97	3.19	3.4	3.66	3.61	3.24	3.18	3.15	3.21	3.32	3.13	3.14	2.87	2.47	2.4	2.43	2.28	2.45	1.73	2.03	1.73	1.8

Figure 11.6: Directly standardised mortality rates for Childhood (15- 19 yrs) cancers (ICD10:C00-C97 excl. C44 non-melanoma skin) in Tees 1985-2008



	1985-1987	1986-1988	1987-1989	1988-1990	1989-1991	1990-1992	1991-1993	1992-1994	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Hartlepool	4.69	9.83	5.13	5.28		5.48	5.65	5.84	11.93	12.07	18.25	6.08	6.01							5.06	5.05	15.37
Middlesbrough	7.81	5.34	11.12	14.59	12.36	3.29			7.04	6.82	6.6				3.09	3.06	3.02	3.02	6.06	9.17	9.24	6.3
R&C			3.08	3.22	6.65	3.4	10.61	11.07	19.1	11.67	7.82		3.79	3.74	3.7		3.59	6.91	6.86	3.4		
Stockton	7.89	11	14.27	5.88	2.98		3.13	3.16	3.14	3.11	6.09	5.94	2.89						2.46	4.89	4.85	2.42
NECN	3.88	5.05	6.16	6.5	5.03	4.1	3.79	4.98	5.4	5.56	5.3	3.97	3.89	3.67	3.82	3.09	2.54	2.99	3.31	3.94	4.24	4.23

Blank cells denote where data is not available or suppressed (< 5 cases)
Source: Northern and Yorkshire Cancer Registry Information Service

12. Staging data

12.1 About the data

Staging data is important because they relate to how early in the disease process cancer is diagnosed and treated. So the chances of surviving and quality of life are improved if cancer is diagnosed at stage1 than stages 2, 3 and 4. The treatments for cancers diagnosed at stage 1 can also be less invasive.

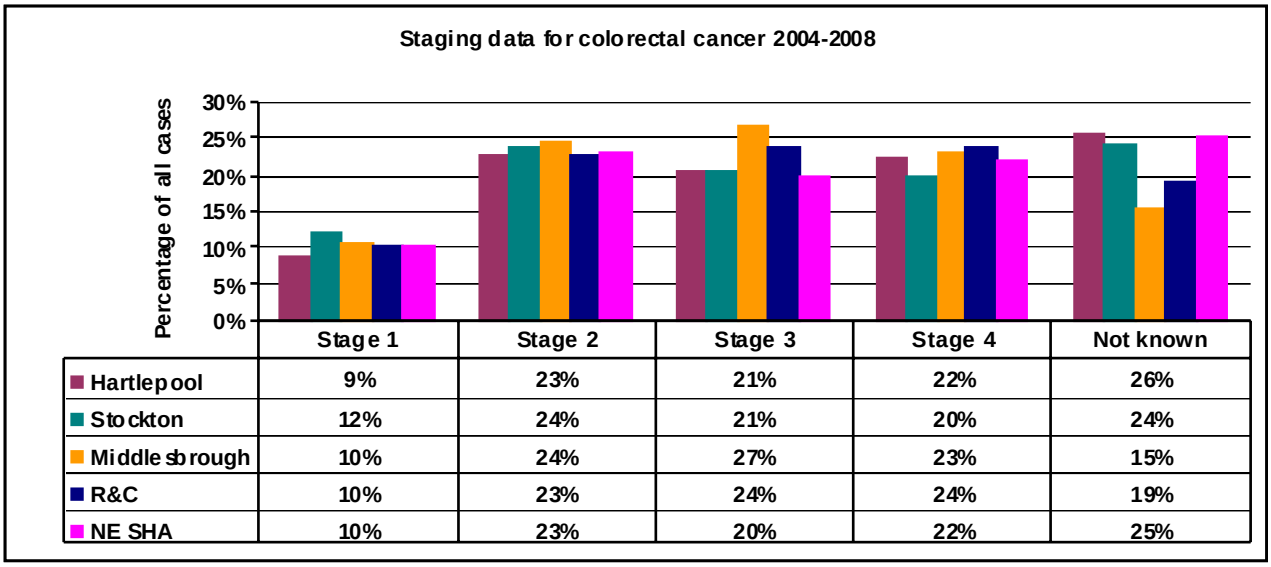
Staging data are obtained from pathology reports where clinicians provide specific information on stage of cancer at diagnosis. Cancer registries do not derive staging data. The large proportion of cases with staging not known may therefore be related to this factor. Other factors such as hospital recording and late diagnosis may make the data both incomplete and inaccurate.

12.2 Colorectal cancer

Slightly less than 1 in 10 of colorectal cancer was diagnosed at Stage 1 in Hartlepool at 9% in 2004-2008, slightly less than the figures achieved in the other three NHS Tees PCTs and the North East average.

There are large proportions (15% - 26%) of cases where staging is not known, Hartlepool with the largest proportion at 26% in NHS Tees and also slightly higher than the North east average (Figure 12.1)

Figure 12.1: Staging data for colorectal cancer (C18-C20) in Tees PCTs 2004-2008



	Stage 1	Stage 2	Stage 3	Stage 4	Not known
Hartlepool	9%	23%	21%	22%	26%
Stockton	12%	24%	21%	20%	24%
Middlesbrough	10%	24%	27%	23%	15%
R&C	10%	23%	24%	24%	19%
NE SHA	10%	23%	20%	22%	25%

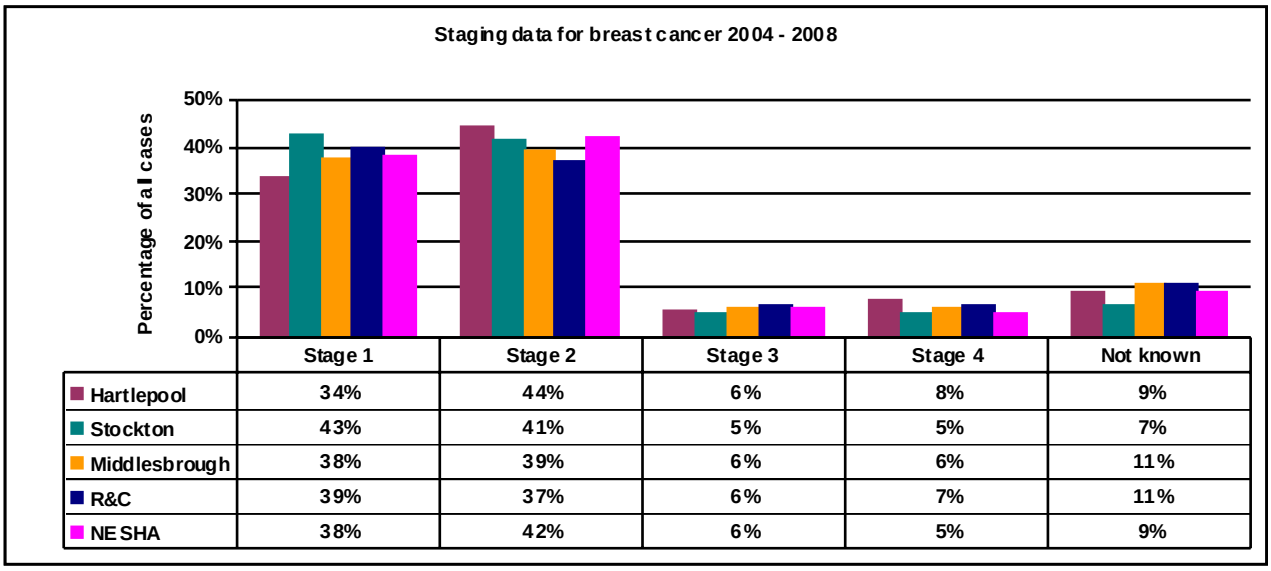
Source: Northern and Yorkshire Cancer Registry Information Service

12.3 Breast cancer

In Hartlepool 34% of breast cancer were diagnosed at stage 1. This is lower than elsewhere in Tees and lower than the North East average. This may relate to poorer uptake of breast screening in Hartlepool (see Figure 14.1 below).

About 1 in 7 of cases of breast cancer was diagnosed at stages 3 and 4 in Hartlepool, respectively. This is higher than other Tees PCTs and the North East average (Figure 12.2)

Figure 12.2: Staging data for breast cancer (C50) in Tees PCTs 2004-2008



	Stage 1	Stage 2	Stage 3	Stage 4	Not known
Hartlepool	34%	44%	6%	8%	9%
Stockton	43%	41%	5%	5%	7%
Middlesbrough	38%	39%	6%	6%	11%
R&C	39%	37%	6%	7%	11%
NE SHA	38%	42%	6%	5%	9%

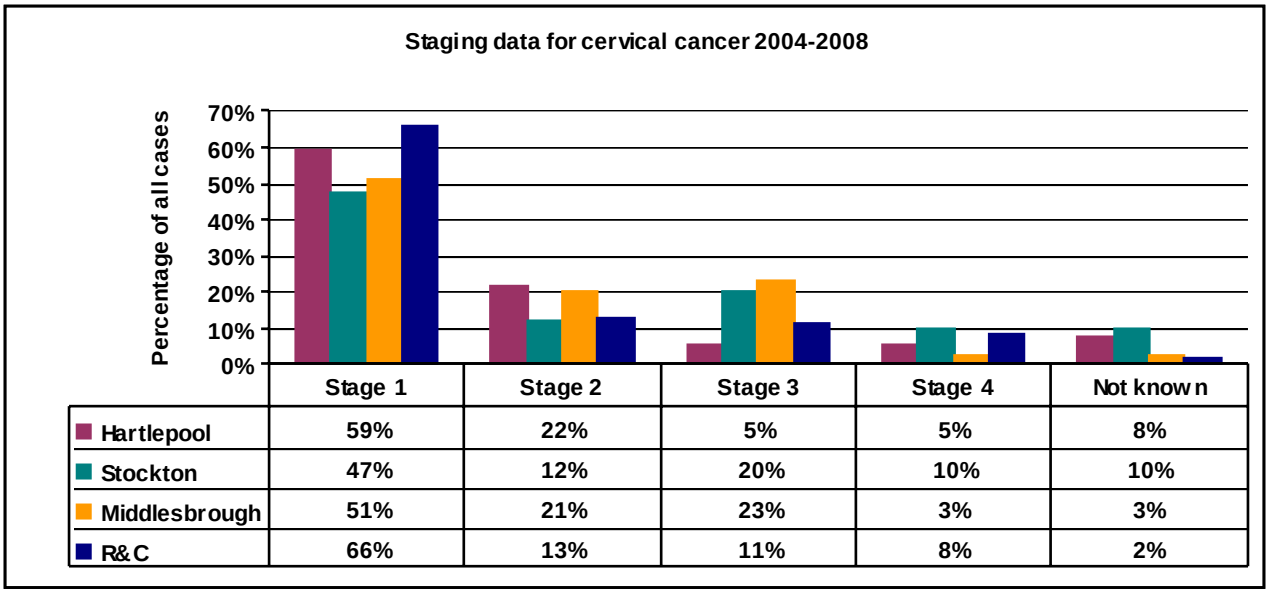
Source: Northern and Yorkshire Cancer Registry Information Service

12.4 Cervical cancer

About 60% of all cases of cervical cancers were diagnosed at stage 1 in Hartlepool, second highest in Tees. There were 8% of cervical cancers in Hartlepool with stage at diagnosis not known (Figure 12.3).

The difference in the percentage with stage at diagnosis not known between the north and south of Tees PCTs may indicate a service issue.

Figure 12.3: Staging data for cervical cancer (C53) in Tees PCTs 2004-2008



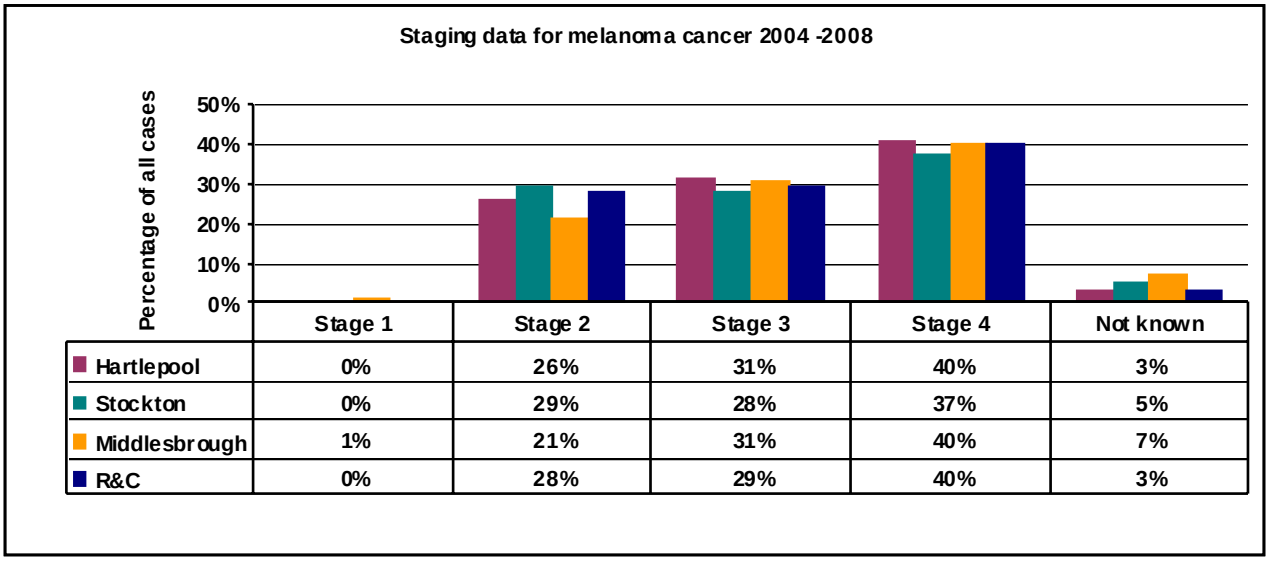
	Stage 1	Stage 2	Stage 3	Stage 4	Not known
Hartlepool	59%	22%	5%	5%	8%
Stockton	47%	12%	20%	10%	10%
Middlesbrough	51%	21%	23%	3%	3%
R&C	66%	13%	11%	8%	2%

Source: Northern and Yorkshire Cancer Registry Information Service

12.4 Melanoma cancer

Virtually no melanoma cancer was diagnosed at stage 1 in Hartlepool and across Tees. Forty percent of cases were diagnosed in stage 4 Hartlepool, with similar proportions across Tees.

Figure 12.4: Staging data for melanoma cancer (C43) in Tees PCTs 2004-2008



	Stage 1	Stage 2	Stage 3	Stage 4	Not known
Hartlepool	0%	26%	31%	40%	3%
Stockton	0%	29%	28%	37%	5%
Middlesbrough	1%	21%	31%	40%	7%
R&C	0%	28%	29%	40%	3%

Source: Northern and Yorkshire Cancer Registry Information Service

13. General practice cancer profiles

13.1 About the data

General Practice Cancer Profiles, published in October 2010 by the National Cancer Intelligence Network, bring together information on a range of process and outcome indicators on cancer in primary care in people aged 65 years and over. The profiles provide a means of comparing and reviewing variations at general practice level in order to facilitate the planning and provision of cancer services, in particular in promoting awareness and early diagnosis.

The Quality and Outcomes Framework (QOF) 2008/9 provides the 'Master List' for the profiles and other data are linked to it and used to calculate the indicators. Practice populations were closely matched to the PCTs that they lie within. Therefore, PCT populations may not be comparable to that published by, for example, the Office for National Statistics.

Eleven out of 15 practices in Hartlepool are included in the analysis: Westview Millenium, Havelock Grange, Chadwick and Hart Lodge were excluded. This gives a total population of 70,414 for Hartlepool (current total population is 91,865). The comparison of practice profiles indicators with the PCT average is based on the total population of **70,414**.

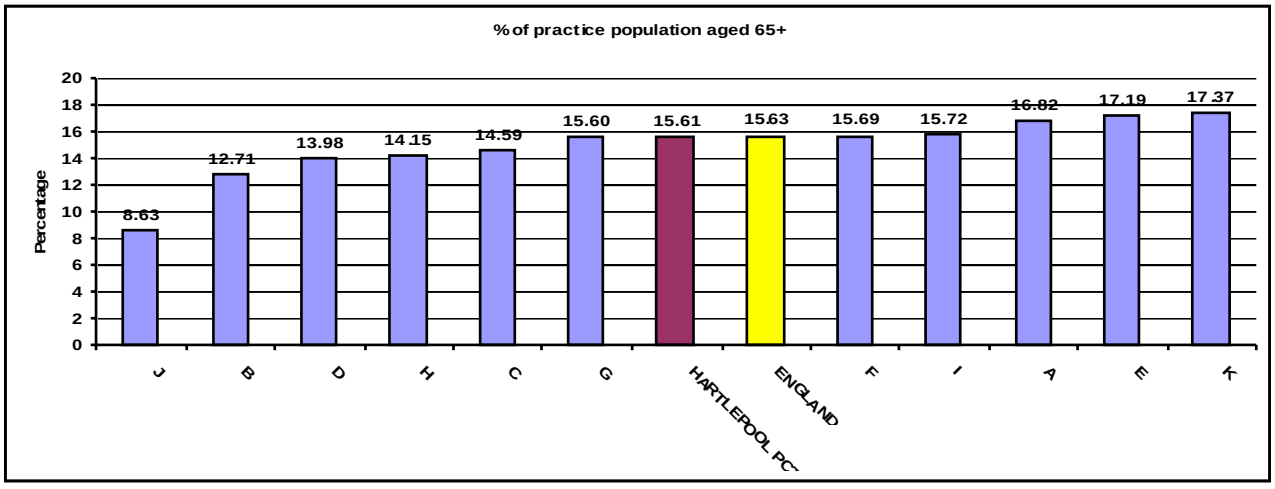
The data presented below need to be interpreted with caution because of the accuracy of practice data and the different assumptions made in the analysis. The usefulness of data is also limited by the fact that the numbers of cancer events are small and some of the analyses are based on one year data and often different years. These factors make interpretation of data and comparing indicators difficult.

13.2 Practice populations aged 65+

The percentage of practice populations aged 65 years and over was calculated based on the 2008/09 QOF data. It varied from 8.53% in Practice J to 17.37% in Practice K. Five of the eleven practices have a larger older population than the Hartlepool and England averages of 15.6% (Figure 13.1).

Generally, practices with higher proportions of over 65s are likely to have higher incidence of and mortality from cancers.

Figure 13.1: Percentage of people aged 65 years and over in Hartlepool GP Practices



Source: Source: National Cancer Intelligence Network, Practice Profiles 2010 - QOF Data 2008/09

13.3 Deprivation level

Practices were ranked nationally by the Income Domain of the Index of Multiple Deprivation (IMD) scores and allocated into quintiles (1 most affluent and 5 as the most deprived). The quintiles represent the percentage of the practice population that is income deprived.

Based on this classification 9 of the 11 GP practices in Hartlepool are in the 5th quintile (the 20% of most deprived practices in England.) The remaining two practices are in the 4th quintile (Table 13.1).

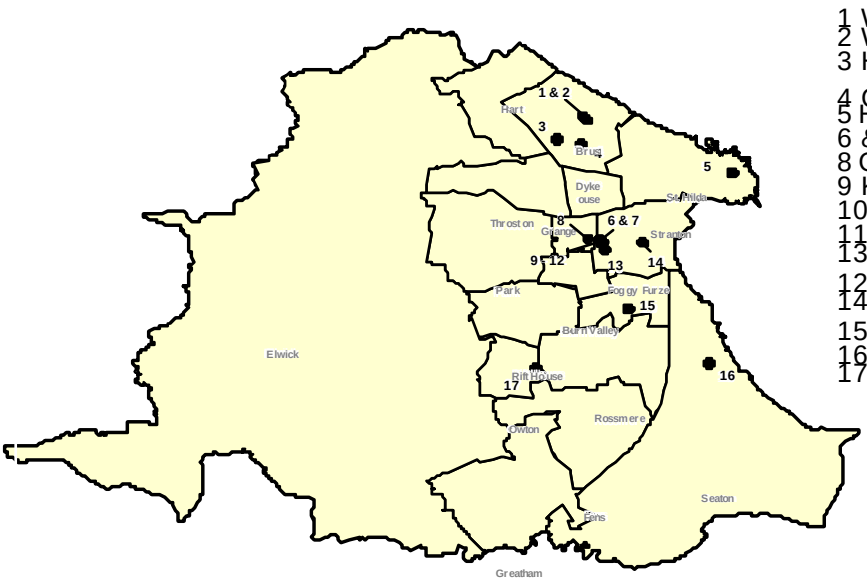
The more deprived practices can be expected to have higher levels of cancer and deaths from cancer.

Table 13.1: GP Practices by Index of Multiple Deprivation

Practice	IMD (Income Domain)
A	Quintile 5
B	Quintile 5
C	Quintile 5
D	Quintile 5
E	Quintile 5
F	Quintile 4
G	Quintile 4
H	Quintile 5
I	Quintile 5
J	Quintile 5
K	Quintile 5

Source: Source: National Cancer Intelligence Network Practice Profiles 2010

Figure 13.2: Map showing Hartlepool GP practices and wards



1 West View Millenium A*
2 West View Millenium B*
3 Hart Lodge*
4 General Medical Practice
5 Headland Medical Practice
6 & 7 Gladstone House*
8 Grange House*
9 Koh Practice
10 Bank House Surgery
11 Dr Gallagher Practice
13 York Road Surgery
12 Hazle Practice
14 Secure Patient Unit*
15 McKenzie House
16 Seaton Surgery
17 Wynyard Road Primary Care Centre

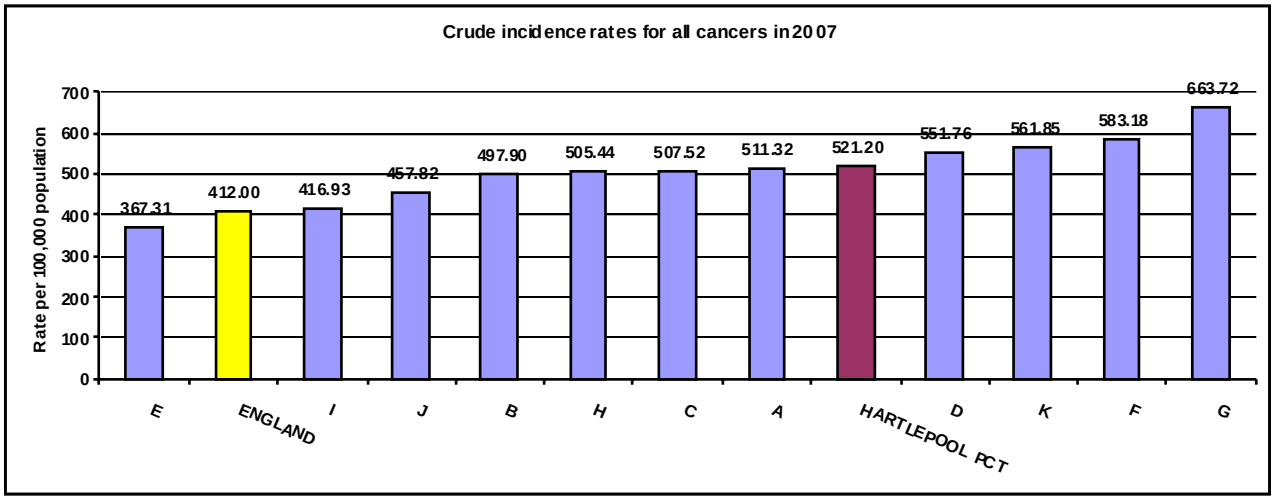
* Practices excluded from analysis

14.4 Incidence

The crude incidence rate for all cancers in 2007 in general practices in Hartlepool ranged from 367.3 per 100,000 persons in Practice E (with the second highest population aged 65 years and over) to 663.7 per 100,000 persons in Practice G (average population aged 65 years and over). Ten of the eleven practices have rates above the England average. The average rate for Hartlepool of 521.2 per 100,000 persons is higher than the rate of 453 per 100,000 for the total Hartlepool population in Figure 4.2 above. The difference is likely to reflect the difference in population size used in the calculation as outlined in section 13.1 above.

Data for more years are needed to establish a trend. A range of factors will influence the cancer incidence rate at practice level. For example, some practices might be poor at case finding and the NAEDI (National Awareness and Early Diagnosis Initiative) is being implemented to support practices in proactive case finding (Figure 13.3).

Figure 13.3: Crude incidence rate – proportion of new cases of cancer (ICD-10 C00-C97 excluding C44) diagnosed and registered by cancer registry in 2007 per practice list size and per 100,000 persons



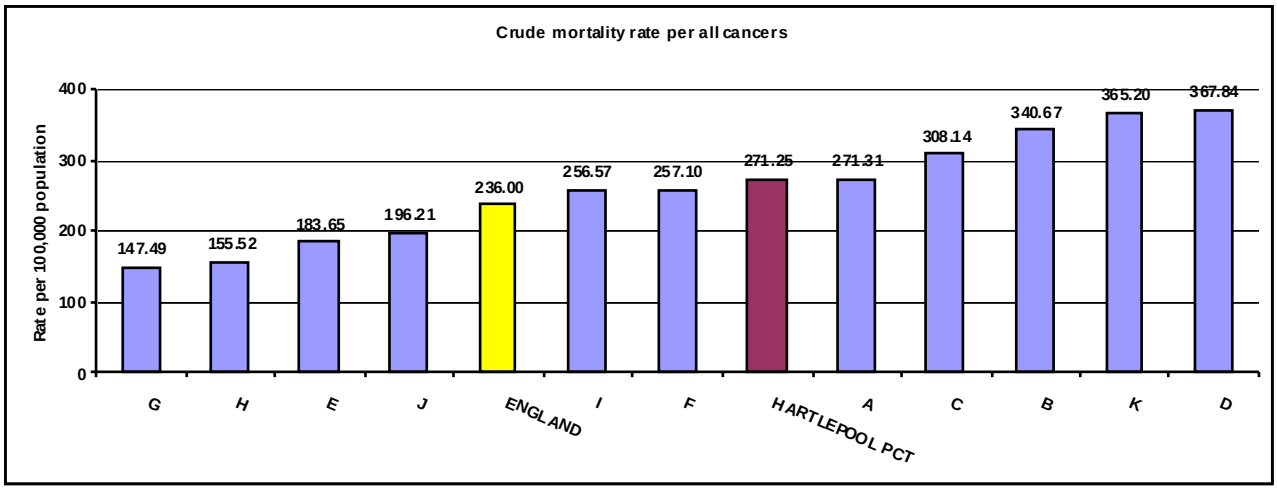
Source: National Cancer Intelligence Network, Practice Profiles 2010

13.5 Mortality

The crude mortality rates for all cancers in general practices in Hartlepool (date of data not provided) range from 147.5 per 100,000 persons (Practice G) to 367.8 (Practice D) with the average for Hartlepool and England at 271.2 per 100,000 population and 236.0 per 100,000 population, respectively (Figure 13.4).

The date of data and data for more years is needed for meaningful interpretation of data and to establish a trend.

Figure 13.4; Crude mortality rate – proportion of cancer deaths (ICD-10 C00-C97 excluding C44) per practice list size per 100,000 population – year of data not stated



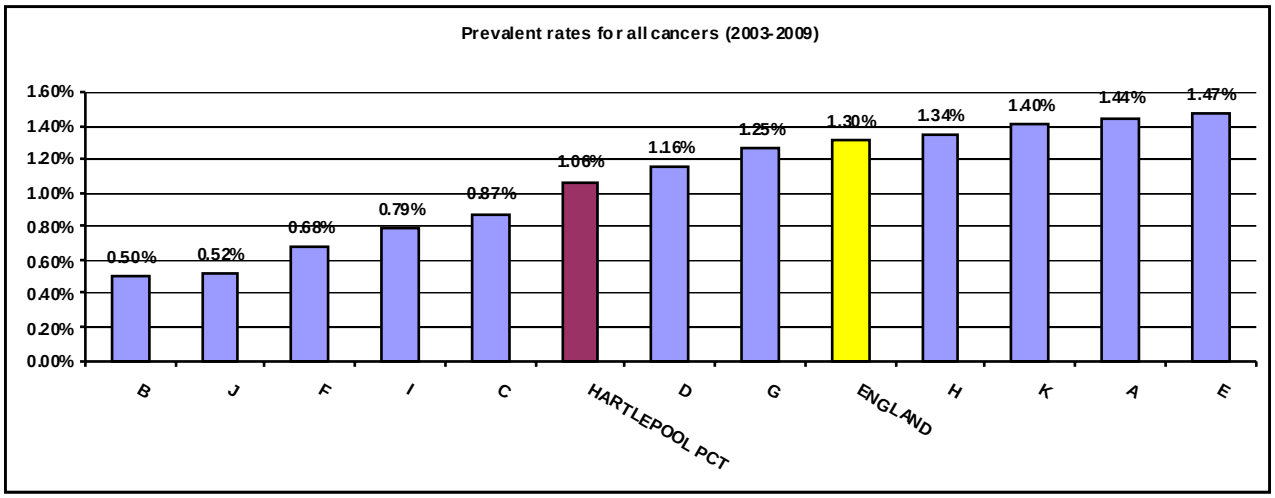
Source: National Cancer Intelligence Network, Practice Profiles 2010

13.6 Prevalence

The prevalence rate refers to the proportion of people with cancer in practices over a 7-year, from 2003 to 2009. It ranges from 0.50% (Practice B) to 1.47% (Practice E) with the average rates for Hartlepool and England at 1.06% and 1.30%, respectively (Figure 13.5).

There is a general correlation. Practices with larger proportions of over 65s (Practices A, E and K) have higher prevalence rates.

Figure 13.5: Period prevalence rate for all cancers (ICD-10 C00-C97 excluding C44) - proportion of persons age 65 years and over (in 2008/09) on the practice cancer register, 7 years pooled data Apr 2003 – Jan 2009



Source: QOF 2008/09 - Cancer Prevalence Field

13.7 Conversion rate

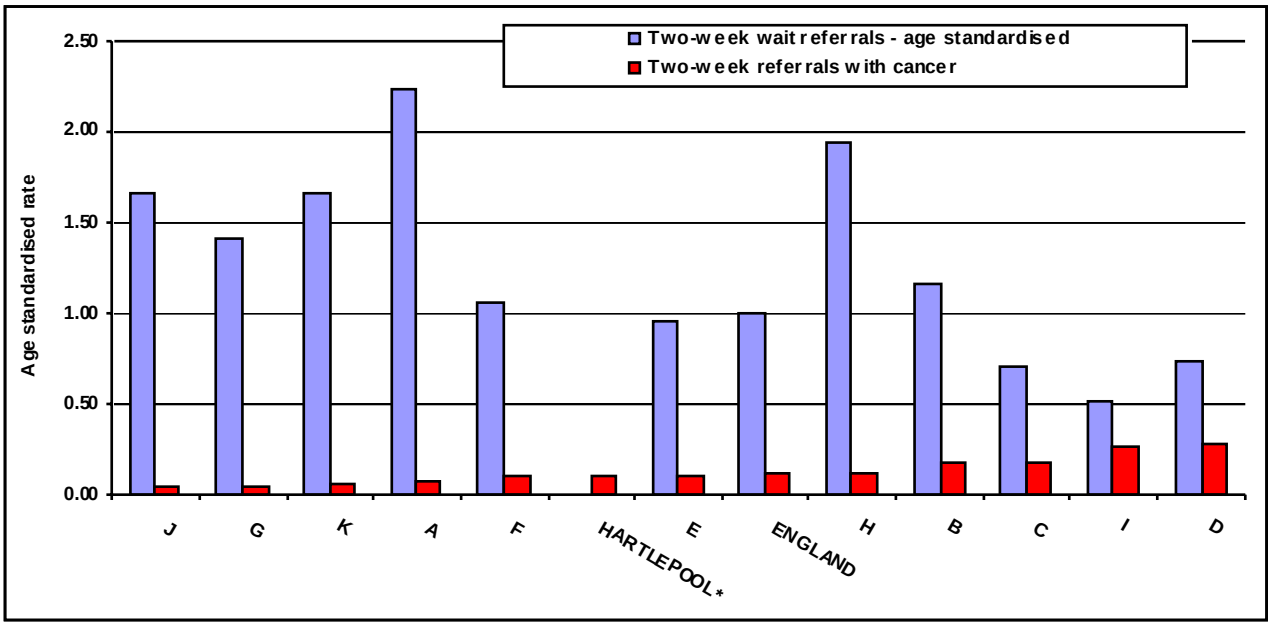
The conversion rate represents the proportion of Two Week Wait referrals from general practices to secondary care which received a first treatment for cancer in 2009[6]. This is presented together with the volume (age standardised) of Two Week Referral to help with

[6] A small number of cases referred in 2009 will have started treatment in 2010 and also a small number of those referred in 2008 will have started treatment in 2009

interpretation (Figure 13.6). The rates range from 3.4% (Practice J) to 27.9% (Practice D) with the average for Hartlepool at 9.6%, which is lower than the England average of 11.2%.

The conversion rate is based on numbers diagnosed from Two Week referrals and is likely to be accurate, but will reflect a number of practice (e.g. referral patterns and appropriateness of referrals), patient (e.g. awareness of symptoms and early presentation) and service (e.g. accuracy and completeness of data on the times when treatments started) factors.

Figure 13.6: Conversion rate - the proportion of Two Week Wait referrals which received a first treatment for cancer (ICD-10 C00-C97 excluding C44) in 2009 compared with volume (age standardised) of Two Week Wait referrals in Hartlepool general practices



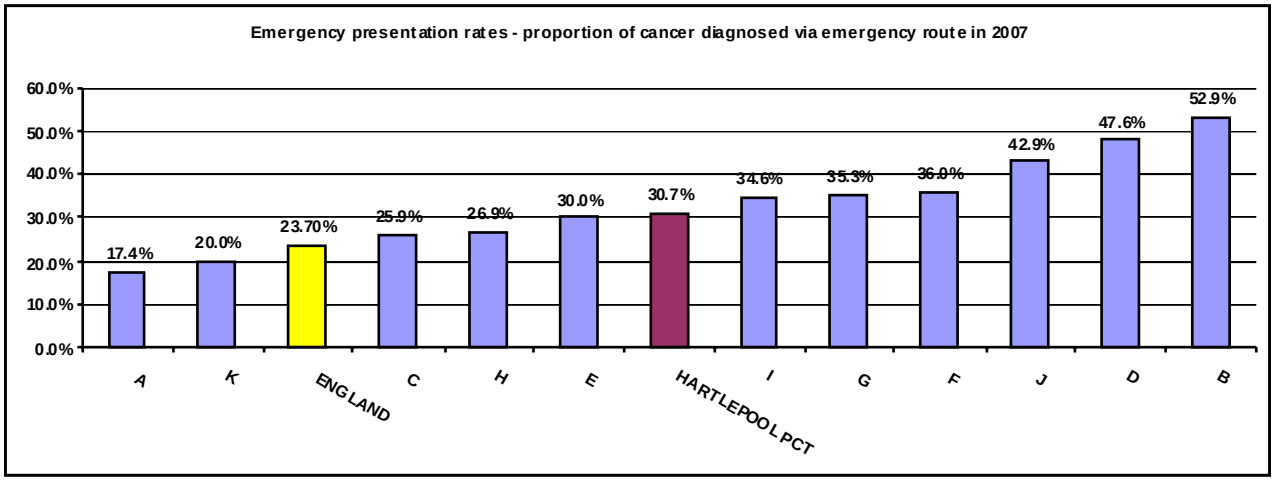
*Source: Department of Health Waiting Times Database 2009. *Referral data note available*

13.8 Emergency presentation rate

In 2007 the proportion of all cancers diagnosed as a result of patients attending hospital for an emergency event of any type ranged from 17.4% in Practice A to 52.9% in Practice B. The average emergency presentation rate for Hartlepool was 30.7%. Nine of the eleven practices had rates higher than the England average of 23.7% (Figure 13.7).

The data for more years are needed to establish a trend. The conversion rates will be determined by patient and service factors such as patients' knowledge and awareness of symptoms and delays in referring patients for appropriate investigations.

Figure 13.7: Emergency presentation rates - proportion of cancers (ICD-10 C00-C97 excluding C44) diagnosed via emergency route in 2007



Source: Routes to Diagnosis Project Database

14. NHS Cancer screening programmes

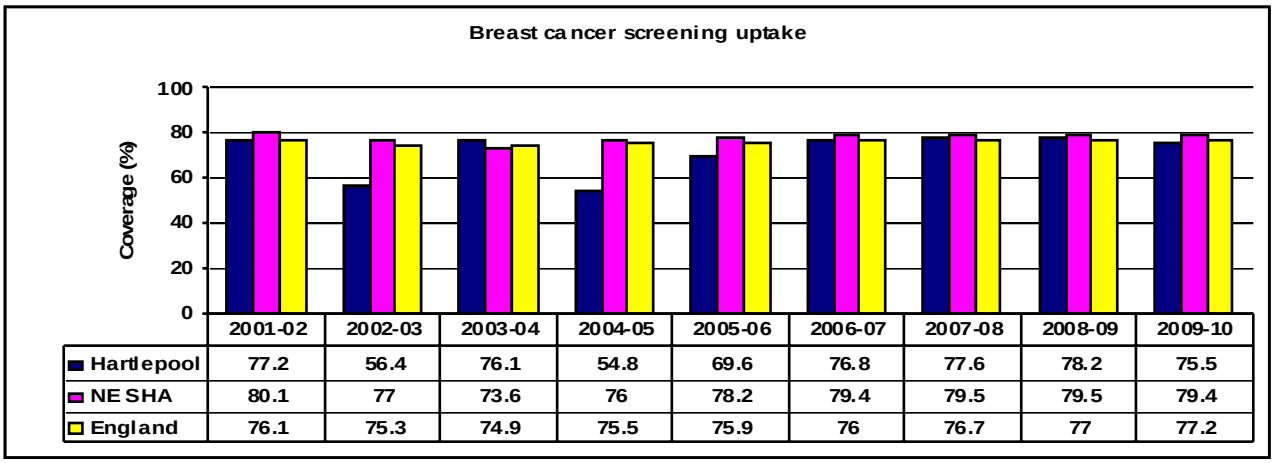
14.1 Breast screening

In England there is a free breast screening programme aimed at all women aged 50-70 years who are registered with a GP. Women are invited to a screening appointment, a mammogram, every three years. Women over 70 years can be screened on demand. From 2012 screening is being extended to cover women between the ages of 47 and 73.

14.1.1 Uptake

Data on uptake of breast screening in Hartlepool for 2001/02 – 2009/10 show no clear trend but coverage rates are generally low compared with the North East and England average rates (Figure 14.1). Nationally, the aim is to achieve a target of 80% and above in the uptake of screening.

Figure 14.1: Breast screening uptake 2001/02-2009/10 in Tees



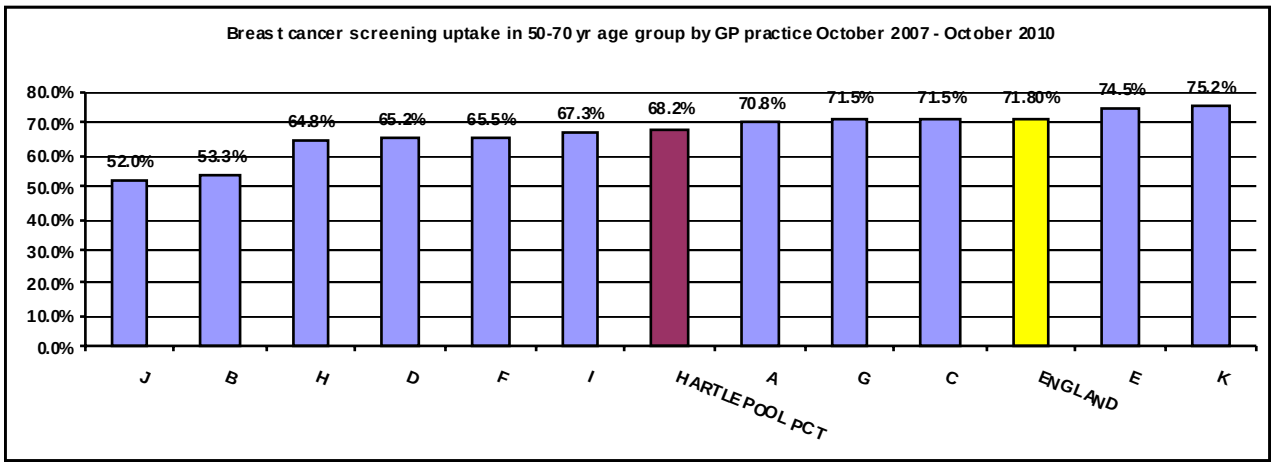
	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10
Hartlepool	77.2	56.4	76.1	54.8	69.6	76.8	77.6	78.2	75.5
NE SHA	80.1	77	73.6	76	78.2	79.4	79.5	79.5	79.4
England	76.1	75.3	74.9	75.5	75.9	76	76.7	77	77.2

Source: NHS Cancer Screening Programme

At general practice level uptake rates for a 3-year period (Oct 2007-Oct 2010) vary between Hartlepool GP practices from the lowest of 52.0% (Practice J) to the highest of 75.2% (Practice K) (Figure 14.2).

The difference between the Hartlepool average of 68.2% and the average of 77.1% for the period 2007/08 – 2009/10 (Figure 14.1 above) may reflect the difference in the population used as the denominator, 70,414 and 91,865 respectively.

Figure 14.2: Breast screening uptake by general practices in Hartlepool, October 2007-October 2010



Source: National Cancer Intelligence – Practice Profiles

14.2 Cervical screening

Cervical screening aims to prevent cancer by detecting and treating early abnormalities which, if left untreated, could lead to cancer in a woman's cervix (the neck of the womb). A sample of cells is taken from the cervix for analysis to detect early cell changes that could lead to cancer.

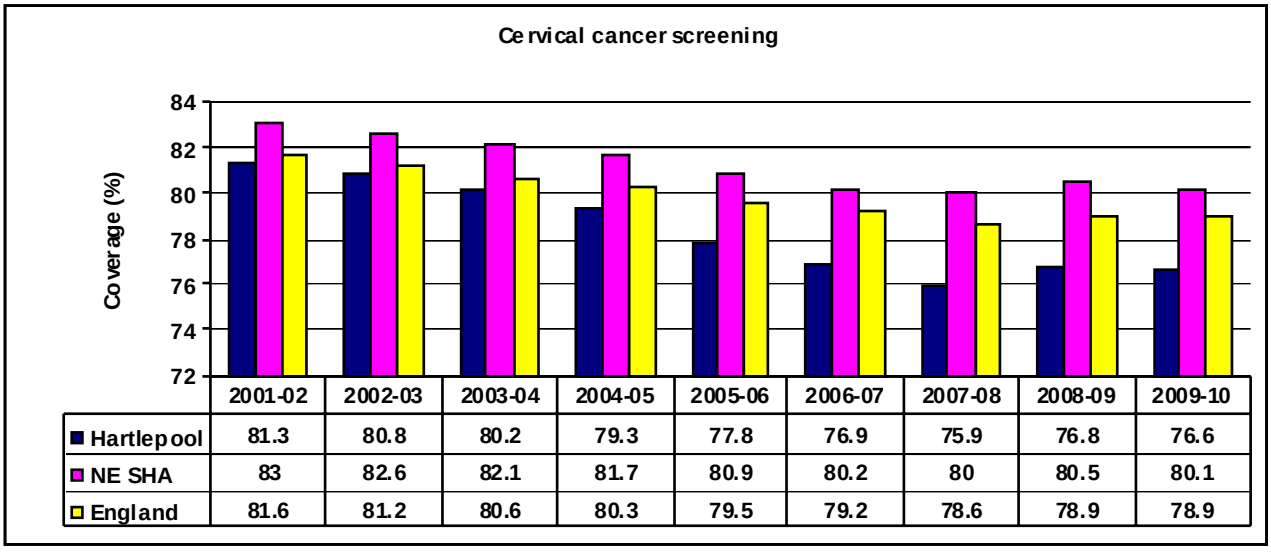
All women between the ages of 25 and 64 are eligible for cervical screening test every three to five years depending on age:

25 years	First invitation
25-49 years	3 yearly
50-64	5 yearly
65+	Only women who have been screened since age 50 or have had recent abnormal tests are invited

14.2.1 Uptake

Uptake rates for cervical screening in Hartlepool follow the decreasing trend across England but are consistently lower than NE SHA and England averages (Figure 14.3).

Figure 14.3: Cervical cancer screening uptake 2001/02-2009/10 in Tees



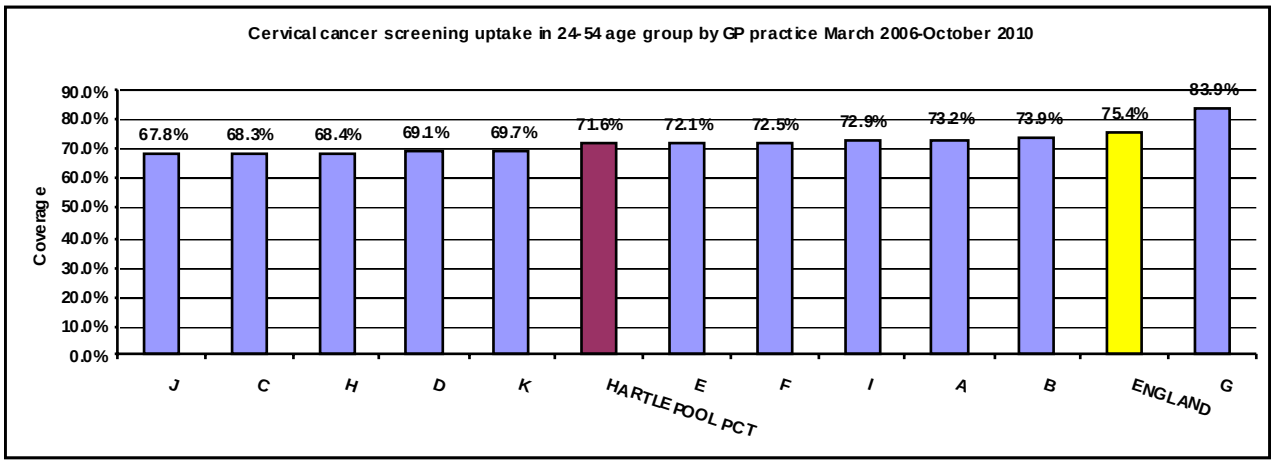
	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10
Hartlepool	81.3	80.8	80.2	79.3	77.8	76.9	75.9	76.8	76.6
NE SHA	83	82.6	82.1	81.7	80.9	80.2	80	80.5	80.1
England	81.6	81.2	80.6	80.3	79.5	79.2	78.6	78.9	78.9

Source: NHS Cancer Screening Programme

At general practice level uptake rates for the period Mar 2006-Oct 2010 vary from 67.8% (Practice J) to 83.9% (Practice G) (Figure 14.4).

The difference between the Hartlepool average of 71.6% and the average of 76.6% for the period 2006/07 – 2009/10 (Figure 14.3 above) may reflect the difference in the population used as the denominator, 70,414 and 91,865, respectively.

Figure 14.4: Cervical cancer screening uptake by general practices in Hartlepool, March 2006-October 2010



Source: National Cancer Intelligence – Practice Profiles

14.3 Bowel screening

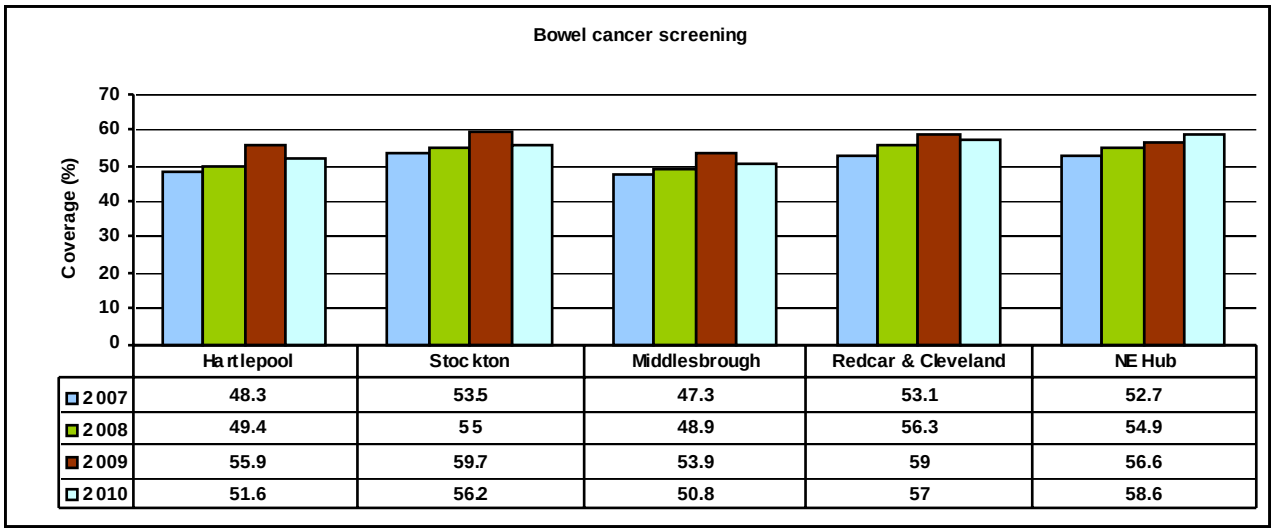
Bowel cancer screening aims to detect bowel cancer early when treatment is more likely to be effective. It can also detect polyps, which are not cancers, but may develop into cancers over time. Polyps can easily be removed, reducing the risk of bowel cancer developing.

The programme offers screening every two years to all men and women aged 60 to 69. Those eligible for screening receive a faecal occult blood (FOB) test kit with step-by-step instructions for completing the test at home and sending the samples to the hub laboratory. People over 70 can request a screening kit.

14.3.1 Uptake

There is a general increasing trend in uptake of bowel screening in Hartlepool but lower than the North East Hub rate (Figure 14.5).

Figure 14.5: Bowel cancer screening uptake 2007- 2010 in Tees

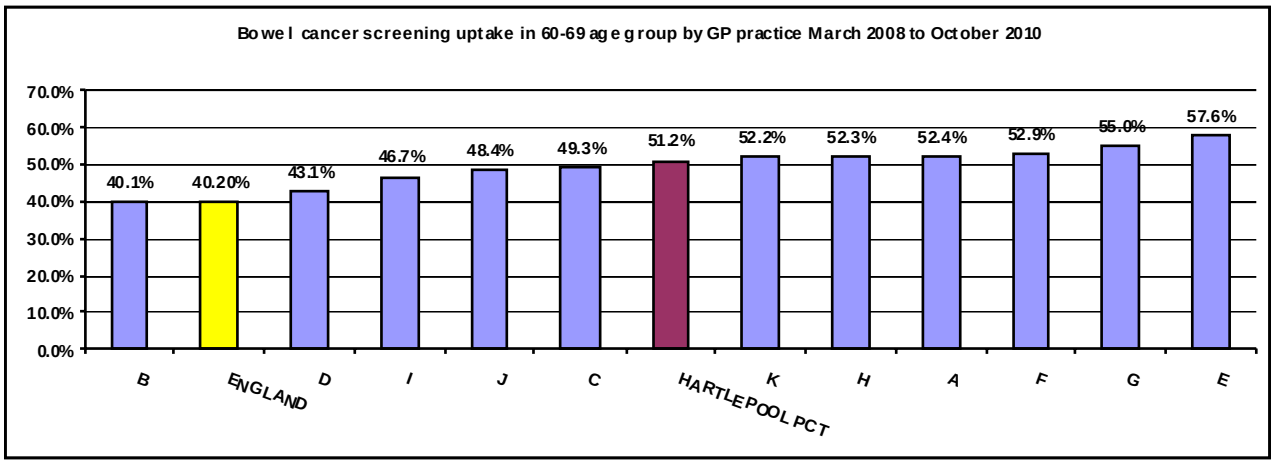


	Hartlepool	Stockton	Middlesbrough	Redcar & Cleveland	NE Hub
2007	48.3	53.5	47.3	53.1	52.7
2008	49.4	55	48.9	56.3	54.9
2009	55.9	59.7	53.9	59	56.6
2010	51.6	56.2	50.8	57	58.6

Source: NHS Cancer Screening Programme

Bowel screening average uptake for a 2-year period (Mar 2008 to Oct 2010) in general practices range from 40.1% (Practice B) to 57.6% (Practice E) with the Hartlepool average of 51.2% (Figure 14.6).

Figure 14.6: Bowel cancer screening uptake by general practices in Hartlepool, March 2008-October 2010

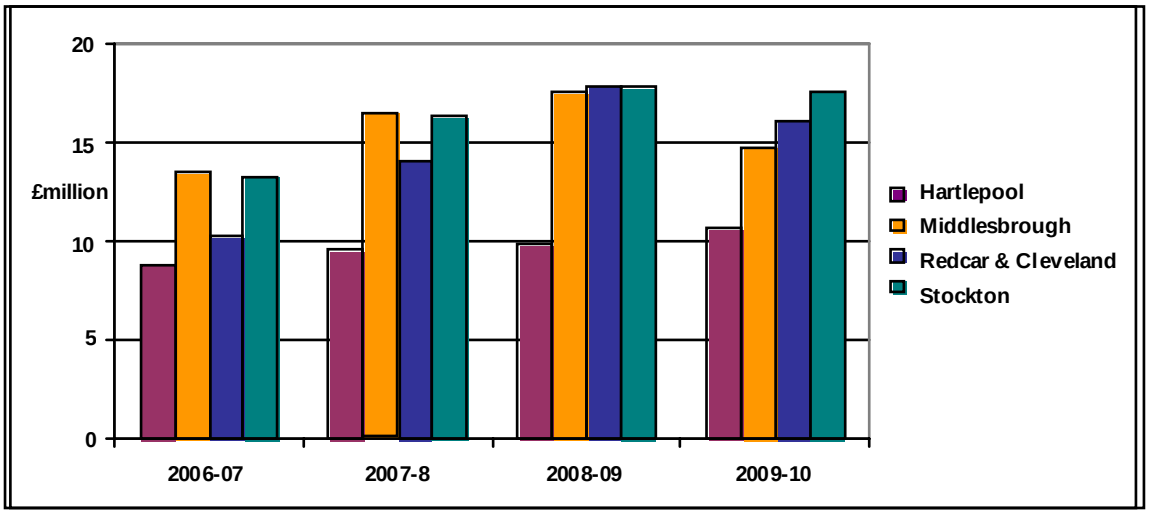


Source: National Cancer Intelligence – Practice Profiles

15. Spend on cancer

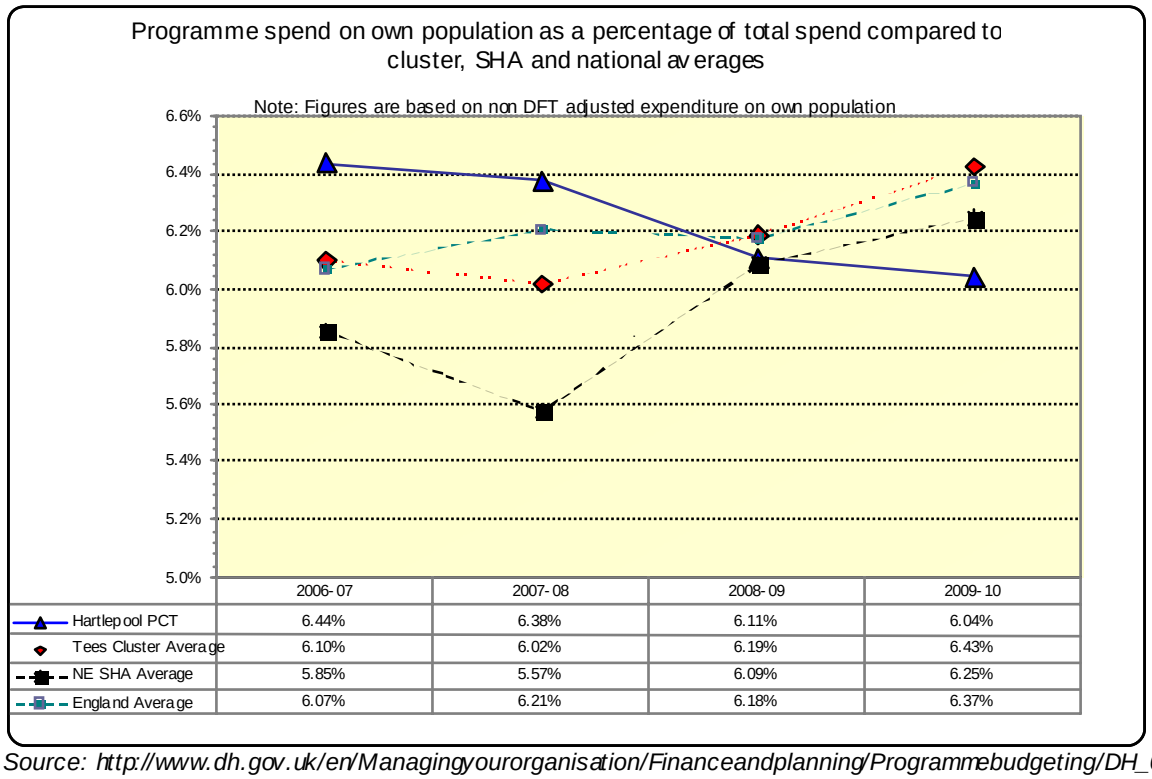
Hartlepool has the smallest population in NHS Tees PCT Cluster and the lowest spend on cancer. Spending increased by 21.5% from £8.8 million in 2006-07 to £10.7 million in 2009-10 per own population, an average of 6.2% of total expenditure (Figures 15.1). However, spend per 100,000 population, as a percentage of total spend decreased from 6.44% in 2006-07 to 6.04% in 2009-10, compared with increases in comparable areas both in Tees, North East and England (Figure 15.2). This probably reflects Hartlepool's small population.

Figure 15.1: Cancer expenditure on own population in NHS Tees Cluster 2006/07– 2009/10



Source: http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743

Figure 15.2: Expenditure on own population, £million per 100,000 population



	2006-07	2007-08	2008-09	2009-10
Hartlepool PCT	6.44%	6.38%	6.11%	6.04%
Tees Cluster Average	6.10%	6.02%	6.19%	6.43%
NE SHA Average	5.85%	5.57%	6.09%	6.25%
England Average	6.07%	6.21%	6.18%	6.37%

Source: http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743

Appendices – Hartlepool Cancer Factsheet

Northern and Yorkshire
Cancer Registry and Information Service

NHS

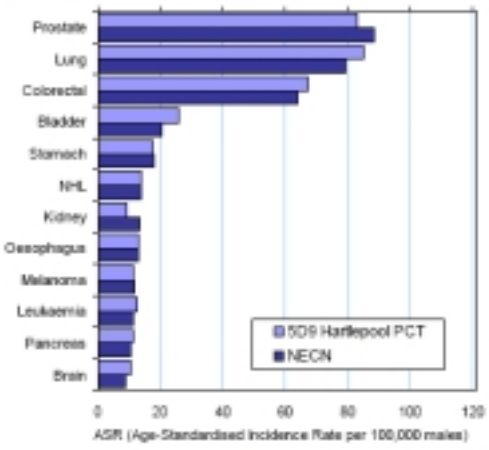
Hartlepool PCT

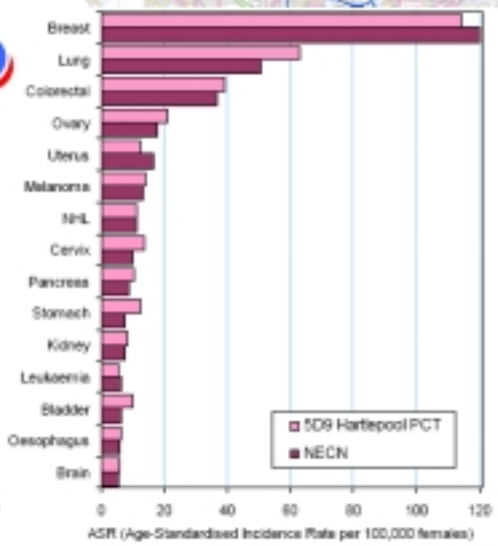
- Hartlepool PCT is responsible for a total population of approximately 91,000 people.
- Mortality from all cancers combined is statistically significantly higher for both males and females in Hartlepool PCT, compared to the North of England Cancer Network (NECN).
- Lung cancer incidence and mortality are high priority public health issues in Spearhead PCTs; in Hartlepool PCT, female incidence and mortality from lung cancer is statistically significantly higher when compared to the NECN.
- In females, incidence of bladder cancer is statistically significantly high when compared to the NECN average.

www.nycris.nhs.uk

PCT Factsheets

Incidence 2003-2007





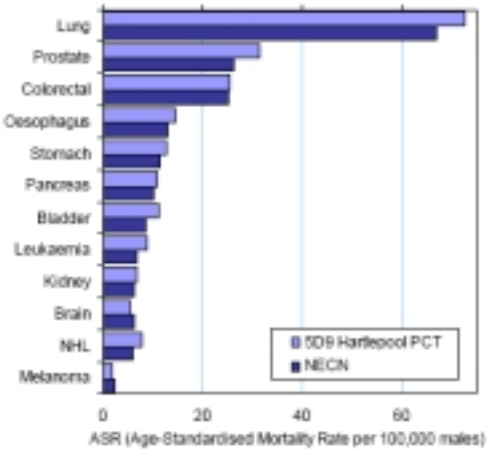
Mean Annual Cases & Incidence Rates 2003-7	Males								Females							
	5D9 Hartlepool PCT				NECN				5D9 Hartlepool PCT				NECN			
	Cases	ASR	LCI	UCI	Cases	ASR	LCI	UCI	Cases	ASR	LCI	UCI	Cases	ASR	LCI	UCI
C00-C97 excluding C44	242.0	455.1	429.3	482.2	8,133.0	438.2	433.9	442.6	247.6	397.9	374.9	422.2	8,102.2	377.3	373.4	381.3
C15 Oesophagus	7.0	12.9	8.9	18.4	240.0	13.1	12.3	13.9	4.6	6.5	4.0	10.4	148.2	5.8	5.3	6.2
C16 Stomach	9.6	17.4	12.8	23.5	349.8	18.1	17.2	18.9	8.4	12.4	8.8	17.5	204.0	7.7	7.2	8.2
C18-C20 Colorectal	36.4	67.3	57.7	78.3	1,203.4	64.1	62.4	65.7	27.0	39.0	32.4	47.0	904.8	36.9	35.7	38.0
C25 Pancreas	6.0	11.5	7.7	16.8	196.2	10.6	10.0	11.3	7.6	10.5	7.3	15.2	216.8	8.7	8.1	9.3
C33-C34 Lung	46.4	85.2	74.4	97.4	1,514.2	79.1	77.3	81.0	44.2	63.1	54.7	72.8	1,203.2	50.8	49.5	52.2
C43 Melanoma	6.0	11.4	7.6	16.7	196.0	11.6	10.9	12.4	7.0	14.1	9.7	20.0	237.4	13.3	12.5	14.1
C50 Breast	-	-	-	-	-	-	-	-	64.8	114.6	102.0	128.5	2,317.6	120.0	117.7	122.3
C53 Cervix	-	-	-	-	-	-	-	-	7.2	14.0	9.7	19.8	163.8	9.7	9.1	10.5
C54-C55 Uterus	-	-	-	-	-	-	-	-	7.4	12.6	8.7	17.9	335.2	16.5	15.7	17.3
C56 Ovary	-	-	-	-	-	-	-	-	11.8	20.8	15.6	27.4	355.6	18.0	17.1	18.9
C61 Prostate	45.2	83.2	72.5	95.3	1,688.0	88.3	86.4	90.3	-	-	-	-	-	-	-	-
C64 Kidney	4.6	9.4	5.9	14.5	239.0	13.3	12.6	14.2	5.0	8.3	5.2	12.8	163.2	7.6	7.1	8.2
C67 Bladder	14.6	25.8	20.1	32.9	396.6	20.4	19.5	21.3	7.6	10.1	7.0	14.6	173.0	6.4	5.9	6.9
C71 Brain	5.0	10.5	6.7	15.9	149.2	9.0	8.4	9.7	3.4	5.9	3.3	10.0	102.8	5.5	5.0	6.1
C82-C85 NHL	6.8	13.6	9.4	19.4	244.4	13.6	12.9	14.4	6.6	11.2	7.6	16.3	241.6	11.3	10.6	12.0
C91-C95 Leukaemia	6.4	12.4	8.4	17.9	201.6	11.6	10.8	12.3	3.2	5.6	3.1	9.6	142.0	6.6	6.1	7.2

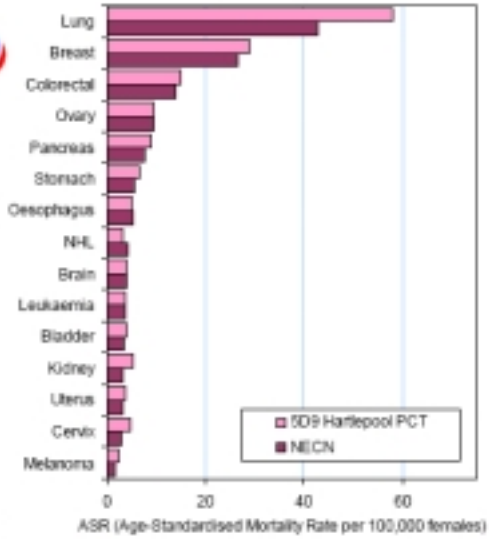
ASR = European Directly Age Standardised Rate (per 100,000 population) with 95% Confidence Interval (LCI=Lower, UCI=Upper)
NECN = North of England Cancer Network. NHL = Non-Hodgkin's Lymphoma. 'Persons' rates available on website

NYCRIS - Northern and Yorkshire Cancer Registry and Information Service (August 2010)

Hartlepool PCT

Mortality 2003-2007





Mean Annual Deaths & Mortality Rates 2003-7	Males								Females							
	5D9 Hartlepool PCT				NECN				5D9 Hartlepool PCT				NECN			
	Deaths	ASR	LCI	UCI	Deaths	ASR	LCI	UCI	Deaths	ASR	LCI	UCI	Deaths	ASR	LCI	UCI
C00-C97 excluding C44	152.8	**280.6**	260.6	302.0	4,641.6	**242.2**	239.0	245.4	142.4	**204.4**	188.8	221.3	4,249.6	**171.2**	168.7	173.7
C15 Oesophagus	7.8	**14.5**	10.3	20.3	242.8	**13.0**	12.3	13.8	3.8	**5.2**	3.0	8.8	143.6	**5.3**	4.9	5.7
C16 Stomach	7.0	**12.8**	8.9	18.2	224.4	**11.4**	10.7	12.1	5.4	**6.7**	4.3	10.5	152.8	**5.4**	5.0	5.9
C18-C20 Colorectal	13.8	**25.4**	19.6	32.6	487.8	**25.3**	24.3	26.4	11.2	**14.9**	11.1	20.1	378.8	**13.9**	13.2	14.6
C25 Pancreas	5.8	**10.8**	7.2	16.0	187.2	**10.0**	9.4	10.7	6.6	**9.0**	6.1	13.4	195.2	**7.6**	7.1	8.1
C33-C34 Lung	40.2	**72.6**	62.7	83.9	1,298.2	**67.1**	65.5	68.8	41.4	**58.0**	50.0	67.3	1,046.0	**42.6**	41.4	43.8
C43 Melanoma	1.0	**1.9**	0.6	5.0	44.6	**2.5**	2.2	2.9	1.4	**2.4**	0.9	5.5	34.0	**1.5**	1.3	1.8
C50 Breast	-	-	-	-	-	-	-	-	17.8	**29.0**	22.9	36.4	601.2	**26.6**	25.6	27.7
C53 Cervix	-	-	-	-	-	-	-	-	2.6	**4.9**	2.6	8.8	59.4	**3.9**	2.6	3.4
C54-C55 Uterus	-	-	-	-	-	-	-	-	2.8	**3.6**	1.9	6.8	77.6	**3.1**	2.8	3.5
C56 Ovary	-	-	-	-	-	-	-	-	6.6	**9.7**	6.5	14.3	218.2	**9.7**	9.1	10.3
C61 Prostate	17.0	**31.4**	24.9	39.3	526.6	**26.3**	25.3	27.4	-	-	-	-	-	-	-	-
C64 Kidney	3.6	**6.8**	4.0	11.2	121.2	**6.5**	5.9	7.0	3.0	**5.3**	2.9	9.2	81.4	**3.3**	3.0	3.7
C67 Bladder	7.0	**11.3**	7.8	16.3	175.6	**8.8**	8.2	9.5	3.6	**3.9**	2.3	7.0	100.8	**3.4**	3.1	3.8
C71 Brain	3.0	**5.7**	3.2	9.8	108.4	**6.3**	5.7	6.8	2.6	**4.2**	2.1	7.8	75.2	**3.9**	3.5	4.3
C82-C85 NHL	4.2	**7.9**	4.8	12.6	114.0	**6.0**	5.5	6.6	2.4	**3.3**	1.7	6.5	110.0	**4.4**	4.0	4.8
C91-C95 Leukaemia	4.6	**8.9**	5.5	13.7	126.4	**6.8**	6.3	7.4	2.4	**3.8**	1.8	7.3	93.4	**3.7**	3.3	4.1

ASR = European Directly Age Standardised Rate (per 100,000 population) with 95% Confidence Interval (LCI=Lower, UCI=Upper)
Mortality data supplied by ONS (Office for National Statistics) via YHPHO (Yorkshire & Humber Public Health Observatory)
NECN = North of England Cancer Network. NHL = Non-Hodgkin's Lymphoma. "Persons" rates available on website

Funnel Plots

Funnel plots have been created to compare the Age Standardised Rates (ASR) in each PCT within the North of England Cancer Network with the overall England rate. The ASR is plotted against an adjusted population which is based on the number of events and the ASR in each PCT (adjusted population=events/ASRx100000). This is calculated separately for each sex and site so the adjusted population may vary across sites for each PCT. The national ASR is calculated using data from all PCTs in England and plotted against the adjusted population; control limits are calculated based on a Poisson distribution to produce 95% and 99.8% control limits. This method was applied using the "funnelcompar" command in STATA (written by Silvia Forni, Rosa Gini, Agenzia regionale di sanità della Toscana, Italy), which computes data and plots a funnel plot as defined by Spiegelhalter 2005. For all funnel plots, the solid black line represents the national ASR for England, while the dashed blue lines are the 95% control limits and the dashed red lines (the outermost line) are the 99.8% control limits. This type of chart avoids spurious ranking of areas but still identifies areas that are outliers. PCTs that lie outside the control limits have significantly different rates to England and these differences may warrant further investigation.

Codes used in funnel plots:

1 5E1 North Tees PCT
2 5D7 Newcastle PCT
3 5D8 North Tyneside PCT
4 5D9 Hartlepool PCT
5 5J9 Darlington PCT
6 5KF Gateshead PCT
7 5KG South Tyneside PCT
8 5KL Sunderland Teaching PCT
9 5KM Middlesbrough PCT
10 5ND County Durham PCT
11 5QR Redcar and Cleveland PCT
12 TAC Northumberland Care Trust
13 5NV North Yorkshire and York PCT
14 5NE Cumbria PCT

www.nycris.nhs.uk

PCT Factsheets

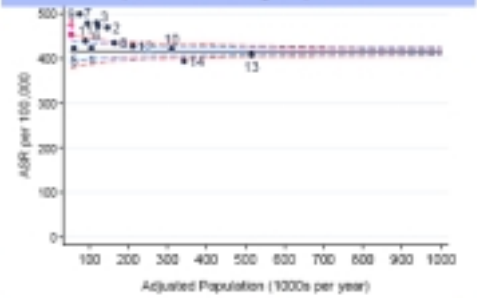
www.nycris.nhs.uk

PCT Factsheets

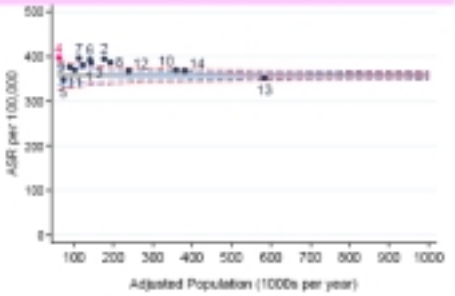
Hartlepool PCT

Incidence 2003-2007 by PCT (Funnel Plots)

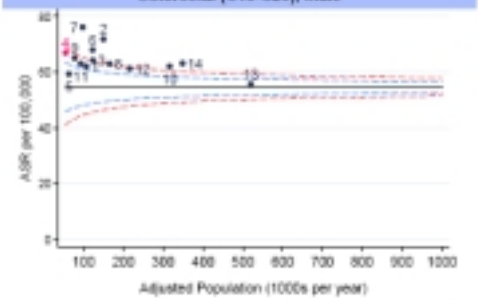
All cancers excluding non-melanoma skin cancer (C00-C97 excluding C44), male



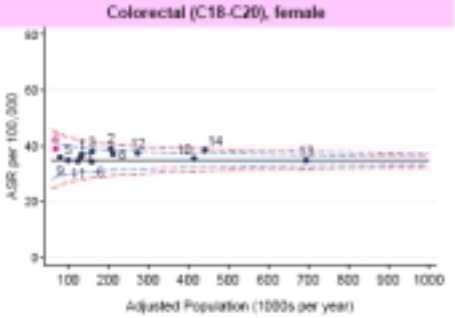
All cancers excluding non-melanoma skin cancer (C00-C97 excluding C44), female



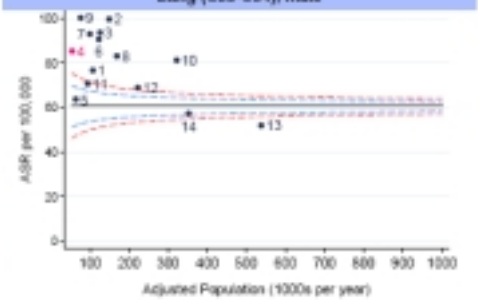
Colorectal (C18-C20), male



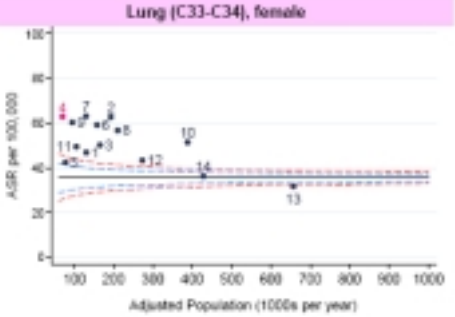
Colorectal (C18-C20), female



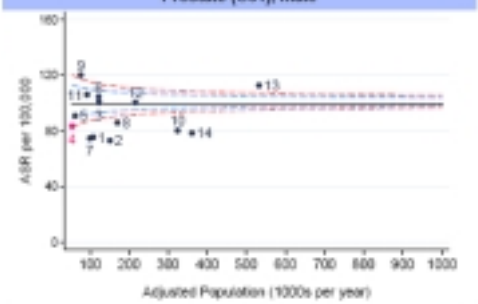
Lung (C33-C34), male



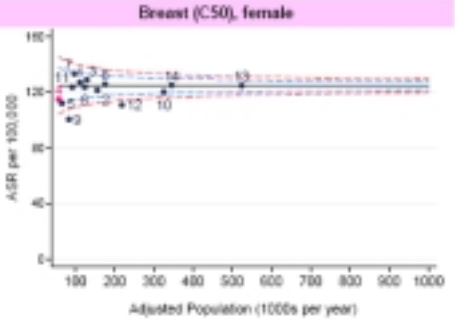
Lung (C33-C34), female



Prostate (C61), male



Breast (C50), female



NYCRIS - Northern and Yorkshire Cancer Registry and Information Service (August 2010)

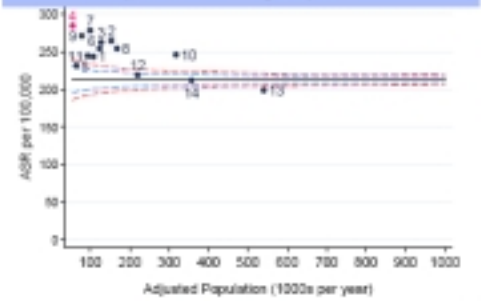
Hartlepool PCT

Mortality 2003-2007 by PCT (Funnel Plots)

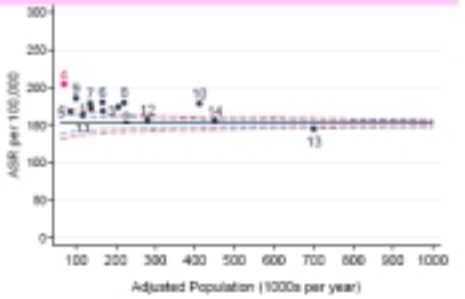
www.nycris.nhs.uk

PCT Factsheets

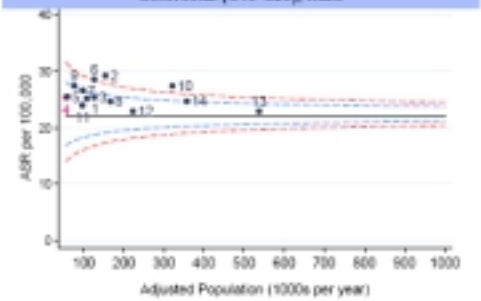
All cancers excluding non-melanoma skin cancer (C00-C97 excluding C44), male



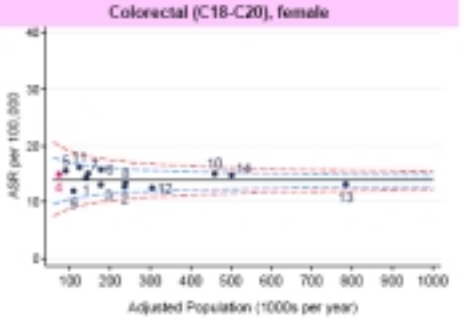
All cancers excluding non-melanoma skin cancer (C00-C97 excluding C44), female



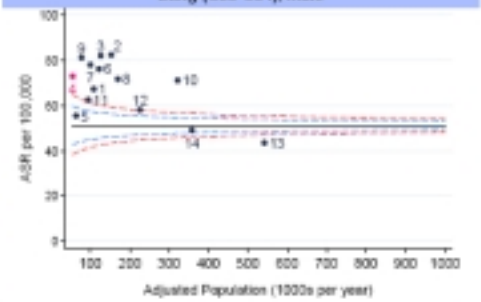
Colorectal (C18-C20), male



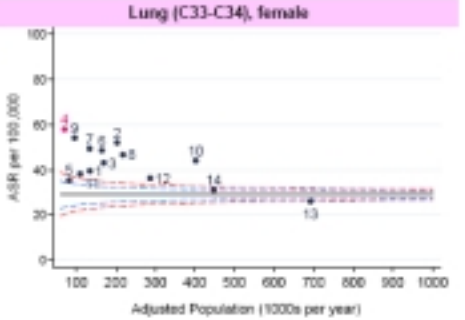
Colorectal (C18-C20), female



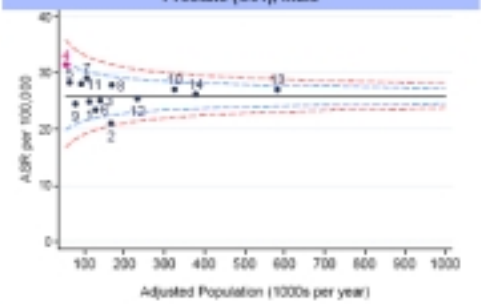
Lung (C33-C34), male



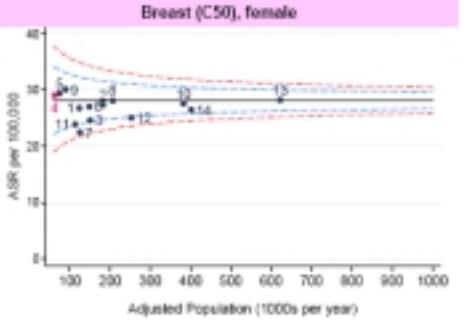
Lung (C33-C34), female



Prostate (C61), male



Breast (C50), female



NYCRIS - Northern and Yorkshire Cancer Registry and Information Service (August 2010)

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Health Profile 2011

Hartlepool

This profile gives a picture of health in this area. It is designed to help local government and health services understand their community's needs, so that they can work to improve people's health and reduce health inequalities.

Visit the Health Profiles website for:

- Profiles of all local authorities in England
- Interactive maps – see how health varies between areas
- More health indicator information
- Links to more community health profiles and tools

Health Profiles are produced by the English Public Health Observatories working in partnership.

www.healthprofiles.info

Population 91,000

Mid-2009 population estimate

Source: National Statistics website: www.statistics.gov.uk

DH Department of Health

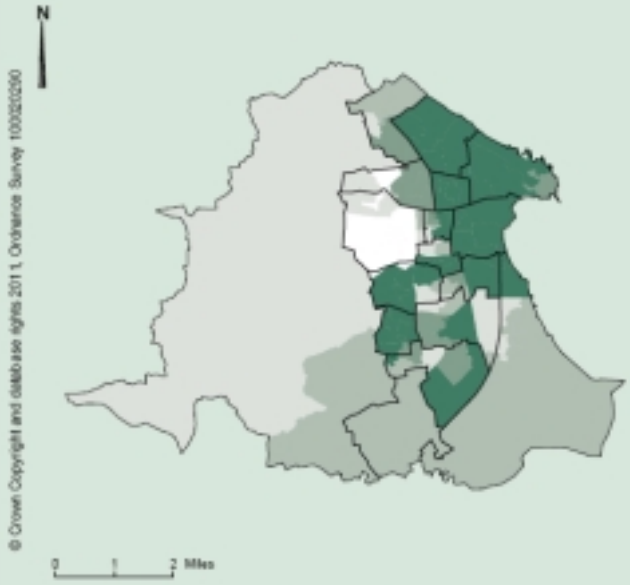
Hartlepool at a glance

- The health of people in Hartlepool is generally worse than the England average. Deprivation is higher than average and 6,180 children live in poverty. Life expectancy for both men and women is lower than the England average.
- Life expectancy is 11 years lower for men and 8 years lower for women in the most deprived areas of Hartlepool than in the least deprived areas (based on the Slope Index of Inequality published on 5th January 2011).
- Over the last 10 years, all cause mortality rates have fallen for men but have fluctuated for women. The early death rate from heart disease and stroke has fallen, the trend for cancer is less clear, but both remain worse than the England average.
- About 22.1% of Year 6 children are classified as obese. A lower percentage than average of pupils spend at least three hours each week on school sport. Levels of teenage pregnancy and GCSE attainment are worse than the England average.
- Estimated levels of adult 'healthy eating', smoking and obesity are worse than the England average. Rates of hip fractures, smoking related deaths and hospital stays for alcohol related harm are higher than average.
- Priorities in Hartlepool include smoking, alcohol abuse and improving uptake of cancer screening programmes. For more information see www.teespublichealth.nhs.uk

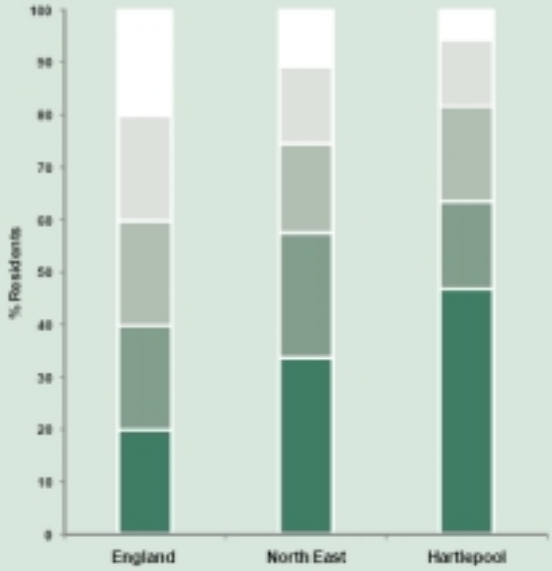
NHS

Deprivation: a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.



This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.

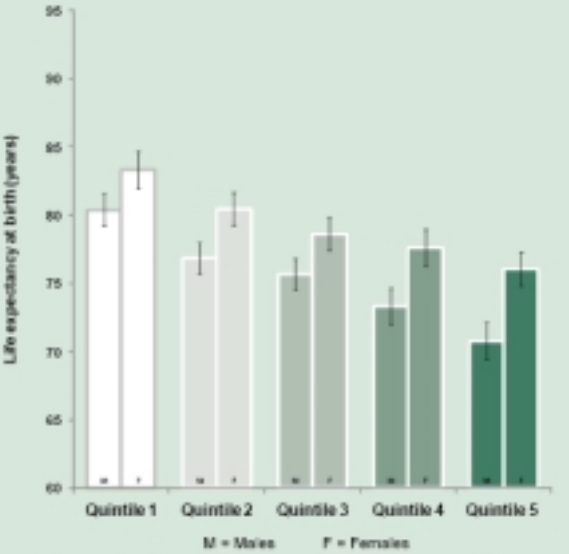


1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.

This chart shows the life expectancy at birth for males and females (2005-2009) for each of the quintiles in this area.



95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

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Health inequalities: changes over time

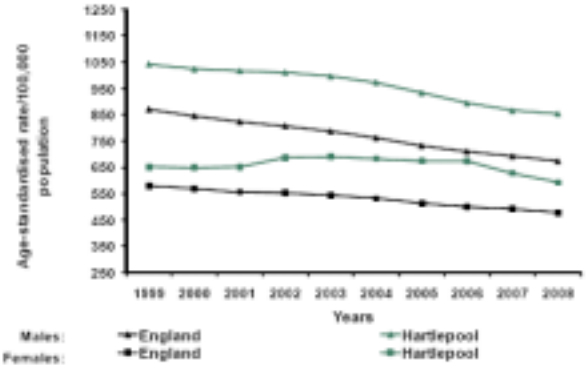
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

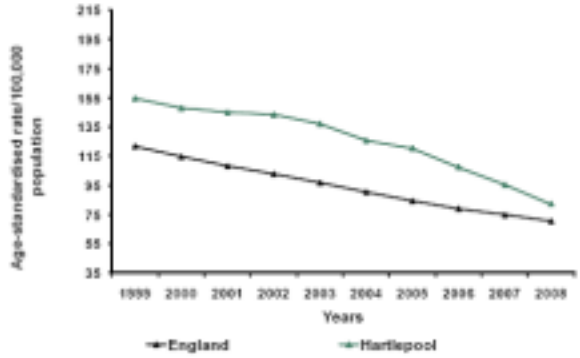
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

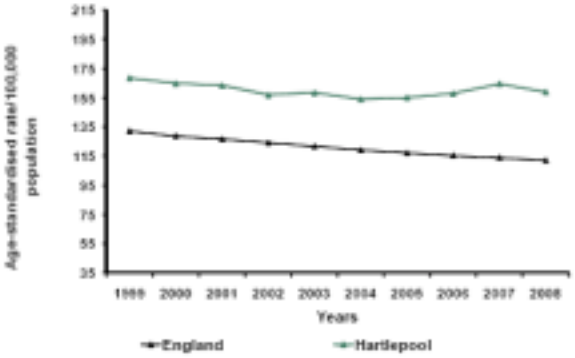
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

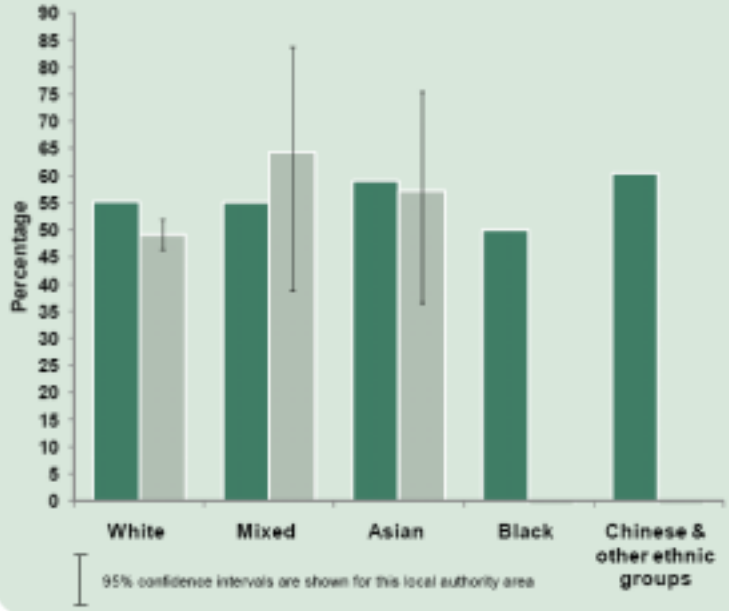


Trend 3:
Early death rates from cancer



Health inequalities: ethnicity

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2009/10 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.



Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	49.1	589
Mixed	64.3	9
Asian	57.1	12
Black		
Chinese/other		

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Hartlepool

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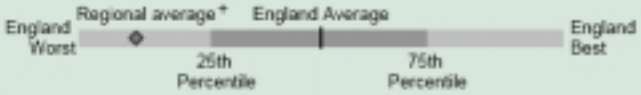
The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average



*In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	42477	46.7	19.9	89.2		0.0
	2 Proportion of children in poverty	6180	26.9	20.9	57.0		5.7
	3 Statutory homelessness	18	0.46	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	620	49.8	55.3	38.0		78.8
	5 Violent crime	1837	19.0	15.8	35.9		4.6
	6 Long term unemployment	665	11.5	6.2	19.8		1.0
Children's and young people's health	7 Smoking in pregnancy	312	26.9	14.0	31.4		4.6
	8 Breast feeding initiation	506	43.5	73.6	39.9		95.2
	9 Physically active children	6502	51.0	55.1	26.7		80.3
	10 Obese children (Year 6)	221	22.1	18.7	28.8		10.7
	11 Children's tooth decay (at age 12)	n/a	0.6	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	120	63.5	40.2	69.4		14.8
Adults' health and lifestyle	13 Adults smoking	n/a	24.5	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	30.8	23.6	39.4		11.5
	15 Healthy eating adults	n/a	19.3	29.7	19.3		47.9
	16 Physically active adults	n/a	8.9	11.5	5.8		19.5
	17 Obese adults	n/a	27.5	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	13	13.9	13.1	27.2		3.1
	19 Hospital stays for self-harm	296	344.9	169.3	497.5		49.3
	20 Hospital stays for alcohol related harm	2872	2572	1743	3114		849
	21 Drug misuse	1119	19.0	9.4	23.8		1.8
	22 People diagnosed with diabetes	3883	5.28	5.40	7.87		3.28
	23 New cases of tuberculosis	7	9	16	120		0
	24 Hip fracture in 65s and over	118	627.3	467.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	63	20.7	18.1	32.1		5.4
	26 Life expectancy - male	n/a	75.4	78.3	73.7		84.4
	27 Life expectancy - female	n/a	79.8	82.3	79.1		89.3
	28 Infant deaths	6	5.12	4.71	10.63		0.89
	29 Smoking related deaths	206	316.1	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	85	82.1	70.5	122.1		37.9
	31 Early deaths: cancer	164	159.1	112.1	159.1		76.1
	32 Road injuries and deaths	32	35.6	46.1	155.2		12.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

For links to health intelligence support in your area see www.healthprofiles.info More indicator information is available online in The Indicator Guide.

HEALTH SCRUTINY FORUM

6 October 2011

Report of: Scrutiny Support Officer

Subject: NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST'S GOVERNORS

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1. PURPOSE OF REPORT

1.1 To provide information to Members on the Governors of North Tees and Hartlepool NHS Foundation Trust.

2. BACKGROUND INFORMATION

2.1 Members will recall that at the meeting of this Forum on 8 September 2011 Members requested more details on the Governors of North Tees and Hartlepool NHS Foundation Trust (NTHFT).

2.2 To become a Governor of NTHFT or to vote for a Governor you need to be a member of NTHFT. Membership is free and can either be done online at www.nth.nhs.uk/joinustoday via email to membership@nth.nhs.uk or telephone on 01642 383765. To qualify for membership of NTHFT you:-

(i) Need to be at least 16 years of age; and

a. Live in the area covered by NTHFT service provision; or
b. Have been a patient at Hartlepool or North Tees Hospital within the last seven years; or
c. Been a carer of a patient at Hartlepool or North Tees Hospital within the last seven years; or
d. Be a member of staff at NTHFT with a permanent contract; or
e. Be a member of staff who has been employed by NTHFT for a minimum of 12 months.

2.3 In explaining the role of a Governor at NTHFT, the Trust has provided the following information which Members may find useful in answering questions raised at the meeting of 8 September 2011:-

(i) Annual Report and Accounts 2010-2011 (attached as **Appendix A**):
Pages 75-81 have been extracted from the 'Annual Report and Accounts 2010-2011' to highlight who the Governors are, including their terms of office and attendance records.

(ii) Information Pack for Public and Staff Governors October 2011 (attached as **Appendix B**):
Details; the role of the Governor (section 3.3 of **Appendix B**); code of conduct for Governors (section 5.1 and Appendix 1 of **Appendix B**); and the Committees / Groups that the Governor can be a member of (section 3.6.1 of **Appendix B**).

(iii) Anthem Magazine Issue 24 August / September 11 (attached as **Appendix C**):
This magazine now incorporates the 'Keeping iNTouch' publication and is distributed to all members of NTHFT and is a valuable link to the work that Governors do. Pages 12, 14, 22, 27, 30 and 31 have been extracted from the current issue as they highlight the work of Governors at NTHFT.

2.4 Members are asked to note that there have been a couple of Governor changes since the publication of the Annual Report and Accounts 2010-2011 and that the next set of Governor Elections are planned for October 2011.

3. RECOMMENDATION

3.1 It is recommended that the Members of the Health Scrutiny Forum note the content of this report and the information detailed in **Appendices A-C**.

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

BACKGROUND PAPERS

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

(i) Minutes of the Health Scrutiny Forum meeting held on 8 September 2011

(ii) NTHFT (2011), *Annual Report and Accounts 2010-2011*, Available from: http://www.nth.nhs.uk/assets/x/51332 (Accessed 19 September 2011)

(iii) NTHFT (2010), *Information Pack for Public and Staff Governors*, Available from: http://www.nth.nhs.uk/assets/x/51117 (Accessed 19 September 2011)

(iv) NTHFT (September 2011), *Anthem*, Issue 24, Available from: http://www.nth.nhs.uk/assets/x/51323 (Accessed 19 September 2011)

(v) NTHFT (2011), *NHS – join us today*, Available from: http://www.nth.nhs.uk/joinustoday (Accessed 20 September 2011)

APPENDIX A

Organisational Structure

The Council of Governors' membership includes elected public, staff and others appointed to represent a diverse number of stakeholder organisations. In June 2010 an additional patient and carer area was added by a Constitutional amendment, approved by the Council of Governors and the Board of Directors and endorsed by Monitor.

Council of Governors

Governors have a number of statutory duties that include the appointment and terms and conditions of the Chairman and Non-Executive Directors and ratification of the appointment of the Chief Executive and approval of the appointment of the Trust's External Auditors. They also receive the Annual Report, Annual Accounts and Auditor's report, and hold to account the Board of Directors for its management of the Trust. Throughout the year the Council of Governors have assisted the Trust's Strategic document, debated on key issues of interest, including quality and patient safety, infection prevention and control, the financial performance of the Trust, the forward plan and Quality Report.

The Trust values the contribution of its Governors and in particular the perspectives that they bring to the development of services.

The Trust has demonstrated strong working links with the Council of Governors and Board of Directors at its general meetings and working groups held throughout the year. Board members have participated in all Council of Governors seminars and attended meetings of the Council of Governors.

Public and Staff Governor Elections

Public and staff members are elected to the Council of Governors from the Trust's membership. Governors for public and staff constituencies are elected to office on varying terms of up to three years and may seek election for further terms of up to a maximum of three terms. Elections are held on an annual basis for Governors. The last round of elections were held in December 2010 and were conducted by Electoral Reform Services who were satisfied they were held in accordance with good electoral practice and constitutional requirements. The outcome of the Trust's last elections was announced in December 2010 and is detailed in the table below.

Elections to Council of Governors 2010/11

Date of Election	Constituency	Number of Votes Cast	Turnout %	Number of Eligible Voters
2 December 2010	Hartlepool	380	29.1	1,308
2 December 2010	Stockton	640	27.3	2,344
2 December 2010	Easington	294	24.7	21,189
2 December 2010	Sedgefield	135	27.7	488

Governor Meetings

The Council of Governors meetings are public meetings which are held at least quarterly throughout the year. There were a total of four general meetings in 2010/11. In addition to the formal meetings that are attended by the full Council of Governors five working groups met to focus on specific issues which were:

Strategy Committee – this committee reviewed and contributed to the development of the Trust's developing service strategy.

Membership Strategy Committee – this committee is responsible for the implementation of the membership strategy to increase membership over future years and to increase members' involvement. It reviewed membership information to determine whether it is fully representative of the communities served.

Advisory and Guardianship Committee – this committee received, reviewed and updated information on the patient treatment pathways, service performance, compliance, patient experience and involvement and the patient environment.

Travel and Transport Group – this group has worked towards its aim of drafting and implementing a Travel and Transport Strategy that underpins the plans for the new hospital development and also to deliver appropriate improvements to the current transport services.

Internet Working Group – this group has worked on the development of a dedicated Governor area within the Trust's internet site for Governors and members' communication.

In January 2011 Governors were invited to join the Quality Review Panels as independent members which is further explained within the Quality Report.

A register of Governors' interests that may conflict with their responsibilities at the Trust is maintained and available for inspection by members of the public. If anyone would like to inspect the register they can view it by contacting the Trust Secretary, North Tees and Hartlepool NHS Foundation Trust, University Hospital of North Tees, Hardwick, Stockton, TS19 8PE or email us at: membership@nth.nhs.uk

APPENDIX A

Thomas Sant and Chris Broadbent, Elected Public Governors for Hartlepool and Wendy Gill, Elected Public Governor for Sedgefield view the One Life Centre at Hartlepool

APPENDIX A

Council of Governors
Who's who

Public Governors	Constituency	Appointment	Year term of office ends	Actual attendances
Christopher Broadbent	Hartlepool	3 years from 2010	2013	1
Lisa Lister	Hartlepool	3 years from 2007	2010	3
Roger Morrow	Hartlepool	2 years from 2007 re-elected for 3 years 2009	2012	3
Maureen Rogers	Hartlepool	1 year from 2007 re-elected for 3 years 2008	2011	4
Thomas Sant	Hartlepool	3 years from 2010	2013	1
Keith Thomas	Hartlepool	2 years from 2007 re-elected for 3 years 2009	2012	3
Ron Watts	Hartlepool	3 years from 2008	2011	4
Janet Atkins	Stockton	3 years 2009	2012	3
Carol Ellis	Stockton	3 years from 2010	2013	1
Patricia Ferguson	Stockton	1 year from 2010	2011	1
Jonathan Fletcher	Stockton	3 years from 2007 re-elected for 3 years	2013	3
Carol Hannant[1]	Stockton	3 years from 2008	2011	3
Ken McCreesh	Stockton	2 years from 2007 re-elected for 2 years 2009	2011	3
Mary Morgan	Stockton	3 years from 2007 re-elected for 3 years 2010	2013	3
James Newton	Stockton	2 years from 2007 re-elected for 3 years 2009	2012	4
Richard Sidney	Stockton	3 years from 2008	2011	3
Stan Slater[2]	Stockton	2 years from 2008	2010	2
Pat Upton	Stockton	1 year 2007 re-elected for 3 years 2008	2011	4
Maurice Critchley	Stockton	3 years from 2009	2012	4
Kate Wilson	Stockton	3 years from 2009	2012	4
John Cairns	Easington	3 years from 2008	2011	2
Maureen Lenehan	Easington	1 year from 2007 re-elected for 2 years 2008	2010	3
Maureen Taylor-Gooby	Easington	3 years from 2009	2011	3
Mary King	Easington	3 years from 2010	2013	1
Sheila Sutherland	Sedgefield	3 years from 2007	2010	3
Wendy Gill	Sedgefield	3 years from 2010	2013	1
Staff Governors				
Hasan Bandi	Staff	2 years from 2007 re-elected for 3 years 2009	2012	4
Ian Fraser	Staff	1 year from 2007 re-elected for 3 years 2008	2011	3
Deborah Gardner	Staff	3 years from 2010	2013	1
Siva Kumar	Staff	1 year from 2007 re-elected for 3 years 2008	2011	3
Cath Linford	Staff	3 years from 2007 elected unopposed for 3 years 2010	2013	4
Stephen Pett	Staff	3 years from 2007	2010	1
John Rhodes	Staff	2 years from 2007 re-elected for 3 years 2009	2012	3

Possible attendances	Member of committee (see key)
1	-
3	SC, EAWG
4	CoCG, AGC
4	NC
1	-
4	EAWG, SC
4	EAWG, SC
4	MSC, AGC
1	-
1	-
4	EAWG
3	MSC, AGC
4	NC, MSC
4	AGC, MSC
4	AGC
4	AGC, SC
2	AGC
4	AGC, MSC, SC
4	MSC, SC, EAWG
4	AGC
4	TTG
3	-
4	SC
1	-
3	MSC
1	-
4	EAWG
4	InG, TTG
1	-
4	AGC
4	NC, MSC
3	TTG
4	SC

Appointed Members	Representing	Actual attendances	Possible attendances	Member of committee (see key)
Tim Blackman	University of Durham	3	4	SC
Jim Beall[3]	Stockton Borough Council	3	3	AGC, MSC
Alistair Burt	University of Newcastle upon Tyne	2	4	SC
Gerard Hall	Hartlepool Borough Council	1	4	EAWG
Eunice Huntington	Durham Council	3	4	NC
Tom Lennard	University of Newcastle upon Tyne	1	1	SC
Ann McCoy[4]	Stockton Borough Council	2	2	AGC, MSC
Alan Oliver	University of Teesside	1	4	EAWG
Graham Prest	NHS Stockton	3	4	-
Stephen Wallace	NHS Hartlepool	0	4	-

Key

NC – Nomination Committee
MSC – Membership Strategy Committee
TTG – Travel And Transport Group
InG – Internet Group
CG – Constitution Group
AGC – Advisory And Guardianship Committee
SC – Strategy Committee
EAWG – External Audit Working Group
CoCG – Code of Conduct Group

[1] Carol Hannant resigned 8 October 2010
[2] Stan Slater passed away July 2010
[3] Jim Beall appointed from 1 July 2010
[4] Ann McCoy appointment ended 30 June 2010

Nomination Committee

The Nomination Committee met throughout the year and made recommendations to the Council of Governors on the terms and conditions of appointment of the Chairman and Non-Executive Directors and the procedure for managing the Chairman and Non-Executive Director absences. The Committee also advised the Council of Governors on levels of remuneration for Non-Executive Directors, recommended two Non-Executive Directors to the vacant positions, and received reports on the outcome of appraisals for the Chairman and Non-Executive Directors. All decisions for appointments and remuneration were decided at general meetings of the Council of Governors.

The Nomination Committee engaged the services of the Appointments Commission to assist with the Non-Executive Director recruitment campaign during 2010. The position adopted open advertising methods with interviews held in July 2010.

The appointments of the two Non-Executive Directors were confirmed by the Council of Governors at its general meeting held on 20 July 2010 to serve for a period of a three-year term of office.

The Committee established an annual performance evaluation process for the Chairman which has been led by the Senior Independent Director on an annual basis since 2009. As part of the process all members of the Council of Governors and Board of Directors completed questionnaires during the year which reviewed the Chairman's performance. The results of the questionnaires were independently assessed with the outcome reported by the Senior Independent Director to the Council of Governors without the Chairman present.

There were no increases to the Chairman's or Non-Executive Directors' remuneration or allowances in 2010/11.

Nomination Committee

Name	Actual	Possible
Paul Garvin	3	3
Eunice Huntington	3	3
Cath Linford	1	3
Kenneth McCreesh	3	3
Maureen Rogers	3	3
Alan Foster[1]	1	1
Clare Curran[1]	2	2
Lynn Hughes[1]	2	2

[1]Attends to advise the Committee upon invitation.

Membership of our Trust

The Trust is accountable to its members whilst members support the activity of the Trust and assist with its decision making to ensure the Trust remains true to its National Health Service values and future direction as a NHS Foundation Trust. The Trust's membership is seen as a valuable asset and provides an additional method for the Trust to communicate with public and staff through the following categories:

Public Membership – individuals that are 16 years or over that reside in the Trust's constituent areas of Hartlepool, Stockton on Tees, Easington and Sedgefield.

Patient/Carer membership – individuals that reside outside of the Trust's constituent areas that have been a patient or a carer in the last seven years.

Staff Membership – employees of the Trust with an employment contract of one year or more, as well as staff who are based at the Trust but work for a partner organisation or as a contractor as well as registered volunteers who are not eligible for any other categories of public membership. Members that meet these requirements are automatic members within the staff constituency unless they choose to inform the Trust that they do not wish to be a member.

As at 1 April 2010 public membership totalled 5,207. With the work of the membership strategy the Trust exceeded its 2010/11 membership target by increasing its public membership by over 5%. This has resulted in a total membership of 11,520 members which consist of 5,467 public, 62 patient/carer and 5,991 staff members. Public membership equates to 1.5% of the local eligible population and staff membership equates to 99.8% of the total staff body.

The Trust aims to have a membership that is representative of the diverse community it serves and will continue to work towards gaining greater understanding of the profile of members in relation to service users and the population the Trust serves by increasing its 16 to 24-year-old members with the delivery of an engagement programme to meet their needs.

Members receive regular mailings that update on developments and events in the Trust and are invited to attend events as well as the Trust's Annual General Meeting. Member Events in particular have proved popular with topics including the New Hospital Development, Cardiac Services and Stroke Services.

Members are able to communicate with any Elected Governor of the Council of Governors or Directors through the Membership Office or by the Trust internet site. Information is also available on the Trust website for individuals who would like to become a member. If you would like to find out more about membership contact the Foundation Trust Membership Office.

Alan Foster, Chief Executive pictured with volunteers and retired members at the Thank You Event held at the University Hospital of Hartlepool

North Tees and Hartlepool NHS
NHS Foundation Trust

Information Pack
Public, Patient / Carer and Staff Governors
October 2011

Information Pack for Public and Staff Governors of North Tees and Hartlepool NHS Foundation Trust

The following information is intended to brief potential Governors about the role of Governors within North Tees and Hartlepool NHS Foundation Trust. Anyone that wishes to apply to become a Governor should read this information carefully. We are happy to answer any queries on the enclosed information and can be contacted by telephoning ***01642 383765*** or by email: membership@nth.nhs.uk.

The information included in this pack covers the following:

- Membership
- Council of Governors
- Roles and Responsibilities of Governors
- Committees and Working Groups
- Future Governor Involvement Groups for 2011/2012
- The Trust's Aims and Objectives
- Eligibility to be a Governor
- Code of Conduct
- Criminal Records Bureau Check

1.0 Membership

Membership is in either a Public or Staff constituency.

1.1 Public

- **Public Membership** of North Tees and Hartlepool NHS Foundation Trust is open to people living in the constituency areas and aged 16 or over. Public constituencies are divided into four geographical areas, Stockton, Hartlepool, Easington (principally postcodes TS27-4, SR8 – 1, 2, 3, 4, and 5, DH6-2, TS28-5) and Sedgefield (principally postcodes TS29-6, TS21-2, 3 and 4, DL17-9). Members in each geographical area have the ability to elect Governors for their constituency area.

- **Patient/Carer** was introduced to allow members of the public outside the Trust's constituent areas (Hartlepool, Stockton, Easington and Sedgefield) to join as a member if they have ever been a patient or carer at one of the Trust's hospitals within the last 7 years. Members in this constituency have the ability to elect a Governor to represent Patients or Carers.

1.2 Staff

- **Staff Membership** is open to those who are directly employed by North Tees and Hartlepool NHS Foundation Trust, or hold an honorary contract, or are seconded to or carry out employment on the Trust premises but may be directly employed by another organisation as well as volunteers. Staff members are eligible to elect Staff Governors to represent their constituency.

2.0 Governors' Communication with Members

The Trust is committed to supporting communication between members and Governors which is carried out through the Foundation Trust Membership Office. Any member can communicate with any Governor by emailing membership@nth.nhs.uk or via individual and secure Governor nhs.net email accounts contactable via the www.nth.nhs.uk website, monitored by the Foundation Trust Membership Office (members are not given Governors'

personal contact details and written replies and other secretarial support and information if required is given as indicated above via the Foundation Trust Membership Office.)

Arrangements will be made for Governors to meet with members throughout the year giving members the opportunity to raise issues directly with Governors within their constituency area. These meetings will take place at various locations within the Trust's catchment area and will include Member Events (usually delivered by hospital staff on topics that members have requested with an opportunity for members to ask questions or express their points of view).

There is a dedicated membership telephone number and a dedicated email address which support communication between members, the Foundation Trust and Governors. The Chairman, in consultation with the Governors, communicates with the membership through the quarterly membership magazine and various letters from the Chairman throughout the year.

3.0 Council of Governors

A majority, (22 out of 37), of the Governors are elected by Public membership constituencies of North Tees and Hartlepool NHS Foundation Trust. The remaining Governors are elected by Staff membership, (six), and nominated by Partner Organisations (nine) which include Local Authorities, Primary Care Trusts and Universities. Elections to the Council of Governors takes place under a system published by the NHS Foundation Trust and, consistent with the Election Rules of the NHS Foundation Trust Constitution. The Constitution can be accessed via the Foundation Trust's website at www.nth.nhs.uk or Monitor's website: www.monitor-nhsft.gov.uk.

The Foundation Trust holds an Annual General meeting where members are encouraged to attend. All public meetings are set for the year ahead and this information is available through the Trust's website and the newsletter publications to members.

3.1 Composition of the Council of Governors

Chairman of the NHS Foundation Trust	
Public (elected) – 22 Governors	**Staff (elected) 6 Governors**
11 - Stockton on Tees 6 - Hartlepool 3 - Easington 1 - Sedgefield (part) 1 - Patient/Carer	
Stakeholders (nominated) Governors	
3 - PCTs 3 - Local Authorities 3 - Partnerships	

3.2 Governance Arrangements

The Governance arrangements for North Tees and Hartlepool NHS Foundation Trust were developed after a formal public consultation process which supported the Trust's application for NHS Foundation Trust status in 2007, together with the vision for the development of services and the Human Resources strategy. The feedback from the consultation shaped the governance arrangements for the Foundation Trust. The Constitution was approved by Monitor and the Trust was granted approval as a Foundation Trust with effect from 1 December 2007 and revised and approved by Monitor in June 2010. The Constitution will be reviewed on a regular basis to ensure it is in line with regulatory requirements and best practice.

3.3 Roles and Responsibilities of the Council of Governors

The Council of Governors of North Tees and Hartlepool NHS Foundation NHS Trust holds statutory duties and responsibilities. The Trust acknowledges and respects the unique contribution that individual Governors and the Board as a whole contribute to the future development of our Foundation Trust.

The Council of Governors is a formal link between the Trust and its members and is responsible for representing the interests of the local community in general rather than specific groups or interests, and for sharing information about important decisions with other members or, in the case of appointed members, the organisation that appointed them.

The duties of Governors are laid down in the Trust's Constitution and in the National Health Services Act (2006).

These are to:

- Represent the interests of members of the Trust and stakeholder organisations in the governance of the Trust;
- Ensure that the Trust operates in accordance with its Terms of Authorisation;
- Regularly feed back information regarding the Trust, its vision and performance to the constituency they represent;
- Be consulted and advised on future plans and priorities;
- Appoint or remove the Trust Chairman at a general meeting;
- Appoint or remove the Non-executive Directors at a general meeting;
- Agree the remuneration and allowances of the Non-executive Directors;
- Approve an appointment (by the Non-executive Directors) of the Chief Executive;
- Appoint or remove the Trust's Auditor at a general meeting;
- Receive at a public meeting the Annual Report, Annual Accounts and Auditor's Report;
- Hold the Board of Directors to Account.

Governors must act in the best interests of the NHS Foundation Trust and abide by its values and Code of Conduct. Further information on the role of a NHS Foundation Trust Governor can be found on Monitor's website: www.monitor-nhsft.gov.uk.

3.4 Methods for Governors to Provide Scrutiny and Assistance

The standard methods for Governors to provide scrutiny and assistance include: receiving the Annual Report and Accounts; receiving the Quality Report and Accounts; receiving in-year information updates from the Board of Directors; receiving performance appraisal information for the Chair and Non-executive Directors; and inviting the Chief Executive or other Executive and Non-executive Directors to attend Council of Governor meetings as appropriate.

3.5 Governor Involvement

Governors must be willing to attend the full public meetings of the Council of Governors. In addition to these meetings much activity takes place in Governor Working Groups which are described on page 5.

The main function of the Council of Governors is to advise the Board of Directors to ensure the Foundation Trust acts in a way which is consistent with its objectives and that it operates

under the terms of its licence. They do this as ***guardians*** of the Foundation Trust and in an ***advisory*** capacity by providing the stakeholder, public, patient and/or carer and staff representation to the ***strategic*** direction of the Foundation Trust.

The Foundation Trust has an Annual Plan and a Quality Report which is submitted each year (at the end of May) to Monitor, the Independent Regulator of NHS Foundation Trusts. A copy can be found on the Trust's website www.nth.nhs.uk or Monitor's website: www.monitor-nhsft.gov.uk. These documents are prepared in consultation with the full Council of Governors.

The overall responsibility for running an NHS Foundation Trust lies with the Board of Directors. The Council of Governors is the collective body through which the Directors explain and justify their actions.

3.6 The Work of the Council of Governors

The role of Governors at North Tees and Hartlepool NHS Foundation Trust has begun to develop since the Trust was authorised as a Foundation Trust in December 2007. This is reflected in the expanded Governor work programme which includes areas of activity where Governors can have an influence both within and outside of the Foundation Trust. All Governors meet regularly with the Chairman and are invited to visit the Trust's premises. It is recognised that Governors have varied time commitments. Although the working groups involve varied numbers of Governors it should be recognised that those who sit on them, ***act as representatives for the full Council of Governors***. They regularly report back to the full Council at the scheduled Council of Governor meetings on activities undertaken and may bring recommendations for further actions back to the full Council for further discussion and agreement. It needs to be noted that any actions/recommendations brought to the full Council have been fully considered and discussed before their presentation. Further it needs to be noted that any actions/recommendations agreed at the Council of Governors meetings are not solely the responsibility of the Working Group members but apply to the full Council of Governors as a whole.

3.6.1 Committees and Working Groups

- **Nomination Committee**
  It is a statutory requirement in order that Governors have the mechanism in place for the remuneration and allowances and other terms and conditions of office of the Chair and Non-executive Directors. In the past, this group has been involved with the recruitment campaign to appoint the Chairman and Non-executive Directors. These appointments were approved by the full Council of Governors following each interview.

- **Membership Strategy Sub-committee**
  This working group is one of the key Governor groups. It has a remit to:

  - establish and develop membership communications;
  - develop membership recruitment initiatives and evaluate the membership profile for future targeted recruitment initiatives;
  - establish and develop membership activities.

- **Advisory and Guardianship Committee**
  Governors will be encouraged to act as guardians to ensure the Trust operates in a way that fits with the Trust's vision and values to ensure it complies with its authorisation whilst acting in an ambassadorial role for the welfare of the organisation. The committee will review and receive information on patient treatment pathways, service performance, compliance, patient experience and involvement and patient environment.

- **Strategy Committee**
  This Committee aims to advise on the long term direction of the Trust and provide a steer on how the Trust carries out its business to assist the Board of Directors to effectively

determine policies. This group will receive and review information on the strategic development, annual plan, and business development.

- **Travel and Transport Project Team**
  This group aims to draft and implement a travel and transport strategy to deliver appropriate cost improvements.

- **Code of Conduct Group**
  A working group consisting of Governor representatives was established to review and revise the Code of Conduct for Governors to ensure it is in line with best practice.

- **Induction Programme**
  All Governors are required to undergo an induction which will incorporate a number of elements.

3.6.2 Staff Governors

Staff Governors can communicate with their members through the membership magazine and via a dedicated area on the Trust website for staff to communicate with their Governors. Staff Governors are encouraged to attend meetings to hear concerns, issues and queries, report back on Council of Governor meetings, report back on events and activities and, raise their profile within the organisation. *Please note that the role of Staff Governor is not that of line management nor is it one of Union representation*.

3.6.4 Annual General Meeting

The last Trust Annual General meeting was held on 15 September 2011 and was attended by Governors and members.

4.0 The Trust

North Tees and Hartlepool NHS Foundation Trust is a vibrant and successful provider of hospital and community based health care services to the people of Stockton and Hartlepool in Teesside and parts of Easington and Sedgefield in Durham.

The Corporate Strategy provides the overarching direction for the Trust to 2015 and provides the framework by which the Trust plans, delivers, monitors and manages everything that it does.

The Corporate Strategy can be summarised in the following diagram:

Taking each of the areas in turn:

4.1 Our Patients

Our patients are at the pinnacle of our triangle. It is for our patients that we are here.

4.2 Our Vision

To be the best healthcare provider by delivering excellent services for our patients.

4.3 Our Mission

North Tees and Hartlepool NHS Foundation Trust will become the healthcare provider of choice by putting patients first, delivering efficient, safe and reliable services, enabling excellence, encouraging innovation, embracing learning, knowledge and change.

We will achieve this by operating a LEAN performance focussed organisation that thrives on change and provides:

- Good patient care through safe, modern high quality health services
- Efficient services by recognising that waste in one area compromises patient care in another
- A good place to work by being a good employer, working together and valuing people
- Education and training to enable staff to deliver individual, professional, team and organisational objectives

4.4 Our Values

Health care is a people business and therefore we place great emphasis on all the people associated with our business, namely, patients, public and our staff. All are key to what we do. This is recognised in our People First Values which underpin our service delivery. We expect our People First Values to drive our behaviour when we are delivering care to our patients and their families as well as in our dealings with colleagues and people in our own and other organisations. Our People First Values expect that we will:

- Be responsive to the needs of our patients as individuals
- Be responsive to the needs of our stakeholders
- Treat all people with compassion, care, courtesy and respect
- Respect each person's right to privacy, dignity and individuality
- Take time to be helpful
- Respond quickly and effectively
- Always give clear, concise explanations
- Practise good listening skills
- Develop and maintain an appropriate environment
- Look the part
- Deal effectively with difficult situations
- Perform as a team

Fundamentally, 'Putting Patients First' is what we stand for and believe in.

4.5 Our Direction

We have identified six key strategic themes for the organisation as follows:

- Putting Patients First
- Momentum: Pathways to Healthcare
- Community Integration
- Manage our Relationships

- Service Development
- Maintain Compliance and Performance

These have been translated into strategic aims as follows:

a) Putting Patients First

To create a patient centred organisational culture by engaging and enabling all staff to add value to the patient experience which is demonstrated through patient safety, service quality and LEAN delivery.

b) Momentum: Pathways to Healthcare

To develop and implement a new healthcare system for the people of: Easington, Hartlepool, Sedgefield and Stockton.

c) Community Integration

To develop and expand the portfolio of services to provide healthcare services to our communities as close to home as possible.

d) Service Development

To improve and grow our healthcare services to better meet the needs of our patients, commissioners and the Trust.

e) Manage our Relationships

To ensure our services, and the way we provide them, meet the needs of our patients, commissioners and other partners by proactively engaging with all appropriate stakeholders, including our staff, through communications, engagement and partnership working.

f) Maintain Compliance and Performance

To maintain our performance and compliance with required standards and continually strive for excellence by good governance and operational effectiveness in all parts of the Trust's business.

Strategic objectives underpin all of the strategic aims which identify outcomes to be delivered for the aims to be achieved. These in turn are underpinned by specific strategies and delivery plans.

4.6 Our Foundations

Our vision, mission, values and direction are built upon the firm foundations and track record of:

- Excellent patient care
- Training and education
- Provision of efficient services
- Clinical governance
- Being a good employer
- Sound finances

These are encapsulated in a range of plans and strategies which support the delivery of the Corporate Strategy.

5.0 Eligibility to be a Governor

If you are a member of public and live in the Trust's catchment area as described in 1.0 and are aged 16 or over or if you have been a patient or carer of the Trust within the last 7 years and are 16 or over and live outside of the Trust's constituent areas but reside in England.

Staff Governors are elected by staff members of the Trust, individuals that are employed by the Trust and volunteers. Those who hold an honorary contract, or are seconded to or carry out employment on the Trust premises but may be directly employed by another organisation as well as may stand for election in the staff constituency.

Public Governors are elected by Public Members of the Trust and must live in the geographical area that they represent.

Patient/Carer Governors are elected from the Patient/Carer constituency.

5.1 Code of Conduct for Governors of North Tees and Hartlepool NHS Foundation Trust

All Governors are required to sign up and abide to the Code of Conduct (attached at Appendix 1) prior to being accepted as a Governor. Specific issues relating to confidentiality will be adhered to as defined in the Code. Advice is available from the Foundation Trust Membership Office if Governors are unsure of the confidential boundaries within a particular situation or issue raised.

You may not become a Governor if:

- You are an un-discharged bankrupt or have had your estate sequestrated;
- You have made a composition or arrangement with; or granted a Trust Deed for, your creditors and have not been discharged from it;
- You have been convicted of any offence within the last five years (whether suspended or not) for a period of at least three months;
- You have been dismissed within the last two years from paid employment with a health service body (other than by redundancy);
- You have had a tenure of office as the Chairman or a Member or a Director of an NHS body terminated on the grounds that the appointment is not in the interest of the health service or for not attending meetings or for not revealing a relevant pecuniary interest;
- You are an Executive or Non-executive Director of the Trust, or a Governor, Non-executive Director, Chairman, Chief Executive officer or employee of another NHS organisation;
- The Council of Governors' reasonably considers you unfit to discharge the functions of a Governor;
- You have been disqualified from membership of your profession by the Professional or Regulatory body;
- You are an elected member of a local authority that is eligible to appoint a Governor;
- You have been expelled from another NHS Foundation Trust for any reason;
- Monitor has removed or suspended you as a Member or disqualified you from holding office in this or any other NHS Foundation Trust;
- You are not considered suitable by the Chief Executive, on the basis of disclosure obtained through an application to the Criminal Records Bureau;
- You are the subject of a sex offender order;
- You are a vexatious or persistent litigant or complainant;
- You are a Member of Parliament;
- You are incapable by reason of mental disorder, illness or injury of managing and administering your property and affairs; or

- You are the spouse/partner or otherwise related to any member of the Board of Directors.

Resignation from office:

A Governor may resign from office at any time during the term of office by giving notice in writing to the Trust Board Secretary.

If a Governor fails to attend 3 consecutive meetings of the Council of the Governors his or her tenure of office is to be immediately terminated unless the Chairman and other Governors are satisfied that:

- the absence was due to a reasonable cause; and
- he or she will be able to start attending meetings of the Trust again within such a period as they consider reasonable.

5.2 Criminal Records Bureau Check

Upon being elected or appointed as a Governor you will be required to consent to a Criminal Records Bureau (CRB) check. All organisations that have a responsibility for young and vulnerable people are required by law to carry out CRB checks. The CRB check is designed to confirm whether you have a criminal record.

A member will be disqualified if on the basis of checks of disclosures obtained through a CRB check, he or she is not considered suitable by the Foundation Trust.

Further information on CRB checks can be found at: www.disclosure.gov.uk

North Tees and Hartlepool NHS
NHS Foundation Trust

Code of Conduct
for
Council of Governors

1. Introduction

The purpose of this Code is to make clear the requirements of the office of all individuals that occupy a position of Governor at North Tees and Hartlepool NHS Foundation Trust's Council of Governors. As an elected constituent or appointed representative it is important that Governors are in no doubt of the standards of conduct and personal behaviour expected of anyone that holds public office. Whilst it is fully anticipated that these standards will be complied with the Trust considers an explicit Code of Conduct to be an essential guide for all Governors, particularly those who are newly elected or appointed to the role.

It is essential that Governors recognise the Trust is an apolitical public benefit organisation that seeks to promote social inclusion. Therefore in the development and delivery of services to patients and the public, the Trust will not seek to discriminate against any part of the communities it serves, on any grounds. The promotion of any personal or political view that is at odds with this principle will be grounds for dismissal from the Council of Governors. Given the confidential and often sensitive nature of the issues considered by the Council, Governors both individually and collectively must always act with total discretion and integrity, and in the interests of the Trust and its patients in the execution of their role.

Elected Governors who are members or affiliates of any trade union body, political party, or other organisation that seeks to influence public opinion, must recognise that they will not be representing the views of such organisations: they are elected to represent views of their constituency members.

This Code is intended to support and complement the Trust's Constitution and will be included in candidate packs for prospective Governors. Prior to the selection process, all members seeking election to the Council of Governors will be required to personally sign the Code as confirmation that they fully comply with and be bound by its provisions.

2. Principles of the Code

The principles of the code include public service values that are integral to the success of the NHS Foundation Trust which can be grouped into four main areas:

1. **Accountability** – everything that is done by North Tees and Hartlepool NHS Foundation Trust employees must be able to stand the test of parliamentary and regulatory scrutiny, public judgements and propriety and professional codes of conduct.

2. **Probity** – honesty should be standard when dealing with the assets of North Tees and Hartlepool NHS Foundation Trust. Integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and supplies and in the use of information acquired in the course of duties.

3. **Openness** – there should be adequate transparency within North Tees and Hartlepool NHS Foundation Trust's activities to promote confidence between the Trust and its employees, patients, public and partner organisations.

4. **Fairness** – the basic principle of fairness should be at the heart of all decisions and actions that are undertaken.

The principles that underpin the Code of Conduct are drawn from the 'seven principles of public life' as defined by The Nolan Committee report (1996). The seven principles are:

1. **Selflessness** – holders of public office should take decisions solely in terms of public interest. They should not do so to gain financial or other material benefits for themselves, their family or their friends.

2. **Integrity** – holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

3. **Objectivity** – in carrying out public business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

4. **Accountability** – holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

5. **Openness** – holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

6. **Honesty** - holders of public office have a duty to declare any private interest relating to their public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

7. **Leadership** - holders of public office should promote and support these principles by leadership and example.

3. Qualifications for Office of Governor

The qualifications for the office of Governor are detailed in the Trust's Constitution. All Governors are required to continue to comply with these qualifications throughout the period of their tenure.

The Trust Secretary must be informed of any changes in circumstances that may preclude a Governor from continuing in office.

4. Termination and Removal from Office

The grounds on which a person holding the office of Governor shall cease to do so are set out in the Constitution at paragraph 12 and Annex 5 and are summarised here for ease of reference:

4.1 They resign by notice in writing to the Trust Secretary;

4.2 It otherwise comes to the notice of the Trust Secretary at the time that the member of the Council of Governors takes office or later that the member is disqualified in accordance with paragraph 12 of the Constitution;

4.3 They fail to attend three consecutive meetings in any financial year unless the members of the Council of Governors are satisfied that:

4.3.1 The absences were due to reasonable causes; and

4.3.2 They will be able to start attending meetings of the Council of Governors again within such period as the Council considers reasonable.

4.4 In the case of an elected member of the Council, they cease to be a member of the Trust;

4.5 In the case of an appointed member of the Council the appointing organisation terminates the appointment;

4.6 They have failed to undertake training that the Council of Governors require all members to undertake, unless the Council is satisfied that:

4.6.1 The failure to undertake training was due to a reasonable cause; and

4.6.2 They will be able to undertake the required training within such a period as the Council considers reasonable.

4.7 They have failed to sign or deliver to the Trust Secretary a statement in the form required by the Council of Governors confirming acceptance of this Code of Conduct;

4.8 They are removed from the Council of Governors by a resolution approved by the majority of the remaining members of the Council present and voting at a General Meeting of the Council on the grounds that:

4.8.1 They have committed a serious breach of this Code; or

4.8.2 They have acted in a matter detrimental to the interests of the Trust; or

4.8.3 They have failed to discharge their responsibilities as a member of the Council Governors.

5. Roles and Responsibilities

Roles and responsibilities of the Council of Governors, which are to be carried out in accordance with the terms of Authorisation, are detailed in the Trust's Constitution. Prior to seeking election or appointment to office, Governors must agree to support the fulfilment of these roles and responsibilities. Whilst doing so they must:

5.1 At all times, act in the best interest of the Trust;

5.2 Actively support the Trust's vision and aims in developing as a successful Foundation Trust;

5.3 Abide by any appropriate legislation, the Trust's Constitution, Trust's Standing Orders, Standing Financial Instructions and any such policies and procedures that are deemed relevant to Governors;

5.4 Contribute to the working of the Council of Governors in order that it fulfils its functions, as detailed in the Trust's Constitution;

5.5 Recognise that their role is a collective one, whereby they exercise collective decision-making at Council of Governor meetings and Sub-committees, the outcome of which are formally recorded in the minutes;

5.6 Ensure that no one is discriminated against because of their race, religion, beliefs, colour, gender, marital status, disability, sexual orientation, age, social and economic status or nation origin or any other reason;

5.7 Recognise that, outside of the Council meetings, a governor has no more rights or privileges than any other member of the Trust;

5.8 Recognise that the Council of Governors does not exercise a managerial role nor does it have any operational involvement in the day to day management of the Trust;

5.9 Support and assist the Trust's Chief Executive in their responsibility to answer to Monitor, Commissioners and the general public in terms of:

- Fully and faithfully declaring and explaining the use of the resources
- The performance of the Trust, in enacting national policy and delivering national targets.

6. Visits to Trust Premises

Governors will, as part of their role, visit Trust premises. However, governors will recognise that as the Trust buildings are very busy facilities it is important that visits are planned to coincide with operational requirements and may require to be conducted in groups to maximise staff availability.

When Governors wish to visit the premises of the Trust in a formal capacity as opposed to individuals in a personal capacity, they should liaise with the Trust Secretary to make the necessary arrangements.

7. Accountability

Governors are accountable to the membership and should demonstrate this. They should attend events and provide opportunities to interface with members or partner organisations they represent in order to best understand their views.

8. Confidentiality

All Governors must at all times recognise and respect the confidentiality of the information they are privy to by way of their office.

9. Personal Conduct and Behaviour

Whilst performing their duties Governors are expected to abide by the highest standards of personal conduct and behaviour. In particular, as holders of public office, Governors will:

9.1 Conduct themselves in a manner that reflects their role as ambassadors of the Trust, and which supports its vision and objectives;

9.2 Value and respect their fellow Governors, the Trust's Board of Directors and all members of staff with whom they have contact;

9.3 Value and respect the views of their constituent members and accurately represent these views at meetings of the Council of Governors;

9.4 Adhere to good practice with regard to the conduct of meetings, respecting the views of their fellow Governors, ensuring that judgements relating to colleagues are consistent, fair, unbiased and are properly founded;

9.5 Be mindful of behaviour that could be deemed to be unfair, discriminatory or against the best interest of the Trust and its membership;

9.6 Recognise that the Council of Governors and management have a common purpose in ensuring the continued success of the Trust and therefore demonstrate their commitment to working and contributing effectively as a team member.

10. Conflicts of Interest

Governors must in the course of their duties be honest and act with the utmost integrity, probity and objectivity. The office of Governor must not be used to seek any form of personal advantage or preferential treatment.

Governors have a duty to openly declare any potential conflict of interest that may arise and must not vote on any such matters. This includes any involvement a Governor may have in any organisation with which the Trust may be considering entering into a contract. Where there is any doubt in this respect, Governors must seek advice and guidance from the Chairman or the Trust Secretary.

Governors must be committed to ensuring that any conflicts of interest whether potential or actual are properly addressed and are seen to be actioned in the best interests of the Trust and its members.

A Register of Interests is maintained by the Trust Secretary in which Governors must enter any pecuniary and non-pecuniary interests that may give rise to a conflict of interests. Failure to disclose such interests may result in dismissal from the Council of Governors. The Register of Interests is a public document, the contents of which will be publicly accessible to anyone who wishes to examine it.

11. Breach of Code of Conduct

Non-compliance of this Code of Conduct may result in action being taken as follows:

11.1 Where a clear case of misconduct occurs, the Chair of the Council of Governors is authorised to take such action as may be immediately required, including the exclusion of the Governor from a meeting.

11.2 Where misconduct is alleged, it will be open to the Council of Governors to determine by simple majority decision, to lay a formal charge of misconduct, whereupon it will be the responsibility of the Council to take the following actions:

11.2.1 Notify the Governor in writing of the charges, detailing the nature of the alleged misconduct and inviting and considering their response within a prescribed timescale;

11.2.2 Inviting the Governor to address the Council of Governors in person if the matter cannot be resolved in a satisfactory manner through correspondence;

11.2.3 Deciding by simply majority of those present and voting, whether to uphold the charge of conduct detrimental to the Trust;

11.2.4 Impose such sanctions as shall be deemed appropriate. Sanctions will range from, but not be limited to, the issuing of a written warning as to the Governor's future conduct and consequences, non payment of expenses and the removal of the Governor from office.

In order to aid participation of all parties, it is imperative that all Governors observe the points of view of others and conduct likely to give offence will not be permitted. The Chairman will reserve the right to ask any member of the Council of Governors who, in their opinion fails to observe the Code, to leave the meeting.

This Code of Conduct does not limit or invalidate the right of the Governors or the Trust to act under the Constitution.

12. Personal Declaration

The following declaration must be signed as a requirement of an individual's election or appointment to the Council of Governors. Failure to do so will preclude a prospective Governor from taking office.

Declaration:

I …… (full name) have read, understood, and agree to abide by this Code of Conduct for the Council of Governors of North Tees and Hartlepool NHS Foundation Trust.

Signature: ……

Date: ……

APPENDIX C

Trust passes Care Quality Commission inspection with flying colours

The Care Quality Commission (CQC), the independent regulator of health and adult social care today published the third batch of reports from an inspection programme examining if elderly people receive essential standards of care in 100 NHS hospitals throughout England. The programme focuses on whether people are treated with dignity and respect, and if they get food and drink that meets their needs.

The University Hospital of Hartlepool, which is run by North Tees and Hartlepool NHS Foundation Trust, was one of only four out of the 15 hospitals included in this batch that has been found to be compliant in both of the standards, without any recommendations being made for improvement.

Director of nursing, patient safety and quality Sue Smith said: "We were delighted to be rated as compliant in both of the essential standards. It was particularly pleasing to see that we received one of the best reviews

"Treating people with respect, involving them in discussions about their care and treatment as well as enabling people to influence how the service is run is a fundamental part of patient care. The quality and availability of food is also very important to people who are unwell and recovering from illnesses, injuries and operations.

"It was good to hear our patients saying they were happy with these aspects of care in our hospitals and that staff were respectful when addressing them.

"There were some minor points raised for example, staff offering to open wet wipes for hand cleaning for all patients before meals and we are working with our nursing and catering teams to achieve this.

"My senior nursing team make regular visits, both announced and unannounced, to our wards and I believe this makes our ward staff feel supported in their work to provide the highest standards of care. It is thanks to the hard work and dedication of our staff that we are able to achieve our high quality of service and we welcome reports like this because they let us all know that we are getting it right.

"Myself and the director responsible for catering also regularly walk around together to ask patients about the quality of their meals and their overall experience of their care.

"These actions also reassure patients because they can see for themselves that we take this matter very seriously. On the rare occasions where there is a problem we can put things right straightaway."

"The real thanks for this positive outcome goes to our patients and staff for ensuring that we constantly understand how we are doing and what we can do to further improve."

Governor Carol Ellis speaks to a patient

Governors look at quality and patient experience

Governors Pat Upton, Carol Ellis and Wendy Gill headed out on the wards at the University Hospital when they joined director of nursing and patient safety Sue Smith and her senior nursing team on the patient experience and quality standards panel.

They asked patients a series of questions which looked at elements such as the cleanliness, safety and patient documentation and the patient's opinions about their stay in hospital.

Governor Carol Ellis said: "It is an excellent opportunity to get out and speak to the patients myself. I visited a couple of areas and I was very impressed with the patient's comments."

Governors Tom Sant and Christopher Broadbent took a look at some of the facilities in the community with clinical director for community services Linda Watson and her team.

Integrated services manager Sue Judge reviewed the quality of care at One Life Hartlepool with governor Tom Sant. They spoke to a number of patients who were waiting for their appointments before checking nursing documentation and the cleanliness of the clinics.

Sue said: "We've received some really excellent feedback."

Director of nursing and patient safety Sue Smith added: "Governors are starting to regularly come along on the patient experience and quality standards panel now. It's a chance for them to see for themselves the fantastic work our staff are doing."

Governor Tom Sant, integrated services manager Sue Judge and specialist health care assistant Deborah Rigby review nursing documentation at a clinic in One Life Hartlepool.

Dot with her daughter Tracy

APPENDIX C

Governors get a tour of One Life Hartlepool

Governors Wendy Gill, Christopher Broadbent, Tom Sant and Mary King took a tour of the state of the art facilities at One Life Hartlepool.

Musculoskeletal, podiatry, the community respiratory service, audiology clinic, contraceptive and sexual health teams and the Tees community dental service are just some of the services being provided in the £20m facility in Park Road, Hartlepool.

Centre manager Andrew McMinn explained how services were previously provided at various locations in Hartlepool, such as Tees Street, Wynyard Road Primary Care Centre and Caroline Street Health Centre and are now together in one modern facility. There was also the chance to take a look at the new minor injuries unit.

Birthing centre staff celebrate with families

Hartlepool birthing centre celebrates its third birthday

The birthing centre at the University Hospital of Hartlepool opened its doors to women and their families for a special event yesterday, to mark the centre's third birthday.

It was a great chance for mums-to be to take a look round the centre and for mums who have delivered at the centre to celebrate with other families and birthing centre staff.

Midwifery matron Judith Stout said: "We were delighted to see so many mums-to-be and parents and their children who were born at the centre, to mark yet another milestone with us.

"The last three years have been very successful. There have been more than 1,100 babies born and parents have been very complimentary. People choose to come here from Hartlepool, Stockton, areas of Durham and further afield. I have no doubt that the success will continue"

Specialist lead midwife Dennise Butcher, community lead Karen Stevens, midwife Sandra Mason and (front) healthcare assistant Sarah Cooper and community midwife Maureen Jones

Community lead Karen Stevens with mum Janette Weegram and daughter Suranne

The midwife led centre provides a relaxed home from home environment and continues to receive glowing reviews from parents.

Janette Weegram, 19 from Hartlepool give birth to daughter Suranne on 10 June at the birthing centre. She said: "I absolutely loved it here. I would recommend it to anyone."

Midwives, supported by midwifery assistants provide a wide range of choice of delivery for women with uncomplicated and low risk pregnancies who do not have a history of problems and are fit and healthy.

The centre has four delivery rooms – one with a birthing pool and another with a range of special birthing equipment which allows women to stay upright and supported during labour.

Judith continued: "The new birthing centre is like a home-from-home for soon-to-be -parents with a warm and welcoming atmosphere. We're so pleased that it has been so well received.

"Women can choose to come to the birthing centre by speaking to their community midwife."

APPENDIX C

Governors take a look round lung health

"The consulting rooms are lovely and light. The facilities are absolutely fantastic for patients."

Governors Janet Atkins, Richard Sidney and Pat Upton took a look round the state of the art lung health department at the University Hospital of North Tees.

COPD nurse co-ordinator Sandra Stych took the governors on a tour of the department which uses the latest technology for diagnosing and assessing lung disease.

Sandra explained: "We provide a one stop facility for patients with respiratory disease. Examination rooms, a lung function testing laboratory and digital chest x-ray is all in one place. People come here and see the same staff.

"Our ethos is about putting patients first. We want our patients to get the best possible treatment and continuity.

Governor Janet Atkins commented: "The consulting rooms are lovely and light. The facilities are absolutely fantastic for patients."

Governor Richard Sidney talks to chronic obstructive pulmonary disease nurse co-ordinator Sandra Stych

Super slimmers get in shape for summer

A group of super slimmers have got themselves in shape for summer thanks to the first weight management class for staff run by the trust's nutritionist Fiona Cutting.

The 10-week weight loss group which began in January this year successfully helped information analyst Lynne Blohm, dermatology secretary Gloria Parvin, medical secretary Susan Winship, medical secretary Katherine Gray and admin assistant Gill Meach lose more than five stone between them.

Gloria Parvin, who has had to get her uniform taken in said: "Being able to support each other has been fantastic. It has really helped. It certainly keeps you motivated. We banned the biscuits in the office straightaway!"

Lynne who is looking forward to going on a cruise later this year said: "I've always counted calories. Joining the group has taught me to look at portion sizes. I've enjoyed coming to the group, it's a great idea to encourage and keep staff healthy. It's been good to get to know other staff too."

The exciting programme featured a different topic each week, looking at portion sizes, understanding food labels and takeaways, weekly weigh-ins and how to stay motivated.

Community nutritionist Fiona Cutting added: "The group have done brilliantly well. It's about losing weight gradually. The ladies come back to get weighed each week and its great to see they're maintaining their new healthier lifestyle."

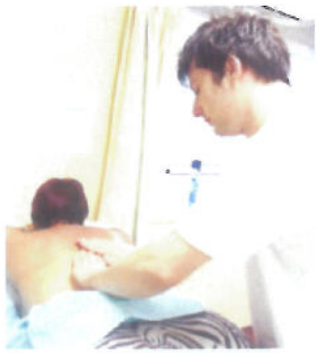
Governor Janet Atkins talks to chronic obstructive pulmonary disease nurse co-ordinator Sandra Stych Sandra Stych and staff nurse Julie Lindberg in the lung health department at the University Hospital of North Tees

Soothing massage offered at fertility support group

The regular meeting of the fertility support group was a meeting with a difference last month. The group which allows parents who've been through assisted reproduction to share their experiences with people who are about to begin treatment is an invaluable addition to the assisted reproduction unit's services. But at the last meeting something else was on offer; a qualified masseur from the George Hardwick Foundation.

Principle embryologist and business manager for the unit Dave Gibbon said: "We know that fertility treatment is stressful for everyone concerned and we thought we'd offer a chance for people to have a soothing back massage. It was certainly popular and is something we hope to repeat at a future meeting.

The support group meets in the University Hospital of Hartlepool's assisted reproduction unit on the first Tuesday of every month. For more information please contact the unit on 01429 522866.



Positive strokes – a member of the patient support group enjoys a soothing back massage

APPENDIX C

Misra Bano-Mahroo (right) pictured with Khalid Siddiqi, Praveen Sharda, Nazar Imam, Siva Kumar, Hafiz Ahmed, Rahda Venkatesan, Mercy Mshelbwala, Krishnasamy Rajasekar, Raj Logishetty and Thida Oo

SAS conference a great success

Around 55 staff grade and associate specialists from across the region gathered at the University Hospital of North Tees recently to attend a regional conference designed to enhance their education and skills.

Associate specialist from the trust's assisted reproduction unit Misra Bano-Mahroo said: "We were delighted with the response and were grateful to the North East Strategic Health Authority and the British Medical Association for helping us publicise the conference.

"The speakers included the renowned authorities like head of the Joint Royal College of Physicians' Training Board Nicholas Grant, head of certification at the GMC Tara Wilmot, chair of certificate of eligibility for specialist registration (CESR) for the Royal College of Paediatrics and Child Health David Beverley and medical director of for Wrightington, Wigan and Leigh Trust Umesh Prabu.

"The programme for the morning session was varied and included previous SAS doctors who had successfully completed the CESR application and gave an account of difficulties for processing the application and how to overcome them. The afternoon session was facilitated by Developmedica, an external consultancy company who spoke about negotiating skills, maintenance of personal e-portfolio and revalidation.

"Umesh Prabhu brought the day to a close and spoke about SAS doctors' contribution to the NHS and how to make use of their excellent talent. The lecture was an eye opener and recognised the talent, expertise, dedication and the impact of this group of doctors on patient care.

"The feedback for the event was excellent. The attendees thought that the event was very useful and that the programme and organisation was exceptional. They thought the sessions were excellent, interactive and versatile with a good range of speakers who provided diverse useful information and ideas.

"Of course conferences like this don't just happen on their own. I would like to thank medical director David Emerton and associate medical director Chris Tulloch for their support and the help and support of Bob Singh, Hafiz Ahmad, Ravi Thakur and Nazar Imam and the SAS educational leads- Praveen Sharda, Tariq Azad, Kameshwar Singh, Mercy Mshelbwala, Kyaw Toe and SAS tutor Siva Kumar.

"The committee is especially thankful to unparalleled support of Vicky Naunton from the education and learning directorate. Her immense hard work and dedication made the event highly successful."

Pat shares her governor experience

When the Foundation Trust Network (FTN) got in touch with trust board secretary Lynn Hughes and asked her if one of the governors could attend their next event it was governor Pat Upton (pictured) who stepped up to do the job.

Pat said: "The FTN holds events for people who will be governors when their trust is successful in becoming an NHS foundation trust so they can learn about what to expect.

"The FTN was interested in the involvement governors have in this trust specifically around how they are involved in evaluating patient experience."

Pat Upton

> "I came out of the meeting on a high, the sun was shining and I decided to walk back towards Trafalgar Square pausing to ring Lynn to tell her of my success. It had been a very enjoyable day!"

The event began wit round table discussions and gave Pat an opportunity to meet shadow governors from Kent, Suffolk, Shropshire and Leicester. The remainder of the sessions were presentations from Leeds, York, Sheffield, the trust and Taunton.

Pat continued: "My presentation based on quality review panels now called patient experience, quality and standards (PEQS) visits. Director of nursing and patient safety Sue Smith put together some slides which had been used in some of her presentations to the governors and Lynn was very helpful in explaining anything I wasn't quite sure of.

"I was a little apprehensive about speaking to so many people (50+) but I was soon into the flow of it. I spoke about the Mid-Staffs report and how we were going to prevent it happening in our trust. I spoke about the PEQS, showing the tool sheets and a copy of a summary sheet used during the visits, the improvements in tackling the spread of infection and the significant decrease in mortality which were all linked to an improvement in standards.

"Talking to patients about their experiences was a topic they showed a great interest in, some of the shadow governors were not sure it was something that they should be doing . I also included the fact that in some departments they were using videos to capture patient stories. My presentation lasted about 25 minutes. At the end several delegates thanked me for a very interesting talk.

"There was only one question and that was 'how the governors managed to take part in this procedure'. I explained that at one of the committee meetings some of the governors asked if it was possible to take part in the reviews and it was up and running within a couple of weeks; all part of the trust's ward to board approach.

"I came out of the meeting on a high, the sun was shining and I decided to walk back towards Trafalgar Square pausing to ring Lynn to tell her of my success. It had been a very enjoyable day!"

APPENDIX C

Member and governor round up

Members and governors play a unique role in the life of an NHS Foundation Trust.

At a recent council of governor seminars governors have had the chance to find out about services the trust is developing for patients. Governors have also been involved in helping the trust plan for the future, including discussing what patient bedrooms might be like in the new hospital.

Regular Saturday morning events also gave members a chance to find out more about their areas of interest. At the most recent event they heard about Parkinson's disease and how the trust is developing community services.

Chief executive Alan Foster said: "There's no doubt that having governors and members enriches the life of the trust. Our governors sit on many committees looking at various aspects of the trust's work. Our member events are popular and I know members appreciate the chance to meet our doctors and other health professionals face to face to find out what services are being developed for patients."

For more information about member events please look at the members' notice board or email membership@nth.nhs.uk

Clinical director for surgery Pud Bhaskar updates the governors on advances in breast surgery

Clinical director for community services Linda Watson talks to the members about developments in community services

Deputy director of human resources Barbara Bright discusses the results of the NHS staff survey with governors

Director of operations and performance Julie Gillon discusses the trust's plans for 2011 and 2012 with the governors

Staff governor and surgeon Hasan Bandi pictured at his last governors' meeting before his retirement

Governor Kate Smith feeds back on her table's ideas about patient rooms in the new hospital

Consultant physician Balakrishna Kumar at a recent member event on Parkinson's disease

Tracy Minns and Michelle Taylor from human resources and director of human resources and organisation development Clare Curran discuss equality and diversity with the governors

Clinical director of orthopaedics and trauma Chris Tulloch and commercial director Kevin Oxley discuss patient rooms in the new hospital at a recent governor seminar

A typical council of governor meeting

APPENDIX C

Member's noticeboard

Annual general meeting

We're holding our annual general meeting on Thursday 15 September at 11am in the teaching centre at the University Hospital of North Tees. This meeting is held in public and all trust members are welcome to attend. Please contact the membership office for more information.

Council of governors meeting

The governors are the voice of our members who help shape the future of the hospitals. Members and the general public are welcome to observe the meetings which are held around four times a year. Please contact the membership office for more information.

Member events

The chairman will be hosting four events this year for members and people who are interested in becoming a member. Hear about catering and pain management at the event on Saturday 3 September at 9.30am, in the education and learning centre, at the University Hospital of Hartlepool. The events are free, but you need to book a place. People can do this by contacting the membership office.

Board of directors meetings

The board of directors meet around six times a year. Members of the public and staff are welcome to observe the meetings. This is your chance to see how the board operates and gain first hand knowledge on the trust's latest developments.

Spaces to attend the meetings are limited so please contact the membership office in advance to ensure your place. The next board of directors meeting is on Thursday 27 October at 1.30pm in the boardroom, University Hospital of North Tees.

Your trust needs you!

We want to increase our membership so that we are truly representative of the community we serve and that more people can become involved with their local hospital. Please encourage your family and friends to join the trust as a member. We would especially like to hear from anyone aged 16-25 years old as we have a number of potential opportunities they could be involved with. You can join by contacting us on membership@nth.nhs.uk , calling 01642 383765 or applying at www.nth.nhs.uk

North Tees and Hartlepool NHS
NHS Foundation Trust

On the web
www.nth.nhs.uk

Join us on
facebook

Follow us on
twitter

Contacting your membership office

You can get in touch with your membership office at 01642 383765 or membership@nth.nhs.uk

HEALTH SCRUTINY FORUM

6 October 2011

Report of: Scrutiny Support Officer

Subject: NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST'S QUALITY ACCOUNT 2012/13 – FORUM RESPONSE

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1. PURPOSE OF REPORT

1.1 To promote discussion amongst Members in agreeing the three key priorities for consideration by North Tees and Hartlepool NHS Foundation Trust for inclusion as part of its Quality Account 2012/13.

2. BACKGROUND INFORMATION

2.1 Members will recall that at the meeting of this Forum on 8 September 2011, Members received a presentation from the Director of Nursing and Patient Safety at North Tees and Hartlepool NHS Foundation Trust (NTHFT) in relation to their Quality Account for 2012/13.

2.2 During the presentation by the Director of Nursing and Patient Safety on the 8 September 2011 a number of suggested priorities were put forward by NTHFT and these are detailed below:-

(i) Mortality;
Could cover: infection, falls, medicine safety, cardiac arrests and dementia.

(ii) Effectiveness;
Could cover: discharge times / processes, full EAU assessment and treatment within 2 hours, communication / documentation.

(iii) Patient Experience;
Could cover: is care good (compassion / respect / dignity), recommendation, compliments and complaints, environment, patient

surveys, external reviews (enter and view, PEAT, peer, CQC, commissioner), staff surveys.

2.3 Members debated the suggested items to be included in NTHFT's Quality Account 2012/13 and items identified by Members are collated below:-

(i) Communication;
Particularly between assessment teams and social workers in relation to systems used.

(ii) Community Provision;
How it is monitored and ensures public safety.

(iii) Dementia;
Use of support workers in community settings for families of dementia sufferers.

2.3 Members agreed at their meeting of 8 September 2011 to identify **three** priorities which they would forward to the Director of Nursing and Patient Safety for consideration as part of NTHFT's Quality Account for 2012/13. Members are advised that any suggestion should be measurable.

3. RECOMMENDATION

3.1 It is recommended that the Members of the Health Scrutiny Forum:-

(i) Consider the suggested key priorities under paragraphs 2.2 and 2.3; and

(ii) Identify **three** key priorities for consideration in North Tees and Hartlepool NHS Foundation Trust's Quality Account 2012/13.

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

BACKGROUND PAPERS

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

(i) Presentation by the Director of Nursing and Patient Safety, North Tees and Hartlepool NHS Foundation Trust entitled 'Quality Accounts 2011/12; moving forward together' Presented to the Health Scrutiny Forum on 8 September 2011.

HEALTH SCRUTINY FORUM

6 October 2011

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Support Officer

Subject: HEALTH SCRUTINY ROADSHOWS – DRAFT SCOPING REPORT

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1. PURPOSE OF REPORT

1.1 To make proposals to Members of the Health Scrutiny Forum for their forthcoming Health Scrutiny Roadshows.

2. BACKGROUND INFORMATION

2.1 At the meeting of Council on 4 August 2011 the following proposal was made:-

"This Council is absolutely opposed to any reduction in existing services at the University Hospital of Hartlepool site until the proposed new Hartlepool Hospital is fully implemented. We, therefore, call upon the Health Scrutiny Forum to continue to review, monitor and challenge the Hospital Trust's commitment to deliver sustainable health services from the University Hospital of Hartlepool site.

Additionally, we call upon Health Scrutiny Forum to facilitate a series of meetings, involving Health Service professionals, in delivering their work programme via a roadshow, within the community, affording ALL residents the opportunity to actively participate whilst raising awareness of the true facts regarding the delivery of hospital services including the reconfigured Accident and Emergency and Minor Injury services."

2.2 When Members of the Health Scrutiny Forum met on 8 September 2011, they received a presentation from the Deputy Chief Executive / Director of Strategic Service Development from North Tees and Hartlepool NHS

Foundation Trust, which made a number of suggestions for the format and content of the Health Roadshows.

3. OVERALL AIM OF THE HEALTH ROADSHOWS

3.1 To have a wide and transparent dialogue about the future of all health services in Hartlepool.

4. PROPOSED TERMS OF REFERENCE FOR THE SCRUTINY ROADSHOWS

4.1 The following Terms of Reference for the Roadshows are proposed:-

(a) To consider the future of healthcare service delivery in Hartlepool as a result of national policy;

(b) To gain an understanding of the financial context for North Tees and Hartlepool NHS Foundation Trust;

(c) To explore the recruitment and retention of staff at North Tees and Hartlepool NHS Foundation Trust;

(d) To examine the transition plans towards the 'new' Hospital and how these plans will shape future delivery of services.

5. PROPOSED TIMETABLE OF THE SCRUTINY ROADSHOWS

5.1 Detailed below is the proposed timetable for the Roadshows to be undertaken, which may be changed at any stage:-

November / December 2011 - Health Roadshows:-

(i) One to be held in each of the three areas of the Town (North, South and Central);

a. North Health Roadshow to be held at 10am at suitable publically accessible venue;

b. South Health Roadshow to be held at 2pm at suitable publically accessible venue;

c. Central Health Roadshow to be held at 6pm in Civic Centre.

(ii) Healthcare Professionals from NHS Tees, Local GPs and North Tees & Hartlepool NHS Foundation Trust to be present along with Health Scrutiny Forum Members;

(iii) Initial short presentation on recommendation (a) (see paragraph 4.1), before smaller groups can discuss recommendations (b)-(d) (see paragraph 4.1);

(iv) Summary of discussions presented back to whole group.

26 January 2012 – Consideration of feedback from Roadshows at Health Scrutiny Forum

6. RECOMMENDATION

6.1 Members are recommended to agree the Health Scrutiny Forum's remit of the Scrutiny investigation as outlined in paragraph 4.1

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

BACKGROUND PAPERS

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

(i) Minutes of the Council meeting held on 4 August 2011

(ii) Minutes of the Health Scrutiny Forum meeting held on 8 September 2011

(iii) Presentation by the Deputy Chief Executive, North Tees and Hartlepool NHS Foundation Trust entitled 'Hartlepool Health Scrutiny Forum' Presented to the Health Scrutiny Forum on 8 September 2011.

HEALTH SCRUTINY FORUM

8 September 2011

Report of: Scrutiny Support Officer

Subject: THE EXECUTIVE'S FORWARD PLAN

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1. PURPOSE OF REPORT

1.1 To provide the opportunity for the Health Scrutiny Forum to consider whether any item within the Executive's Forward Plan should be considered by this Forum.

2. BACKGROUND INFORMATION

2.1 One of the main duties of Scrutiny is to hold the Executive to account by considering the forthcoming decisions of the Executive (as outlined in the Executive's Forward Plan) and to decide whether value can be added to the decision by the Scrutiny process in advance of the decision being made.

2.2 This would not negate Non-Executive Members ability to call-in a decision after it has been made.

2.3 As Members will be aware, the Scrutiny Co-ordinating Committee has delegated powers to manage the work of Scrutiny, as it thinks fit, and if appropriate can exercise or delegate to individual Scrutiny Forums. Consequently, Scrutiny Co-ordinating Committee monitors the Executive's Forward Plan and delegates decisions to individual Forums where it feels appropriate.

2.4 In addition to this, the key decisions contained within the Executive's Forward Plan (October 2011 – January 2012) relating to the Health Scrutiny Forum are shown below for Members consideration:-

DECISION REFERENCE: CE46/11 – REVIEW OF COMMUNITY INVOLVEMENT & ENGAGEMENT (INCLUDING LSP REVIEW): UPDATE ON DECISIONS TAKEN 'IN PRINCIPLE'

Nature of the decision

Key Decision - Test (ii) applied

Background

Following a review Cabinet has agreed the future approach of the Local Authority to community and stakeholder involvement and engagement and the Local Strategic Partnership, including theme partnerships at their meeting on 18th July 2011. This was previously in the Forward Plan as decision reference CE43/11.

At the end of June the Government responded to the NHS Future Forum report. In their response they outlined that as the statutory Health and Wellbeing Board "discharges executive functions of local authorities'" it should operate as equivalent executive bodies do in local government. At the time of Cabinet agreeing the future approach it was unclear exactly what this meant and the implications that this would have on the structure proposed. In response some decisions were requested to be made 'in principle' and that these would be confirmed once guidance was issued on the implementation of the statutory Health and Wellbeing Board.

At their meeting on 15th August 2011 Cabinet agreed for a shadow Health and Wellbeing Board to be established by the end of September 2011. This shadow Board will develop into the statutory Health and Wellbeing Board which is expected to be established by April 2013.

The Health and Social Care Bill, which sets out the statutory requirement to introduce a Health and Wellbeing Board, had its third reading in the House of Commons on 7th September 2011. The Bill has now been passed to the House of Lords for consideration. Once the House of Commons and the House of Lords agree the final Bill it can then receive Royal Assent and become an Act of Parliament i.e. the proposals of the Bill will become law. The Statutory Guidance on Health and Wellbeing Boards will not be published until after the Bill becomes law and this is not expected until Spring 2012.

The 'in principle' decisions related to the structure of community involvement and engagement and the development of a Strategic Partners Group and its membership. It is these decisions that are the subject of this Forward Plan entry. They will be confirmed or reviewed dependent upon the guidance issued for the statutory Health and Wellbeing Board.

Who will make the decision?

The decision will be made by Cabinet however some elements may require Council agreement for changes to the Constitution.

Ward(s) affected

The proposals will affect all wards within the Borough.

Timing of the decision

At the Cabinet meeting on 18th July 2011 it was agreed that a further report would be brought to Cabinet once the statutory Health & Wellbeing Board guidance had been issued. If the 'in principle' decisions that Cabinet have taken are unaffected then they will be agreed for implementation. If those 'in principle' decisions are affected then Cabinet will be asked to consider alternative proposals which reflect the new position. It is anticipated that the guidance will be published in early 2012 and a report will be taken to Cabinet following the publication date in January. The detailed timescales for this are currently unclear and may be subject to change.

Who will be consulted and how?

Cabinet will be asked to consider the implications of guidance on the development of the statutory Health and Wellbeing Board on the 'in principle' decisions relating to the structure of

community involvement and engagement and the development of a Strategic Partners Group and its membership.

Information to be considered by the decision makers

Cabinet will be presented with detail from the guidance on the development of the statutory Health and Wellbeing Board and how this will impact, if at all, on the 'in principle' decisions that they made on 18th July 2011.

How to make representation

Representation should be made to:

Andrew Atkin, Assistant Chief Executive, Civic Centre, Hartlepool TS24 8AY.
Telephone: (01429) 523003.
Email: Andrew.atkin@hartlepool.gov.uk

Catherine Frank, Local Strategic Partnership Manager, Civic Centre, Hartlepool TS24 8AY.
Telephone: (01429) 284322.
Email: catherine.frank@hartlepool.gov.uk

DECISION REFERENCE: CAS99/11 EARLY INTERVENTION STRATEGY AND COMMISSIONING

Nature of the decision

To approve the Early Intervention Strategy which will provide the Local Authority and partners with the framework for the redesign, restructure and commissioning of local services to secure better results for children, young people and families.

Who will make the decision?

Cabinet.

Timing of the decision

October 2011.

Ward(s) affected

All wards.

Who will be consulted and how?

Local Authority Staff (Child and Adult Services) affected by Early Intervention Strategy via Staff Briefings on 2, 3 and 4 November 2011.

Partner Organisations via a series of Early Intervention Seminars (to be arranged)

Partner Organisations via presentations to established groups and boards including:

- Safer Hartlepool Partnership (to be arranged)
- 11 - 19 Partnership (20-10-2011)
- Hartlepool Safeguarding Children's Board (13-09-2011)
- Children's Partnership (28-09-2011)

•	Directors meeting with Primary Heads	(to be arranged)
•	Directors meeting with Secondary Heads	(to be arranged)
•	Health and Wellbeing Partnership	(to be arranged)
•	Teenage Pregnancy Partnership Board	(14-09-2011)
•	North Forum	(19-10-2011)
•	Central Forum	(20-10-2011)
•	South Forum	(21-10-2011)
•	Substance Misuse Commissioning Group	(10-10-2011)
•	Parenting Forum	(to be arranged)
•	Secondary Behaviour and Attendance Partnership	(19-10-2011)

Parents will be invited to attend the North, South and Central Seminars.

General Service Users via an invitation to comment on the Early Intervention Strategy via Local Press and Survey Monkey.

General Service Users via consultation exercises led by individual services (who are currently funded via the Early Intervention Grant) with their respective user groups.

Information to be considered by the decision-makers

In December 2010, the Secretary of State for Education announced the creation of a new Early Intervention Grant which would provide Local Authorities with greater flexibility and freedom to respond to local need.

The grant effectively replaces a number of funding streams that have historically funded specific services such as Children's Fund, Young Peoples Substance Misuse Services, Children's Centres, Connexions, the Teenage Pregnancy Service and the Youth Crime Action Plan and instead provides local authorities and partners with the impetus to act more strategically to pool and align this funding to target disadvantage more effectively, avoid duplication and invest in early intervention to produce better results for local children, young people and families.

This reduction in national prescription regarding how services for children, young people and families are configured and delivered has enabled local partnerships to begin to review local need and the suitability of existing services with a view to restructuring/commissioning services to achieve improved outcomes and best value.

A structured timetable of consultation began on the 11thJuly 2011 seeking to establish how best the Local Authority could allocate and prioritise resources according to local needs and invest in early intervention to improve outcomes for local children, young people and families, to allow for a series of recommendations to be submitted to Cabinet for decision.

Work to date has already highlighted that, in spite of all our efforts, the gap between our most vulnerable children and their peers continues to widen and that this disadvantage is felt most keenly across a number of key geographical areas wherein the town's most vulnerable families and problematic households are concentrated.

If we are to have a significant and lasting impact there appears to be a clear need to develop and commission services that are able to identify and address the needs of whole families at the earliest opportunity and to focus resources on those areas of the town where they are needed most.

A target date for the first phase of implementation is in place for the 1st of April 2012 and it is anticipated that further reports will follow regarding proposals relating to service structures and commissioned services pending agreement from Cabinet to progress with the developing Early Intervention Strategy.

How to make representations

Representations to be made to Mark Smith, Head of Integrated Youth Support Services, Child and Adult Services, Hartlepool Borough Council, Civic Centre, Hartlepool, TS24 8AY. Telephone (01429) 523405. E-mail mark.smith@hartlepool.gov.uk.

DECISION REFERENCE: CAS102/11 EARLY INTERVENTION STRATEGY: SERVICE RESTRUCTURE

Nature of the decision

To consider and approve the proposed restructure of Local Authority services funded through the Early Intervention Grant in line with the development of multi-disciplinary teams to improve how we support children, young people and families at risk of disadvantage.

Who will make the decision?

Cabinet

Timing of the decision

11th November 2011

Ward(s) affected

All

Who will be consulted and how?

Local Authority Staff (Child and Adult Services) affected by Early Intervention Strategy via Staff Briefings (02-11-2011, 03-11-2011, 04-11-2011)

Partner Organisations via a series of Early Intervention Seminars

Partner Organisations via presentations to established groups and boards including:

• Safer Hartlepool Partnership	(to be arranged)
• 0 - 11 Partnership	(to be arranged)
• 11 - 19 Partnership	(20-10-2011)
• Hartlepool Safeguarding Children's Board	(13-09-2011)
• Children's Partnership	(28-09-2011)
• Directors meeting with Primary Heads	(to be arranged)
• Directors meeting with Secondary Heads	(to be arranged)
• Health and Wellbeing Partnership	(to be arranged)
• Teenage Pregnancy Partnership Board	(14-09-2011)
• North Forum	(19-10-2011)
• Central Forum	(20-10-2011)
• South Forum	(21-10-2011)
• Substance Misuse Commissioning Group	(10-10-2011)
• Parenting Forum	(to be arranged)
• Secondary Behaviour and Attendance Partnership	(19-10-2011)

Parents will be invited to attend the North, South and Central Seminars.

General Service Users via an invitation to comment on the Early Intervention Strategy via Local Press and Survey Monkey.

General Service Users via consultation exercises led by individual services (who are currently funded via the Early Intervention Grant) with their respective user groups.

Information to be considered by the decision-makers

In December 2010, the Secretary of State for Education announced the creation of a new Early Intervention Grant which would provide Local Authorities with greater flexibility and freedom to respond to local need.

The grant effectively replaces a number of funding streams that have historically funded specific services such as Children's Fund, Young Peoples Substance Misuse Services, Children's Centres, Connexions, the Teenage Pregnancy Service and the Youth Crime Action Plan and instead provides local authorities and partners with the impetus to act more strategically to pool and align this funding to target disadvantage more effectively, avoid duplication and invest in early intervention to produce better results for local children, young people and families.

This reduction in national prescription regarding how services for children, young people and families are configured and delivered has enabled local partnerships to begin to review local need and the suitability of existing services with a view to restructuring/commissioning services to achieve improved outcomes and best value.

A structured timetable of consultation began on the 11thJuly 2011 seeking to establish how best the Local Authority could allocate and prioritise resources according to local needs and invest in early intervention to improve outcomes for local children, young people and families, to allow for a series of recommendations to be submitted to Cabinet for decision.

Work to date has already highlighted that, in spite of all our efforts, the gap between our most vulnerable children and their peers continues to widen and that this disadvantage is felt most keenly across a number of key geographical areas wherein the town's most vulnerable families and problematic households are concentrated.

This report will set out plans for the restructure and redesign of Local Authority services funded through the Early Intervention Grant and highlights the implications for staff funded via the Early Intervention Grant.

A target date for the first phase of implementation is in place for the 1st of April 2012 and it is anticipated that the Local Authority and Partners will begin to operate within new multi-disciplinary teams to improve support for children, young people and families who are at risk of disadvantage pending approval from Cabinet.

How to make representations

Mark Smith, Head of Integrated Youth Support Services, Child and Adult Services Department, Hartlepool Borough Council, Civic Centre, Hartlepool, TS24 8AY. Tel 01429 523405. E-mail mark.smith@hartlepool.gov.uk

2.5 A summary of all key decisions is attached as **APPENDIX A** to this report.

2.6 Copies of the Executive's Forward Plan will be available at the meeting and are also available on request from the Scrutiny Team (01429 5236437) prior to the meeting.

3. RECOMMENDATIONS

3.1 It is recommended that the Health Scrutiny Forum:-

(a) considers the Executive's Forward Plan; and

(b) decides whether there are any items where value can be added to the decision by the Health Scrutiny Forum in advance of the decision being made.

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 preparation of this report:

(a) The Forward Plan – October 2011 – January 2012

TIMETABLE OF KEY DECISIONS

Decisions are shown on the timetable at the earliest date at which they may be expected to be made.

1. DECISIONS EXPECTED TO BE MADE IN OCTOBER 2011

CE 44/11 (page 6)	Workforce Arrangements	Cabinet
CAS 95/11 (page 13)	Hartlepool Community Pool Grants Review	Cabinet
CAS 99/11 (page 16)	Early Intervention Strategy and Commissioning	Cabinet
CAS 100/11 (page 19)	National Citizen Service 2012 Pilot	Cabinet
RN 13/09 (page 31)	Disposal of Surplus Assets	Cabinet / Portfolio Holder
RN 53/11 (page 34)	Sustainable Construction Strategy	Portfolio Holders
RN 55/11 (page 36)	Hartlepool Compact / Voluntary Sector Strategy Action Plans	Cabinet
RN 57/11 (page 38)	Dog Control Orders	Portfolio Holder
RN 58/11 (page 40)	Allotments	Portfolio Holder
RN 61/11 (page 45)	Selection of Preferred Developer for sites in Seaton Carew	Cabinet
RN 62/11 (page 47)	Seaton Carew Coastal Strategy Northern Management Unit Phase 2	Cabinet / Council
RN 65/11 (page 49)	Review of Waste Management Services	Cabinet
RN 66/11 (page 51)	Future Approach to Neighbourhood Management	Cabinet
RN 69/11 (page 55)	Flexible Support Fund	Cabinet
RN 70/11 (page 56)	Innovation Fund	Cabinet
RN 71/11 (page 57)	Families with Multiple Problems	Cabinet
RN 75/11 (page 61)	Furniture Solutions Project	Cabinet
RN 77/11 (page 63)	Wynyard Master Plan	Cabinet
RN 79/11 (page 66)	Regeneration and Planning Proposed Budget Savings	Cabinet
RN 80/11 (page 67)	Proposed Management Structure and Budget Saving – Private Sector Housing	Cabinet
RN 81/11 (page 69)	Public Protection – Proposed Budget Savings	Cabinet
RN 82/11 (page 70)	Housing Adaptations Policy 2010-2013 Progress Report	Portfolio Holder
RN 83/11 (page 71)	Housing Enforcement Policy – Private Sector Housing	Portfolio Holder
RN 85/11 (page 74)	Delivery of the Church Square Masterplan	Portfolio Holder / Council
RN 86/11 (page 76)	North East PV Retro Fit Scheme	Cabinet

2. DECISIONS EXPECTED TO BE MADE IN NOVEMBER 2011

CE 45/11 (page 7)	Strategy for bridging the budget deficit 2012/13 – ICT, revenues and benefits services	Cabinet
CAS 96/11 (page 14)	Cultural Services SDO	Cabinet
CAS 97/11 (page 15)	Community Services Budget Reductions	Cabinet
CAS 102/11 (page 23)	Early Intervention Strategy: Service Restructure	Cabinet
RN 60/11 (page 43)	Hartlepool Housing Strategy 2011-2015	Cabinet
RN 74/11 (page 59)	Former Leathers Chemical Site	Cabinet
RN 78/11 (page 65)	Sustainability Policy	Portfolio Holders

3. DECISIONS EXPECTED TO BE MADE IN DECEMBER 2011

CE 47/11 (page 11)	Customer and Support Services – Service review	Cabinet
CAS 101/11 (page 21)	Service Delivery Review of Children's Social Care Commissioning	Cabinet
RN 29/10 (page 33)	Hartlepool Domestic Violence Strategy	Cabinet
RN 68/11 (page 53)	Community Cohesion Framework	Portfolio Holder

4. DECISIONS EXPECTED TO BE MADE IN JANUARY 2012

CE 46/11 (page 9)	Review of Community Involvement and Engagement (including LSP Review): Update on decisions taken 'in principle'	Cabinet / Council
RN 84/11 (page 72)	Enterprise Zones Local Development Orders	Cabinet / Council