HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL BOROUGH COUNCIL

Thursday 17 November 2011

at 10.00 a.m.

in Council Chamber
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 6 OCTOBER 2011**

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

   No items.

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

   No items.

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

   No items.

7. **ITEMS FOR DISCUSSION**

7.1 "Our £40m Challenge"

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

(b) Verbal Evidence – *North Tees and Hartlepool NHS Foundation Trust*

Scrutiny Investigation into Cancer Awareness and Early Diagnosis

7.2 Cancer Screening Services

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

(b) Presentation – *Assistant Director for Health Improvement and Clinical Director of Public Health, NHS Tees.*

7.3 Pancreatic Cancer and Diabetes – *Scrutiny Support Officer*

Visit to Minister of State for Health

7.4 Report – *Chair of the Health Scrutiny Forum*.

8. **ISSUES IDENTIFIED FROM FORWARD PLAN**

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

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

9.1 Minutes of the meeting held on 12 September 2011

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 26 January 2012 commencing at 10.00 a.m. in the Civic Centre, Hartlepool**.**

HEALTH SCRUTINY FORUM

MINUTES

6 October 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, Marjorie James, Geoff Lilley, Arthur Preece, Jean Robinson, Linda Shields, Kaylee Sirs and Ray Wells.

Resident Representatives: Maureen Braithwaite and Ian Stewart.

Also Present: Iain Wright MP
Councillor Ged Hall, Portfolio Holder for Adult and Public Health Services
Councillor Edna Wright.
Stephen Thomas, HVDA.

Officers: Louise Wallace, Assistant Director, Health Improvement
Jill Harrison, Assistant Director, Adult Social Care
James Walsh, Scrutiny Support Officer
David Cosgrove, Democratic Services Team

28. Apologies for Absence

None.

29. Declarations of Interest by Members

None.

30. Minutes of the meeting held on 8 September 2011

Confirmed.

31. Responses from the Council, the Executive or Committees of the Council to Final Reports of this Forum – Portfolio Holder's Response to Connected Care *(Joint Report of Child and Adult Services and the Portfolio Holder for Adult's and Public Health)*

Councillor Ged Hall, the Portfolio Holder for Adult and Public Health

Services reported that Cabinet on 30 August considered the final report of the Health Scrutiny Forum's investigation into Connected Care. Subject to some minor amendments, the recommendations and a subsequent action plan were approved by Cabinet. A copy of the action plan was submitted for Members information. The Chair welcomed the report and indicated that this forum would continue to monitor the roll-out of Connected Care in the town.

A Member indicated that concern had been raised by a letter from HVDA (Hartlepool Voluntary Development Agency) as to how the programme was to be procured. Other Members commented that the letter from HVDA had raised concerns in that it alluded to the investigation into Connected Care had not been open to other groups and had not been inclusive. There had been an extensive range of groups included in the investigation and HVDA had also been invited to contribute. There was also an independent report being prepared by the London School of Economics into Connected Care which would be reported to scrutiny. The Assistant Director, Adult Social Care indicated that an independent report conducted by Durham University in Connected Care was also already available in the Members Library.

Recommended

That the Portfolio Holder be thanked for his report.

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

No items.

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

No items.

34. Scrutiny Investigation into Cancer Awareness and Early Diagnosis - Evidence from Member of Parliament for Hartlepool and the Portfolio Holder for Adult's and Public Health (*Scrutiny Support Officer*)

The Member of Parliament for Hartlepool, Iain Wright was present at the meeting and thanked the Chair and the forum for the opportunity to make comment on the forum's investigation into Cancer Awareness and Early Diagnosis. The MP commented that there had been real improvements in health in Hartlepool over recent years but the gap was still widening with the rest of the country; improvements are better elsewhere. This was, however, no criticism of the agencies involved. The treatment people received was fast and effective. The real problem was that people didn't present early enough for diagnosis. This is a particular problem with men. There is a need to encourage and incentivise people to come forward and attend their GP. People were generally aware of the symptoms of cancer

but don't want to know. People do still think of a cancer diagnosis as a death notice but treatment early is shown to have very high success rates.

The MP did feel that more effective screening was required targeting groups such as smokers. Greater partnership was needed, particularly in a small town like Hartlepool, to involve every area of civic life. What is the council doing to encourage staff to be checked for example. In tackling the issue of men being reluctant to attend their GP; what are we doing to go to the places that they go – football grounds etc.

There were still also issues in encouraging women to seek diagnosis; One tactic that had been effective in other parts of the country had been taking health messages into hairdressers.

In a time when finances were getting worse it would be a disgrace if we moved away from prevention and early diagnosis to fire fighting the disease. This would be a false economy at every single level. All the evidence suggested that if people presented early then there were good outcomes. If people presented early rather than waiting until there care became an emergency there was the potential to save £113m annually.

The MP commented that there was a socio-economic link with cancer in this area. By working together we could bring down those rates.

The Portfolio Holder for Adult and Health Services commented that the MP's comments did lay a challenge down to the local authority. The Council's role was already much wider than many understood and that was to grow through the new health and wellbeing agenda.

Hartlepool was at the top of the scale for a wide range of issues under the health improvement agenda. The challenge was how do we do without coming across as patronising. One example was the campaign of the British Heart Foundation where £100k of funding was targeting school children on the messages of healthy lifestyles. It was hoped that through convincing children these messages may then fed through the family.

Maybe a similar approach to cancer awareness may be helpful. The main problem was people not presenting early enough. If we do get message out on healthy lifestyle, cancer, obesity, smoking etc. the health improvement statistics would still take a long time to show improvement. One of the reasons our cancer statistics were not good was the reflection of those with cancers caused by the heavy industry of the past.

The Portfolio Holder indicated that the authority was committed to taking this forward and had established the Shadow Health and Wellbeing Board earlier than required to coordinate this agenda with partners.

The Chair thanked Iain Wright MP and the Portfolio Holder for their comments. The Chair then opened the meeting for debate by Members when the following points were discussed: -

- Many former South Yorkshire miners were being diagnosed with cancers caused not just by inhaling coal dust but also from ingesting it. These stomach and bowel cancers were often not connected to the mining industry.
- Iain Wright MP commented that in Doncaster they had had great success in getting people to attend earlier screening. They had noted that men in their 60's were most often presenting with cancer so decided to screen men in their 50's through GP surgeries. If this could be achieved there it could be done here. There were already many statistical markers used to identify those at greatest risk and they should be used much more. Cancer was not the death sentence it used to be or that people still believe it is.
- Breast cancer screening for women in the town was undertaken in a mobile screening unit; could this unit not go out into the estates to screen women closer to their own GP and homes. Health representatives commented that while the units were mobile, they did require several services from the locations they were stationed at. The mobility was bringing the screening into Hartlepool rather than having to travel out of town.
- The health inequalities in Hartlepool had existed for a long time, perhaps generations. Health services were starting to become 'switched on' to these but it was necessary to review what had been done as the changes that may have created the greatest impact may actually be relatively small. They needed to be identified and rolled out.
- Smoking cessation services had proved a great success in Hartlepool. Services such as this should be considered as an essential part of health provision, not add on services. Health representatives also needed to be more visible in the community and involved in the groups that residents were involved in and trusted. This would allow health messages to be integrated at a much lower level.
- People presume that the reason Hartlepool had high levels of cancer were due to the nuclear power station. The MP wished to dispel that theory and stated that there was no correlation between the power station and cancer in adults or children; cancer rates in children were actually lower than the national average.
- There was concern expressed at the time people had to wait for diagnosis and then for treatment. There seemed to be problems being caused by cancelled clinics and scans. The MP did feel that the time between diagnosis and treatment needed to be tighter but did feel that in Hartlepool the statistics showed that the period between diagnosis and treatment were very good.
- There was some concern that GP's were often the obstacle for patients in getting early diagnosis and treatment. There was anecdotal evidence that highlighted particular GPs surgeries as a problem in this respect. The Chair was concerned that not all GPs were the same and if people had problems they were perfectly entitled to change their GP.
- The statistical evidence based on wards was particularly reliable as it only revealed where people were living when they were diagnosed.
- Messages for people needed to be simple, clear and targeted at key groups out in the community.
- The number of young women smoking was a growing concern that

needed to be addressed now or there would be a significant problem in ten to twenty years time. The Chair commented that this was an area that would be examined by the forum during its investigation.

The Chair thanked Iain Wright MP and Councillor Ged Hall, Portfolio Holder for Adults and Public Health for their contribution to the investigation.

Recommended

That the comments of Iain Wright MP and the Portfolio Holder for Adults and Public Health be noted.

35. Scrutiny Investigation into Cancer Awareness and Early Diagnosis - Setting the Scene (*Scrutiny Support Officer*)

The Assistant Director, Health Improvement, and Dr Victoria Ononeze (Specialty Registrar in Public Health, Tees Public Health) gave a presentation to the Forum on cancer in Hartlepool. Dr Ononeze had been asked by Professor Peter Kelly, the Executive Director of Public Health, to look into producing a report that provided an overview bringing together some of the available data on cancer and aspects of cancer services in Hartlepool. The report focussed on cases of and deaths from cancer over a 24 year period – 1985-2008.

In the presentation Dr Ononeze highlighted that the numbers of cases involved were very low in some instances which made interpretation very difficult at ward or GP surgery level. Therefore, any statistics that included less than five cases could not be shown in the tables displayed at the meeting. All the data had been drawn from reliable sources but like any data there may be issues about completeness and accuracy.

Dr Ononeze also stressed that apart from lung cancer where 90% of all cases were caused by smoking, many cancers had multiple risk factors and complex relationships between these factors e.g. breast cancer is often higher in more affluent areas.

In the presentation Dr Ononeze went on to highlight –

- Cancer accounted for about 37% of the shorter life expectancy between Hartlepool and England in both men and women in 2006-08. Lung cancer was the largest contributor and reducing this was critical to reducing health inequalities.
- Hartlepool average of all cancers increased 17%, from 374 per 100,000 population in 1985 to 436 per 100,000 population in 2008 (reflected in the rising new cases of all cancers from 376 in 1985 to 505 in 2008). Higher than the NorthEast and England averages of 12% & 15%
- Key message was the higher increase of 22% in women (higher than England average of 19%) whilst rate is decreasing in men.
- Numbers of cases were small – a few more or less cases each year could make a significant difference in rates. For this reason rates do

not follow the usual trend of less cancers in less deprived areas e.g. Elwick and Seaton Wards. Other factors needed to be taken into account such as – age structure, beliefs and awareness and uptake of screening (usually higher in more affluent areas and therefore more cancers may be detected).

- Lung cancer rates were decreasing in general but increasing in women. There was a 25% decrease in the overall Hartlepool rate from 96 per 100,000 population in 1985 to 77 per 100,000 population in 2008 (slightly higher than the decrease in the NE & England averages). There was a higher decrease in men, 43% but a 5% increase in rates in women (from 55 to 58 per 100,000 population).
- Bowel cancer rates almost doubled in Hartlepool from 33 to 56 per 100,000 pop (over 5 times higher than the North East average and 10 times the England average). There was an even higher increase in men 78%, from 41 to 73 per 100,000, though a lower increase in women 56%, from 25 to 39 per 100,000.
- New cases of breast cancer in Hartlepool increased from 39 cases in 1985 to 71 cases in 2008. This may be due to a number of factors – obesity, stress, and more cancers being detected through screening programmes.
- Breast cancer survival rates had increased. 1-year survival rates improved 4% from 91% in 1985/89 to 95% in 2003/07 (though still lower than North East and England averages of 8%). 5-year survival rates increased by 22% (less than North East average of 26% and more than England average of 17%).
- Higher 1-year survival rates usually translate to higher 5-year survival rates. This highlighted the importance of early diagnosis and programmes to increase that - NAEDI and screening.
- Childhood (0-14 years) cancer rates – there was a fluctuating incidence rate that gave no clear trends and the pattern was similar across Teesside and the North East. It also had to be noted that the numbers were very small. This was also the case with Childhood Cancer mortality.
- In terms of the stage at which cancers were diagnosed – 9% of bowel cancers diagnosed at Stage 1 (North East average, 10%)
  34% of breast cancer diagnosed at Stage 1(North East average 38%)
  59% of cervical cancer diagnosed at Stage 1 (North East average 62%)
  Virtually no skin cancer was diagnosed at Stage 1.
- The emergency diagnosis of cancers were higher in Hartlepool (30.7%) than the national average (23.7%). Such cancers were more likely to be advanced. The reasons for the 'accidental' diagnosis could be simply a lack of awareness of symptoms, fear and denial. This highlighted the importance of improving awareness and encouraging people to present earlier at their GP.
- Breast screening uptake was under the 80% national target though uptake was generally falling nationally but still lower in Hartlepool.
- There was a progressive decline nationally in the uptake of cervical screening and in Hartlepool it was very low. There had been an increase in 2008/09 and 2009/10 due to the 'Jade Goody effect' which

showed the importance of raising awareness and the power of the media. GPs were central to improving screening uptake as they carry out most of the smear tests.

- Bowel screening uptake in Hartlepool was lagging behind the North East average.
- The priorities for action were -
  Cancer prevention - reducing the individual and community risk of cancer from smoking, diet, obesity, etc.,
  Awareness and early detection of cancers was vital, especially in women,
  Improving the uptake of NHS cancer screening programmes,
  Ensuring that cancer prevention is firmly on the Clinical Commissioning Group and Health and Wellbeing agenda.
- Whilst the environment could be an important factor in cancer – the link between the two is not always easy to prove. The previous report on environmental dust in the Headland area found no increased risk when comparing the St Hilda Ward and Hartlepool in general. NEADI were making good progress in Hartlepool; this was reflected in increased awareness measured through CAM.
- Increasing the uptake of screening important work – some analysis was being performed at ward level to help with a targeted approach. GPs remained central to cancer prevention in raising awareness, early detection and improving the uptake of screening.

Madeleine Johnson (Consultant in Public Health, NHS Tees) and Laura McGuinness (Project Manager – NAEDI Cancer Awareness Project, NHS Tees) were also present and went onto highlight the screening programmes that were in place for detecting cancer. The national programmes for breast, cervical and bowel screening had been established under very strict conditions. There was currently no effective test for prostate cancer as the tests that were currently utilised would show a large number of positives that would never actually develop into cancer.

Breast screening take up was lower in Hartlepool than the national average which was a concern, though expected in areas of higher deprivation. Women received their first invitation for screening between the ages of 50 and 53. Screening would be moving towards inviting women form the age of 47 onwards due to the new digital screening equipment. In response to previous comments on the mobile unit, Dr Johnson indicated that experience proved that the units worked best when located with GP surgeries.

Cervical cancer screening uptake was again lower in Hartlepool, though there had been an increase recently due to the 'Jane Goody effect'. Bowel Cancer screening also had a lower take up than national averages and men tended to lag 5 to 10% behind in screening take up.

While screening did deliver positives, the best thing people could do were to make some minor lifestyle changes. Stopping smoking, reducing obesity, were the two main benefits to health. The screening programme would be a key priority for the new Health and Wellbeing Board.

Members commented that many peoples experience depended on their GP and there were many with experience of GPs not responding well to people who were concerned with their health. There were also still concerns relating to the environment and many still believe that Professor Kelly was wrong on the Headland Dust issue. Comment was also made on the age groups around cancer screening and why they weren't wider; was this some sort of age discrimination.

It was acknowledged that when dealing with cancer the NHS did need to look at each element of the pathway to make sure they worked slickly to get the best out of the service. Some of the stories 'we' get were when some of the things don't work well. GP's are self-employed and the Trust and PCT did work closely with them but they are not under 'our' control.

Dr Johnson commented that the NHS had looked at screening closely and there were different age ranges for screening different cancers for good reasons. The breast screening age range had been extended as women now live longer. Bowel cancer screening had been targeted at 60-69 year olds, now it was 60-74 year olds. Essentially if people were going to develop a rectal cancer we will know by the time you were 74 that you had had the signs in advance of that.

Members questioned what work was being done on the increase in diabetes and pancreatic cancer. It was also indicated that should an initial test prove positive, could not all patients be given a full body scan to ensure that was the only site in their body with cancer. Dr Johnson commented that consultants would make decisions based on the individual patient. The main point behind the screening programmes was to address those people who considered they had nothing wrong.

On the issue of age ranges for screening following further questions, Dr Johnson commented that the age ranges were based on statistical information relating to the likely incidence of the cancer. For bowel cancer, the incidences were higher in the over 60's. The uptake on this screening was lower than would be expected probably due to the fact that people had to request the testing kit.

The Chair commented that he was particularly concerned with the apparently growing numbers of young women in particular that were smoking. Unless this was reduced dramatically, there were long-term issues to be faced. Laura McGuinness commented that a lot of work had been done on smoking reduction. Schools and colleges were targeted through campaigns and one of the main ways of reaching young women in particular was to focus not on health but the impact on their skin and teeth etc. They did seem to respond to aesthetics more than the health messages.

The Chair thanked everyone in attendance for their contribution to the very useful debate. The Chair thanked the health representatives for their input and very useful and detailed information. It was suggested that the

information from the debate should be shared with the MP.

Recommended

That the issues raised in the debate be noted.

36. North Tees and Hartlepool NHS Foundation Trust - Governors (*Scrutiny Support Officer*)

The Scrutiny Support Officer submitted a report setting out information on the Governors of North Tees and Hartlepool NHS Foundation Trust as requested at the meeting of the Forum held on 8 September 2011.

The Trust had provided the information which Members may find useful in answering questions raised at the meeting of 8 September 2011 and this included the following which were submitted as appendices to the report:-

(i) An extract 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 setting out the role of the Governor; code of conduct for Governors; and the Committees / Groups that the Governor could be a member of.
(iii) Anthem Magazine Issue 24 August / September 11 which incorporated the 'Keeping iNToucH' publication and was distributed to all members of NTHFT and was a valuable link to the work that Governors do, an extract from the current issue was submitted highlighting the work of Governors at NTHFT.

Some Members complained that some of the appendices had been poorly reproduced and the Scrutiny Support Officer indicated that they would be re-circulated to Members.

It was highlighted that while the meetings of the Trust were very useful, the Board of Governors could not influence the decisions of the executive Board. Their choice of venue could also make it difficult for everyone to attend. The Chair indicated that he would take this point up with the Trust.

Recommended

That the report be noted and that those appendices that had been poorly reproduced be re-circulated to Members.

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

The Scrutiny Support Officer reported that at the meeting of the 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. During the

presentation by the Director of Nursing and Patient Safety a number of suggested priorities were put forward by NTHFT.

Members had debated the suggested items to be included in NTHFT's Quality Account 2012/13 and items identified by Members were:-

(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.

Members agreed at the meeting on 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.

The Forum confirmed the three issues set out above as the items they would wish to recommend to the Trust be included in the 2012/13 Quality Account.

Recommended

That the three key priorities as set out above be forwarded for consideration in North Tees and Hartlepool NHS Foundation Trust's Quality Account 2012/13.

38. Health Scrutiny Roadshows - Scoping Report (*Scrutiny Support Officer*)

The Scrutiny Support Officer reported on proposals for the forthcoming Health Scrutiny Roadshows.

The following Terms of Reference for the Roadshows were 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.

The proposed timetable for the roadshows, which included meetings in the north centre and south of the town, were set out in the report and were scheduled for late November, early December and would involve Healthcare Professionals from NHS Tees, Local GPs and North Tees and Hartlepool NHS Foundation Trust to be present along with Health Scrutiny Forum Members.

The timetable had not yet been finalised and the Trust had indicated that

they considered that they would be dependent on the decision of the Secretary of State on the new hospital. The Chair indicated that he was hoping to hold the roadshows in late November but if that was not achievable, he did consider that they may need to be delayed until January.

Recommended

That the remit of the Scrutiny investigation as detailed be approved and that the timetable for the roadshows be noted.

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

The Scrutiny Support Officer submitted a report for Members to consider whether any item within the Executive's Forward Plan should be considered by this Forum. Details of the key decisions contained within the Executive's Forward Plan (October 2011 – January 2012) relating to the Health Scrutiny Forum were submitted within the report.

The Portfolio Holder for Adults and Public Health commented that there had been very little time to look in any detail at the Early Intervention Strategy last year due to the delay in the government announcement relating to the grant. The Portfolio Holder considered that as there was sufficient time to allow for scrutiny input into the executive decision on the strategy this year and any comments would be welcomed.

The Chair indicated that it may be useful to hold a joint meeting with the Children's Services Scrutiny Forum on this issue, though the meeting would need to be arranged promptly to meet the executive's timetable.

Recommended

That a joint meeting with the Children's Services Scrutiny Forum be held to discuss the Early Intervention Strategy and to forward any appropriate comments to Cabinet.

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

No items.

41. Regional Health Scrutiny Update

No items.

The meeting concluded at 12.40 p.m.

CHAIR

HEALTH SCRUTINY FORUM

17 November 2011

Report of: Scrutiny Support Officer

Subject: "OUR £40M CHALLENGE" – COVERING REPORT

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1. PURPOSE OF REPORT

1.1 To inform Members that the a representative from North Tees and Hartlepool NHS Foundation Trust has been invited to attend this meeting to provide outline details of the financial challenges facing North Tees and Hartlepool NHS Foundation Trust.

2. BACKGROUND INFORMATION

2.1 On 31 October 2011 a letter was sent by the Chief Executive of North Tees and Hartlepool NHS Foundation Trust to the Chair of the Health Scrutiny Forum detailing the financial challenges facing North Tees and Hartlepool NHS Foundation Trust (attached as **Appendix A**) under the banner of "Our £40m Challenge".

2.2 Subsequently a representative from North Tees and Hartlepool NHS Foundation Trust has agreed to attend today's meeting to discuss outline communication plans for the three year strategy to save £40m.

3. RECOMMENDATION

3.1 It is recommended that the Members of the Health Scrutiny Forum consider the verbal presentation of a representative from North Tees and Hartlepool NHS Foundation Trust 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

No background paper(s) were used in the preparation of this report.

North Tees and Hartlepool NHS
NHS Foundation Trust

University Hospital of North Tees
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Stockton on Tees
TS19 8PE

Telephone: 01642 617617
Fax: 01642 624089
www.nth.nhs.uk

31 October 2011

To
Members of Parliament
Local Authority Chief Executives
Local Authority Press Offices
Health Overview and Scrutiny Committee Chairs

Our £40m challenge

I wanted to write and tell you about the financial challenges facing North Tees and Hartlepool NHS Foundation Trust.

Since becoming chief executive in 2008 I have worked hard, along with all our staff, to ensure we stay in financial balance and we do not compromise performance or quality in doing so. I am very proud of the fact we have actually improved our performance and quality in the interests of patients *and* still achieved our financial targets.

However we now need to save some £40m over the next three years. Largely this has come about because of the wider economic situation and changes in government policy which aims to invest more money in the preventative and early intervention part of the health service.

This is the most difficult financial position we have ever faced and it will mean difficult and in all likelihood unpopular decisions will have to be made to keep the trust afloat.

Tomorrow (1 November), we are planning to announce *our £40m challenge.* This will be the umbrella term we use for the range of clinical and non-clinical areas where savings can be made or income generated.

I am determined we keep patient safety, quality and performance at the top of our agenda as we go through this difficult period. If you would like any more information about *our £40m challenge* please contact me on 01642 624060.

Yours faithfully

Alan Foster
Chief Executive

HEALTH SCRUTINY FORUM

17 November 2011

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Support Officer

Subject: CANCER SCREENING – COVERING REPORT

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1. PURPOSE OF REPORT

1.1 To inform Members that the Assistant Director for Health Improvement and the Clinical Director of Public Health, NHS Tees have been invited to attend this meeting to provide detailed evidence around Cancer Screening 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 Clinical Director of Public Health, NHS Tees have agreed to attend this meeting to provide a detailed presentation Cancer Screening.

2.3 Members may find the investigation undertaken by the Tees Valley Health Scrutiny Joint Committee into 'Cancer Screening Across the Tees Valley', carried out during the 2009-10 Municipal Year (attached as **Appendix A**), a useful comparative baseline.

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 Clinical Director of 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.

AGENDA ITEM:

TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE

JANUARY 2010

CANCER SCREENING ACROSS THE TEES VALLEY

FINAL REPORT

PURPOSE OF THE REPORT

1. To present the Joint Scrutiny Committee's Final Report in relation to Cancer Screening.

CONSIDERATION OF REPORT

2. The Tees Valley Health Scrutiny Joint Committee has considered Cancer Screening Services across the Tees Valley. It has received evidence on the provision of Cancer Screening Services in relation three types of cancer, which are screened for. They are Breast Cancer, Cervical Cancer and Bowel Cancer.

3. In discussion on the issues presented, Members felt it would be useful to have a report that distilled the evidence it has received in relation to Cancer Screening Services. Particularly, a comparison of what happens across the four Tees PCTs and what happens within the area of Darlington PCT was considered to be beneficial.

4. To that end, this report has been prepared by the Joint Scrutiny Committee. The text is divided into the type of Cancer Screening and then into the area.

5. Breast Cancer Screening

Tees PCTs

5.1 In respect of Breast Cancer Screening, Members were advised that it is a free screening programme, aimed at all women 50-70, who are registered with a GP. A screening appointment, which is called a mammogram, takes place every three years, with a guaranteed 7 episodes of screening between 50 and 70 years. Women over 71 can request screenings if they wish. It was confirmed that there are special facilities in place to ensure disabled women, who may be wheelchair users for instance, have equity of access.

5.2 It was confirmed to Members that the North Tees & Hartlepool NHS Foundation Trust provides the service on a Tees wide basis, with locations around the Tees area. Mammography equipment is very costly and also quite large in size, for this reason it is provided in less locations. Members heard that the service is based at One Life in Middlesbrough, in Hartlepool there is a mobile unit based at Hartlepool Health Centre, Redcar & Cleveland has facilities in Redcar & Guisborough, and all women in the Stockton area go to University Hospital of North Tees.

5.3 Members heard that invitations are sent with an appointment already booked. If women do not attend, they get a reminder letter asking them to contact the service and make an appointment, as for the service to have two unused appointments would be too costly.

5.4 Again, it was confirmed to the Joint Scrutiny Committee that if all was normal in tests, people are put back into the recall list. If abnormalities are identified, women are invited to an assessment centre at University Hospital of North Tees.

5.5 It was reported that the average take up rate around the Tees PCTs region is between 76% to 80%.

Darlington PCT

5.6 The Joint Scrutiny Committee were advised that the incidence of breast cancer across England and Wales has increased persistently since 1993, while the mortality rate from breast cancer has decreased. There has been no consistent pattern for breast cancer incidence rates in Darlington. Members heard that between 2003 and 2005, the local breast cancer incidence rate was not significantly different from regional and national rates. Members were advised that local mortality rates for breast cancer were not significantly different from regional or national rates either, and the mortality rates for all areas continue to decline.

5.7 The Joint Scrutiny Committee was interested to learn that Breast Screening takes place from a mobile unit parked in the car park of Darlington Memorial Hospital. This when operational operates from 9.30 to 4.00

5.8 The coverage of breast screening is generally higher in Darlington than coverage across England, although there was particularly low coverage in 2005.

% of eligible women aged 53 to 64 screened for breast cancer within 3 years of their last test

	2002-03	2003-04	2004-05	2005-06	2006-7	2007-8	2008-9
Hartlepool	56.4	76.1	54.8	69.6	76.8	77.6	78.2
Middlesbrough	75.8	46.1	69.1	70	73.8	73	73.1
Redcar & Cleveland	77.9	68.5	80.5	78.6	81	78.4	77.6
Stockton on Tees	64.7	71.2	80.1	82	79.4	78.7	78.5
Darlington	79.1	76.3	58.4	77.8	78.1	77.8	78
North East	77	73.6	76	78.2	79.4	79.5	79.5
England	75.3	74.9	75.5	75.9	76	76.7	77

6. Cervical Cancer Screening

Tees PCTs

6.1 The Joint Scrutiny Committee heard that all women aged 25 to 49, who are registered with a GP, are eligible for a free cervical screening test and are invited on a three yearly basis. Women aged between 50 and 64 years are invited every five years.

6.2 The Joint Scrutiny Committee was advised that to co-ordinate the process, there is a North East Central call and recall process, which sends out letters of invitation to a screening appointment. The invitation includes a factsheet about the test and its importance. The letter invites women to make their own appointment at a choice of clinics. The Joint Scrutiny Committee heard that there are around 30 clinics across the Tees PCTs area that offer the service and there are 13 that offer 6pm to 8.30pm evening appointments.. There are also some clinics that offer Saturday morning appointments. All GP surgeries also offer cervical screening.

6.3 Members heard that women are asked to make their own appointments (rather than being contacted with an appointment), as they are more likely to attend something which they have booked and is, by definition, convenient for them to attend.

6.4 Tests are analysed at hospital laboratories and the results are sent out to people by post. It presently takes 2-4 weeks in South of Tees for

women to get their results and 4-6 in North of Tees. If results are normal, women are placed back into the recall list to be called at the appropriate time for the next test. If the tests show some abnormalities, women are invited to a colposcopy clinic for further examination.

6.5 It was noted in discussion that rates of women taking up the test have fallen recently, particularly young women.

% of eligible women aged 25 to 64 screened for cervical cancer within 5 years of their last test

	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09
Hartlepool	80.8	80.2	79.3	77.8	76.9	75.9	76.8
Middlesbrough	79.7	79.3	78.2	77.3	76.2	74.6	75
Redcar & Cleveland	82.6	82.3	81.8	80.9	80.7	80	80.1
Stockton on Tees	81.6	81.1	80.7	79.5	80	79.4	79.5
Darlington	83.6	82.6	81.8	80.7	79.3	80.2	81.3
North East	82.6	82.1	81.7	80.9	80.2	80	80.5
England	81.2	80.6	80.3	79.5	79.2	78.6	78.9

Darlington PCT

6.6 Members heard that around five women in Darlington get cervical cancer every year. Although the incidence rate for Darlington females is slightly higher than regional and national rates, the differences are not statistically significant. Mortality rates for cervical cancer in Darlington are lower than regional and national rates, but again the differences are not statistically significant.

6.7 There was an increase in cervical incidence and mortality rates for Darlington in the late 1990s but both rates have decreased since 1999-2001.

6.8 Cervical Screening takes place in GP practices (now with extended opening hours). In addition, venue other than GP surgeries include Park Place Health Centre, Parkgate (Mondays 5.30 – 7.00)

6.9 The Joint Scrutiny Committee heard that the coverage of the cervical cancer screening service in Darlington has been dropping for some years but increased recently. However it remains higher than both regional and national rates. Cervical screening take-up rates vary in this age group. In the 25-29 age group the rate is only 71.9%. Among 30-35 year old women, the rate is 80.2%. Current waiting time for cervical screening results in Darlington is 3 weeks.

6.10 Members were interested to hear about particular market research commissioned by the PCT, through Newcastle University, specifically

to examine barriers to younger women accessing cervical screening services.

6.11 Reference was also made to a recent pilot scheme providing additional screening opportunities at Darlington Out Of Hours Centre on late Tuesdays and Saturday mornings until 1pm which was currently being evaluated.

7. Bowel Cancer Screening

Tees PCTs

7.1 The Joint Scrutiny Committee was briefed about the fairly recently introduced Bowel Screening Service. Members were advised that it is a free screening programme, where all men and women, registered with a GP, aged 60-69 years are invited to take part. Those people will receive an invite every two years. People over 70 can request to be screened.

7.2 Members were advised that self-testing kits are sent out from a regional hub (in Gateshead) and those returned are also tested at the hub in Gateshead. If those results highlight a need for further investigation, individuals are invited to University Hospital of North Tees for assessment and possible colonoscopy.

Darlington PCT

7.3 Members heard that Colorectal cancer incidence and mortality rates for males and females in Darlington are not significantly different from regional and national rates. The incidence and mortality rates for colorectal cancer are higher among men than women. Colorectal cancer incidence and mortality rates for Darlington males have decreased since 1997-1999 but the rates for Darlington females have increased steadily since 2001-2003.

7.4 Members heard that Darlington is part of the same, newly introduced screening programme, with take-up rates nationally relatively low at present. As Members had heard previously, It is organised on a hub basis, which covers a large area of North East, Yorkshire and the Humber. The Joint Scrutiny Committee heard that Darlington's rate at 55% is slightly higher than the hub average and compares favourably with local PCT areas.

Bowel Cancer Screening take-up rates as of 1 December 2008

PCT	Percentage Take-up
Darlington	**55%**
Hartlepool	49%
North Tees	54%
Middlesbrough	47%
Redcar & Cleveland	54%
County Durham	54%
Hub Average	**54%**

7.5 The point was made to Members that on this topic, data capture is in its infancy and over time the PCT will get a clearer picture. Members were heard that this is a particularly challenging area and the PCT is investing in the promotion of these services through a range of social marketing initiatives.

Consideration of the Information provided

8. Following the receipt of information pertaining to Cancer Screening Services across Tees and Darlington, the Joint Scrutiny Committee debated a number of points it had heard.

9. The Joint Scrutiny Committee was interested to hear more about take-up rates. It was said that in respect of Cervical Cancer Screening, take-up in Middlesbrough & Hartlepool is around 76% - 77% of the eligible population, whereas in Stockton & Redcar & Cleveland, it is sat around the early 80s as a percentage.

10. It was also noted that Bowel Cancer Screening take-up is presently around 47% – 55%, which may be a cause for concern, although it was felt that this may also be due, in part, to the test being a fairly recent introduction.

11. In so far as Tees is concerned, The Joint Scrutiny Committee made enquiries as to take-up amongst ethnic minorities. Members were advised that the BME community is not monitored as such, as its forms a very small part of the population and is very difficult to monitor.

12. There was discussion round the eligibility age of cervical screening and particularly the fact that it has risen from 20 to 25 years. The Joint Scrutiny Committee acknowledged that there has been a great deal of national publicity around this topic. Members were advised that the increase from 20 years to 25 years had been based on the best available evidence around biological factors. It was felt that in the early 20's, the cervix goes through a lot of changes and routine testing may show up significant abnormalities that may actually be false positives and result in procedures that could do more harm than good.

13. Nonetheless, it was emphasised that if women had any concerns, or particular family histories, they should always and promptly seek the advice of their GP.

14. In this respect, it was noted that the attendance rate for cervical screening amongst the 25 years to 35 years group is around 60% to 70% in Tees, with slightly better results in Darlington. The Joint Scrutiny Committee heard that such take up had fallen around 10% in recent years, which is very much a national trend. A point of interest to Members was that screening rates are lower in Middlesbrough and Hartlepool, than other areas in the Tees Valley, with rates of cervical cancer in Middlesbrough being significantly above the national average.

15. On a different note, It was noted that even in the best performing areas around the Tees Valley, around 20% - 30% of women are not regularly attending their breast screening opportunities, despite the fact that around 99% of the Tees population are registered with General Practice.

16. In an effort to improve matters, the Joint Scrutiny Committee was told that awareness programmes are often provided in GP surgeries. Further, GP's software alerts the Doctor to available screening opportunities when dealing with a particular patient during a consultation.

17. Whilst this was felt to be positive, it was noted that a lot of reminders and awareness programmes were aimed at people who were already attending General Practice and were probably not, on average, the people who were in the most need of this advice. It is the people not engaging with services on a regular basis that are of most concern and most likely to not attend screening services.

18. Members were interested in whether there were any wider socio-economic factors at play in taking up screening services. Whilst it was acknowledged that the topic was incredibly complex, there was a feeling that people from higher socio-economic groups were more likely to take advantage of screening opportunities, who are already fairly well educated on related health matters. The Joint Scrutiny Committee noted that it seemed to be people lower down the socio-economic scale that were less likely to attend screening opportunities.

19. Members were also interested to hear that professional thought would seem to indicate that there would be tests for other kinds of cancer in the near future. Members were advised that there is a great deal of research being undertaken on a national basis on the topic of prostate cancer and a viable and reliable screening tool was being investigated. Whilst it was acknowledged as a matter of conjecture, it was felt possible that a good enough screening tool could be in operation on around 10 years time. Members were also appraised of a research

project around Ovarian Cancer, which was being run at James Cook University Hospital.

20. Members were also reminded of the HPV vaccine aimed at preventing future cervical cancer cases. It was noted that the current Year 8 female pupils were the first to receive the vaccine, although there was also a catch up programme in place for girls from 13 to 17.

21. Members noted that the Cancer Screening Service has a number of national standard and procedures to follow. Nonetheless, the Joint Scrutiny Committee was conscious that significant parts of Tees have lower life expectancy than the national average and local services should be doing some work proactively to suit the local need.

22. The Joint Scrutiny Committee noted that a significant element of the success, or not, of the Cancer Screening Programmes depend on the role of the GP, as gatekeepers of the entire system. Whilst, the Joint Scrutiny Committee could see the merit of using GP lists as a first point of contact, the Joint Scrutiny Committee is interested to hear as to whether some screening opportunities could be offered on a drop in basis, to complement people's other commitments.

23. The topic of access was something that Members were particularly interested in. It was noted that cervical screening is often offered on evening appointments and on Saturday mornings, presumably to take account of the fact that the target group are of a working age, may have children, other family commitments and generally busy lives.

24. The Joint Scrutiny Committee was interested to compare this, with opening hours for Breast Screening. According to the evidence received by the Joint Scrutiny Committee, opening hours for Mammography seem to be very much more along the lines of office hours.

25. Whilst the Joint Scrutiny Committee fully understands that Mammography services cannot be offered in the multitude of locations that cervical screening is, due to the size and cost of the machinery involved, it does not quite understand the reasons for the difference in opening hours. The Joint Scrutiny Committee has noted that from 2012, the starting age for regular Breast Screening will be lowered to 47 years, which is also very much a working age where women could have careers and/or family commitments, with equally busy lives.

26. In short, the Joint Scrutiny Committee does not understand the reason for the differences in opening times for cervical and breast screening, when one considers that both services are aiming at a cohort where a large proportion will be employed women.

27. The Joint Scrutiny Committee was interested to learn about what the local NHS was doing to encourage people to attend screening

opportunities and learn about the importance of taking these opportunities, aside from an invitation to screening, once a certain age is reached.

28. It was mentioned that the local NHS is keen to get into large workplaces to educate people and perhaps even offer screening services with the employers' permission. Whilst there are rigorous checks on standards of care and advice in GPs, it was noted that rates for cervical cancer screening are features of the GP's Quality Outcomes Framework (QOF), bowel and breast screening rates are not.

29. In addition, the Joint Scrutiny Committee heard that the Tees PCTs & Darlington PCT are engaging in social market research to ascertain reasons for some people's non engagement with the service and what may make such services more attractive to people. The Joint Scrutiny Committee expressed a strong interest in hearing about the outcome of such work.

30. The Joint Scrutiny Committee commented that it would be keen to see the local NHS tapping into existing community networks, particularly BME groups and community groups, to publicise the importance of screening and the availability of such opportunities.

31. The Joint Scrutiny Committee heard that overall, the local NHS felt that across Tees, cancer screening quality is very good, with a good range of accessibility. Nonetheless, it was felt that good accessibility and good range of choice is of huge benefit and should be enhanced. Ultimately, anything that urges the public to take up their screening opportunities should be welcomed.

32. The Joint Scrutiny Committee was interested to learn that Darlington PCT, in an endeavour to increase take-up rates, has appointed a social marketing manager. One aspect of the work of the social marketing manager would be to investigate and try and understand better the local reasons for low take-up within particular communities, in order to overcome barriers and more appropriately market the service.

33. In addition, Members were interested to learn that the PCT was planning a comprehensive cancer information initiative to increase awareness and early diagnosis. Such work involved the compilation of baseline data on current levels of cancer and cancer screening awareness, through Darlington being an early adopter site for the new nationally accredited cancer awareness management tool.

Key Information gathered from the Cancer Research UK documents

34. The Joint Scrutiny Committee has also consulted Cancer Research UK to hear their views on a number of key themes connected to Cancer Screening Services.

35. A report by Cancer Research UK, prepared for the Joint Scrutiny Committee, indicates that the risk of being diagnosed with certain cancers was greater among the most deprived families and communities. At the same time, although survival rates for most types of cancer had been improving since the 1970's, the survival gap between the most and least affluent has been increasing, as those at the top are most able to take advantage of improvements.

36. In terms of extending screening services to other cancers, the Joint Scrutiny Committee was advised that whilst they supported certain screening trials they confirmed that until there was evidence of the efficacy of such tests no new programmes should be initiated at a national level.

37. The report outlined campaigns undertaken by Cancer Research UK and PCTs to increase the take-up of cancer screening services. In 2007, Cancer Research UK and partner charities launched 'Screening Matters' a nation-wide campaign aimed to get three million more people into cancer screening. The campaign resulted in more than 100,000 people signing a pledge supporting the campaign and committed to attending cancer screening when invited.

38. Members read with interest that in early 2008, over 9,000 of Cancer Research UK campaigners had written to their MPs asking them to contact their PCTs (total 155) for details about the cancer screening programme in their area. Details were provided of reports from Cancer Research UK, which included a summary of the responses received, which outlined the diverse range of current or future initiatives to increase screening update. Examples were provided of good practice, which included: -

- the use of equity audits and related research to understand the needs of the local population and identify barriers to take-up of screening services;
- the development and dissemination of tailored information for particular communities and groups;
- working with diverse organisations and groups;
- working with communities;
- improving the delivery of cancer screening services.

39. The Joint Scrutiny Committee was advised that in order to make services more accessible Cancer Research UK considered that information about cancer and screening for the disease should be tailored to meet the needs of the local population. It was suggested that health professionals should receive training in communicating with diverse populations so that they were enabled to impart the importance of attending screening to their patients, especially those with traditionally low take-up.

40. The Quality and Outcomes Framework (QOF) was also seen as a possible effective way of encouraging GPs to promote take-up of screening and record information about the take-up rates of their patients. Such information could be used to develop services, which effectively met the needs of the local population.

41. A number of PCT responses to Cancer Research UK's Screening Matters survey included information about pilots seeking to understand how providing screening services in locations other than GP surgeries and at out-of-hours opening times might influence take-up rates. It was felt that such pilots could be used to develop good practice in the provision of services in the Tees Valley.

42. Since the Joint Scrutiny Committee compiled this report and considered screening take up statistics, new figures are available and are outlined below.

	Breast (Q1 2009 5 year take-up)	**Cervical** (2008/9)	**Bowel** (Feb 2009)
Darlington	80.3	81.3	55.3
Hartlepool	74.3	76.8	48.7
Middlesbrough	75.4	75.0	48.0
Redcar & Cleveland	78.7	80.1	54.5
Stockton on Tees	77.8	79.5	54.1

Conclusions

43. The Joint Scrutiny Committee is of the view that the evidence it has gathered, supports the anecdotal evidence it also heard that there are no major differences for Cancer Screening take up in the Tees Valley, when compared to the national average. There are, however, a small number of areas with noticeably lower take-up.

44. The Cancer Screening services across the Tees Valley have made considerable recent progress in making cancer screening services more accessible and more responsive. The Joint Scrutiny Committee feels that the fact that there are longer opening hours for screening services and Saturday morning openings (in Hartlepool initially) demonstrates this. The Joint Scrutiny Committee is also aware of a

significant reduction in the average 'turnaround time' for cervical test results, which is commendable progress.

45. The Joint Scrutiny Committee is pleased to see the Public Health Directorates across the Tees Valley continuing to make efforts to understand people's feelings towards Cancer Screening. Specifically considering the topic of what exactly would motivate people to attend, or what makes people not attend. The Joint Scrutiny Committee would point to the recent work with local radio stations as an example of that.

46. The Joint Scrutiny Committee notes that areas of Middlesbrough and Hartlepool have consistently low cancer screening take up, when compared with the Tees Valley and national average. This applies across Breast, Bowel and Cervical Screening. This could mean that even more cases of cancer in these areas, are not identified until the disease is further advanced.

47. Whilst late diagnosis may be a particular problem in Middlesbrough and Hartlepool, given the lower screening take up rates, the issue of delayed diagnosis is an area of concern for the Tees Valley that the Joint Scrutiny Committee has heard a great deal about. The Joint Scrutiny Committee notes that Professor Mike Richards, in his 2nd Annual Report on the Cancer Reform Strategy, has highlighted this as an area of national concern, for urgent attention. The Joint Scrutiny Committee has heard that hospital based cancer services in the Tees Valley are of a very high standard, although there is concern over the stage that the cancer has often reached, at time of diagnosis.

48. In order to improve Cancer Screening take up rates, the Joint Scrutiny Committee feels that the local NHS could develop its operations in community development work and targeting particular communities where felt appropriate. The Joint Scrutiny Committee would like to see the local NHS approaching relevant local authorities for assistance in this regard.

49. The stage of diagnosis of cancer has a material impact upon a patient's chances of successful treatment. Tackling the late diagnosis of cancer is two fold. Firstly, more people need to be encouraged to attend cancer-screening opportunities when invited to do so. Secondly more people need to become more 'body aware' when noticing possible symptoms and be more empowered to seek advice at the earliest possible opportunity.

Recommendations

50. That the local NHS develops and publishes a clear and coherent strategy for identifying and assertively targeting communities, which are consistently under-represented in the cohorts of people who attend screening programmes. The local NHS should engage with local authorities and particularly Elected Members, to access their expertise

and assistance about local areas. The Joint Scrutiny Committee would expect local authorities to provide all reasonable assistance in what is very much a shared agenda.

51. That the local NHS expedites the rollout of digital mammography services and provides an update for the Joint Scrutiny Committee on the progress in summer 2010.

52. The local NHS give detailed thought to highly localised awareness campaigns of cancer symptoms, aimed at giving people the knowledge to notice changes in their bodies and the confidence or encouragement to approach General Practice with any concerns. It is suggested that such endeavours be focussed on geographical areas, or specific communities, underrepresented in Cancer Screening services.

53. The Joint Scrutiny Committee would like to see discussions on strategy for better screening take up and symptom awareness, take place at Board level. This would ensure that Non Executive Directors have the opportunity to contribute to strategy and provide challenge to Executive Directors, in what is a crucial area of health improvement for the Tees Valley.

54. The Joint Scrutiny Committee would welcome the opportunity to contribute to the debate about future strategy relating in improving Cancer outcomes for the Tees Valley and would like the opportunity to engage with NHS colleagues at a point where strategy is still being formulated.

BACKGROUND PAPERS

55. Please see the supporting papers to, and minutes of, the Joint Scrutiny Committee meetings of 15 December 2008, 30 January & 23 March 2009 and 17 December 2009.

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HEALTH SCRUTINY FORUM

17 November 2011

Report of: Scrutiny Support Officer

Subject: PANCREATIC CANCER AND DIABETES

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1. PURPOSE OF REPORT

1.1 To provide details of a literature research undertaken by the Specialty Registrar in Public Health at NHS Tees into pancreatic cancer and diabetes.

2. BACKGROUND INFORMATION

2.1 During the Health Scrutiny Forum of 6 October 2011, a question was raised by Members if there was a link between diabetes and pancreatic cancer. Following the meeting detailed literature research was undertaken by the Specialty Registrar in Public Health at NHS Tees, with their findings attached as **Appendix A** to this report.

2.2 Members are asked to note that although the evidence has been contextualised to Hartlepool, it is applicable across the Country.

3. RECOMMENDATION

3.1 It is recommended that the Members of the Health Scrutiny note the content of this report and the evidence collated as **Appendix A** to this report.

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BACKGROUND PAPERS

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

(i) Minutes of the Health Scrutiny Forum held on 6 October 2011.

Pancreatic cancer and diabetes – is there evidence of a link?

1. Purpose

1.1 This briefing has been produced in response to the following question raised by Hartlepool Health Scrutiny Forum:

What is the evidence of the link between pancreatic cancer and diabetes?

1.2 The question was asked in the context of an increase in diabetes locally and nationally, with reference to whether there was a link to a particular 'type' of diabetes.

2. Literature review

2.1 A literature search was carried out to investigate the question – *Appendix I* outlines the search strategy.

2.2 The search focused on meta-analyses of the literature. Meta-analyses are generally regarded as the highest quality of evidence as they combine the results of several studies or trials to obtain an overview of the literature on a particular topic. Despite this, all studies have limitations and these are outlined in *Appendix II*.

3. Context – disease epidemiology and risk factors

3.1 Pancreatic cancer

3.1.1 Pancreatic cancer is the 10th most common type of cancer in the UK and about 8,000 people in the UK get pancreatic cancer each year. Approximately 75% of cases are diagnosed in people aged 65 and over[1].

3.1.2 Pancreatic cancer incidence in Hartlepool (Local Authority area) in 2003-5 was 9.7 per 100,000 population, compared to 9.1 in the North East and 9.3 in England. Incidence has fluctuated between 1993-5 and 2003-5, most likely due to the small numbers of cases[2].*

3.1.3 Pancreatic cancer mortality in Hartlepool in 2003-5 was 9.4 per 100,000 population, compared to 8.4 in the North East and 8.6 in England. Mortality also fluctuated between 1993-5 and 2003-5, again most likely due to the small numbers of cases[2].*

* Pancreatic cancer incidence and mortality rates are directly standardized to the European Standard Population
Cancer E-Atlas data are currently being updated for more recent data than 2003-5.

3.1.4 Cigarette smoking is estimated to cause about 30% of pancreatic cancers[3]. Obesity has also been implicated as an independent risk factor[3, 4]. Little is known about the other main risk factors for the disease[3].

3.2 Diabetes

3.2.1 There is a 'hidden' burden of disease: it is estimated that up to one in 20 people in England has diabetes (diagnosed and undiagnosed). Type II diabetes is the most common form of the disease (90% of those adults with diabetes) [5]. Due to this hidden burden, incidence figures are difficult to obtain and prevalence is the most commonly estimated measure.

3.2.2 The estimated diabetes prevalence for Hartlepool was 7.6% (95 % confidence intervals 5.5% - 10.8%) based on 2009 data (PCT area). This is compared to a prevalence of 7.5% (5.3% - 10.5%) for the North East and 7.3% (5.3-10.7) for England. The prevalence is based on PCT areas and adjusted for age, sex and ethnicity, deprivation and projected trends in obesity[6].

3.2.3 Though some people may die of complications from diabetes itself, the greater mortality burden is from other conditions caused by diabetes e.g. cardiovascular disease which is the leading cause of mortality in England[7].

3.2.4 Type II diabetes usually appears in middle-aged or older people, though is more frequently being diagnosed in younger overweight people and younger Black and South Asian people. Risk factors include genetic factors, ethnicity, obesity and lifestyle factors associated with deprivation[5].

4. Is there a link between pancreatic cancer and diabetes?

4.1 In considering this issue, it is important to distinguish between 'association' and 'causation'. An observed statistical *association* between diabetes and pancreatic cancer does not mean we can infer that one is *caused* by the other. This is because an apparent association may be due to bias in the results, pure chance or the influence of other 'confounding' factors[8].

4.2 Is pancreatic cancer a risk for diabetes?

4.2.1 There is good evidence that pancreatic cancer is causally linked to diabetes onset[9] and is possibly associated with an abnormality of islet cell function. Islet cells are pancreatic cells which control the release of insulin. People with diabetes have a shortage of insulin, which regulates blood glucose levels.

4.3 Is diabetes a risk factor for pancreatic cancer?

4.3.1 *Appendix II* summarises the results of the literature search relating to this question. In summary:

* Pancreatic cancer incidence and mortality rates are directly standardized to the European Standard Population

Cancer E-Atlas data are currently being updated for more recent data than 2003-5.

4.3.2 There is insufficient evidence to state that diabetes causes pancreatic cancer.

4.3.3 There is some evidence to suggest there may be an increased risk of having pancreatic cancer if an individual has chronic diabetes. However this must be taken in the context of evidence for other risk factors.

4.3.4 Evidence suggests that obesity is a risk factor for both diabetes and for pancreatic cancer. Therefore an individual could have both conditions, each independently caused by another risk factor such as obesity. Other risk factors such as smoking may also influence disease causation.

4.3.5 Pancreatic cancer can create a 'diabetic state' due to its effect on the pancreas (supported by other evidence[10]). It is possible that an individual could have developed cancer first which lead to diabetes however, diabetes was not detected until the pancreatic cancer was diagnosed.

4.3.6 This could explain why some studies suggest there could be a greater risk of cancer in those with chronic diabetes; whilst others suggest there could be a greater risk of cancer in those with recent diabetes. The recent diabetes could be as a result of the pancreatic cancer, rather than the reverse.

4.3.7 From the available literature, it would seem most likely that any link is between pancreatic cancer and type-II diabetes. There is conflicting evidence as to whether type-I diabetes is associated with pancreatic cancer[11, 12] and this evidence is limited by small sample sizes and short follow-up time[3].

5. Conclusions

5.1 There is insufficient evidence to state that diabetes causes pancreatic cancer. There is some evidence to suggest there may be an increased risk but other disease risk factors may confound this; and pancreatic cancer can also cause a diabetic state.

5.2 Both pancreatic cancer and diabetes are important public health issues. Pancreatic cancer is a relatively uncommon disease, however prognosis is relatively poor. Diabetes is a common condition and the burden of morbidity is great. Diabetes is also a major risk factor for other conditions with significant morbidity and mortality e.g. 52% of people with diabetes die from cardiovascular disease[5].

5.3 Screening is available for those at higher than average risk of pancreatic cancer (due to hereditary pancreatitis or familial pancreatic cancer)[13]. Healthy Heart Checks diabetes and are run in community settings, workplaces and general practice in Hartlepool.

* Pancreatic cancer incidence and mortality rates are directly standardized to the European Standard Population

Cancer E-Atlas data are currently being updated for more recent data than 2003-5.

5.3 Obesity is an independent risk factor for both pancreatic cancer and diabetes. Smoking has also been causally linked to pancreatic cancer. Both of these risk factors are important to the public health agenda, particularly as they also contribute to other conditions such as cardiovascular disease.

Sarah Bowman
Specialty Registrar in Public Health, NHS Tees
31/10/11

* Pancreatic cancer incidence and mortality rates are directly standardized to the European Standard Population

Cancer E-Atlas data are currently being updated for more recent data than 2003-5.

References

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* Pancreatic cancer incidence and mortality rates are directly standardized to the European Standard Population

Cancer E-Atlas data are currently being updated for more recent data than 2003-5.

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Appendices

Appendix I: Search strategy

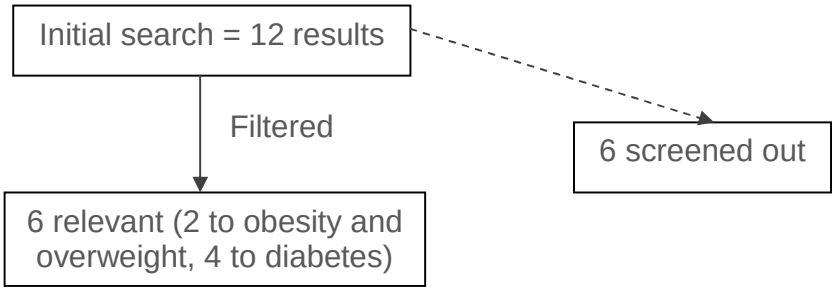
The PubMed database was used to search for meta-analyses relevant to the topic, using the following search terms:

'pancreatic AND cancer AND diabetes'

The following filters were applied to the search:

- Any date
- English
- Human
- Meta-analysis

Results were filtered by reading the abstracts or full articles where available. They were selected as relevant according to their direct relevance to the topic i.e. any possible link between diabetes and pancreatic cancer. The flowchart below illustrates the search and filtering process:



In addition to the database search, key relevant websites relating to cancer, diabetes and population data were searched for background context information and for incidence / prevalence / mortality data (see reference list).

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Appendix II: Summary of literature search results

Citation	Study type	Result	Interpretation	Limits
Huxley R, Ansary-Moghaddam A, Berrington de González A *et al.* (2005) Type-II diabetes and pancreatic cancer: a meta-analysis of 36 studies[3]	Meta-analysis 36 studies: 17 case-control studies and 19 cohort / nested case-control studies This is an update of Everhart and Wright's study (below)	Combined summary OR 1.82 (95% CI 1.66-1.88) For individuals with diabetes for <5years, 50% greater risk of malignancy (OR 2.1 vs 1.5: p=0.005)	80% greater risk of pancreatic cancer among those with type II diabetes but this may also be an overestimate (reverse causality). This is because pancreatic cancer may also lead to a diabetic state. In some cases, diabetes may be an early manifestation of the tumour. Despite this, the 50% increased risk of pancreatic cancer among individuals with chronic diabetes (>5 years) supports a modest causal relationship between diabetes and pancreatic cancer	Some conflict in results regarding level of risk in those with chronic diabetes compared with those with diabetes <5yrs. Varying levels of adjustment for confounders; some publication bias may have been present; potentially some attenuation of association by aspirin use; no differentiation between type-I and type-II diabetes which may have underestimated association; self-reported diabetes status; potential for misclassification of cancers on death certificates
Li D, Tang H, Hassan MM, *et al.* (2011) Diabetes and risk of pancreatic	Pooled analysis 3 case-control studies	1.8-fold risk of pancreatic cancer (95% CI 1.5-2.1) Risk estimates decreased with	Reverse causation may explain association when diabetes diagnosed in close temporal proximity to pancreatic cancer. However, results showed	Case control studies all carried out in the USA – potential transferability issues

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cancer: a pooled analysis of three large case-control studies. Cancer Causes Control, 22(2), 189-97[14]		increasing years with diabetes (p for trend <0.0001) Among diabetics, risk higher in insulin ever users compared with non-users, restricted to insulin use of ≤3 years (OR = 2.4). Insulin use of >10yrs associated with reduced risk (OR=0.5; 95% CI 0.3-0.9)	long-term diabetes remains a risk factor independent of obesity and smoking (though risk diminishes over time)	
Stevens R J, Roddam A W, Beral V (2007) Pancreatic cancer in type 1 and young-onset diabetes: systematic review and meta-analysis. Br. J. Cancer, 96(3), 507-9[12]	Meta-analysis of three cohort studies and six case-control studies	Relative risk for pancreatic cancer in people with (vs without) diabetes was 2.00 (95% CI 1.37-3.01) based on 39 cases with diabetes	Having type-I or young-onset diabetes could increase pancreatic cancer risk but significant limitations to study	Small number of cases and wide confidence intervals limits reliability and precision of result. Unclear whether risk also increased when analysing for type-1 diabetes **or** young-onset diabetes independently
Everhart J, Wright D (1995)	Meta-analysis of 9 cohort and 11 case-control	Pooled RR of pancreatic cancer for diabetics	Pancreatic cancer occurs with increased frequency among persons with long-	Limitations outlined in Huxley *et al.*'s study (above) – including the potential for reverse

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Diabetes mellitus as a risk factor for pancreatic cancer. A meta-analysis. JAMA, 273(20), 1605-9[15]	studies	relative to non-diabetics was 2.1 (95%CI 1.6-2.8). Tendency for a higher RR for the cohort studies (2.6, 95% CI 1.6-4.1) than for the case-control studies (1.8, 95% CI, 1.1-2.7). Diabetes duration of at least 5 years resulted in an RR of 2.0 (95% CI 1.2-3.2)	standing diabetes	causality

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HEALTH SCRUTINY FORUM

17 November 2011

HARTLEPOOL BOROUGH COUNCIL

Report of: Chair of the Health Scrutiny Forum

Subject: VISIT TO MINISTER OF STATE FOR HEALTH

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1. PURPOSE OF REPORT

1.1 To provide details of the visit undertaken to the Minister of State for Health, held on 27 October 2011.

2. BACKGROUND INFORMATION

2.1 On 27 October 2011, myself as Chair of the Health Scrutiny Forum and Deputy Mayor, Cllr Chris Simmons as Leader of the Labour Group, Cllr Hilary Thompson as Deputy Leader of the Association of Independent Councillors, and Cllr Brenda Loynes as a representative of the Conservative Group, attended a meeting with the Minister of State for Health (Simon Burns MP). Also present at that meeting was the MP for Hartlepool (Iain Wright) and the MP for Easington (Grahame Morris).

2.2 The purpose of the meeting with the Minister of State for Health, were to express the concerns raised over the closure of the Accident & Emergency Department at the University Hospital of Hartlepool, which culminated in the vote of no confidence in the Board of North Tees and Hartlepool NHS Foundation Trust passed at reconvened Extraordinary meeting of Council held on 29 September 2011.

2.3 During the meeting a number of issues were raised in relation to what more could be done in relation to the closure of A&E and the future of services at the University Hospital of Hartlepool. The Minister of State for Health confirmed that the issue was a local matter and as such clinicians at North Tees and Hartlepool NHS Foundation Trust should lead the way in the rationale behind change, with both clinicians and Councillors being responsible in taking that message forward.

3. RECOMMENDATION

3.1 It is recommended that the Members of the Health Scrutiny note the content of this report seeking 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) Minutes of the extraordinary meeting of Council held on 8 September 2011 (adjourned until 29 September 2011).

HEALTH SCRUTINY FORUM

17 November 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 (November 2011 – February 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. The first reading took place on 8th September and the second reading took place on 11th October. The next stage for the Bill is the Committee stage during which the Bill will be subject to detailed examination. 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 which at the earliest will be in February. 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: CAS101/11 REVIEW OF CHILDREN'S SOCIAL CARE COMMISSIONING AND 2012/13 SAVINGS PROPOSAL

Nature of the decision

To approve the report on the savings to be achieved in the Prevention, Safeguarding and Specialist Services division of Child and Adult Services. These savings are made up of a review of children's social care. The scope of the review considers the following areas:

- Services currently commissioned by children's social care;
- Placements of looked after children within the independent sector;
- Development of invest to save schemes aimed at reducing the number of children looked after by Hartlepool Council;
- Arrangements for the provision of financial support provided for non looked after children placed with family or friends under Residence or Special Guardianship Orders.
- Review of divisional management arrangements
- Phase 2 restructure of the Youth Offending Service
- Redesign of Child and Adolescent Mental Health Services for looked after children
- Review of workforce development within children's social care

Who will make the decision?

This decision will be made by Cabinet.

Timing of the decision

This decision will be made by Cabinet in December 2011.

Ward(s) affected

All - services delivered through prevention, safeguarding and specialist services are provided to children and their families across the town.

Who will be consulted and how?

A review team has been established comprising of the Assistant Director, Head of Business Unit, Commissioning and Team Manager representatives, Finance Officers and a critical friend and customer champion. Consultation with stakeholders has been built into the review process. The decision will be considered by Corporate Management Team and Children's Services Scrutiny Forum in October and November 2011 respectively.

Information to be considered by the decision-makers

The savings to be realised from the Prevention, Safeguarding and Specialist Services Division of Child and Adult Services was £485,500 to be delivered over the three years. In 2010/11 following a service delivery review of prevention and social care services, a saving of £137,469 was realised. The remainder of the divisional target was to be identified from children's social care commissioning. In addition in 2011/12, a further £60,000 savings target was identified to be achieved by the division for 2012/13.

How to make representations

Representations should be made to Sally Robinson, Assistant Director, Child and Adult Services, Level 4, Civic Centre. Tel: 01429 523732 e-mail sally.robinson@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

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 on 2, 3 and 4 November 2011.

Partner Organisations via Early Intervention Seminars 7th and 14th October.

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	(08-11-2011)
• Directors meeting with Secondary Heads	(08-11-2011)
• 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 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

The Early Intervention Strategy builds upon the recommendations made by Children's Services Scrutiny investigation of 'Think Family Services' in 2010/2011 and proposes a local framework for Early Intervention that will support Hartlepool to realise the strategic priorities highlighted within the Hartlepool Children's Plan (2009 – 2020) and the Hartlepool Borough Council Child Poverty Strategy (2011-2014) by ensuring that children, young people and families who are at risk of disadvantage have support at the earliest possible stage to prevent families reaching crisis.

The strategy document outlines the current arrangements in place for supporting local families and their children, lays out the proposed vision for what the Strategy is aspiring to achieve and identifies what work needs to be undertaken to realise the vision through the development of a series of key emerging strategic principles and priorities that will support the development and commissioning of a town wide Early Intervention Framework. This Framework seeks to embed systems to identify the needs of children, young people and their families as early as possible and respond to their needs promptly whilst retaining the capacity to provide a coordinated response to those families whose needs cannot be met solely within universal settings.

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
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Tel: 01429 523647
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BACKGROUND PAPERS

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

(a) The Forward Plan – November 2011 – February 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 NOVEMBER 2011

CE 44/11 (page 6)	Workforce Arrangements	Cabinet
CE45/11 (page 7)	Strategy for Bridging the Budget Deficit 2012/13 – ICT, Revenues and Benefits Service	Cabinet
CE 48/11 (page 13)	Corporate Strategy Service Review	Cabinet
CAS 95/11 (page 16)	Hartlepool Community Pool Grants review	Cabinet
CAS 102/11 (page 20)	Early Intervention Strategy: Service Restructure	Cabinet
CAS 103/11 (page 22)	Special Educational Needs (SEN) Pathfinder	Cabinet
CAS 104/11 (page 24)	Moving Forward Together: The Vision for Adult Social Care in Hartlepool	Portfolio Holder/Cabinet
CAS 106/11 (page 27)	Priority Schools Building Programme	Cabinet
CAS 108/11 (page 30)	Cost of Care for Older People's Care Homes	Cabinet
RN 13/09 (page 41)	Disposal of Surplus Assets	Cabinet / Portfolio Holder
RN 53/11 (page 44)	Sustainable Construction Strategy	Portfolio Holders
RN 57/11 (page 46)	Dog Control Orders	Portfolio Holder
RN 58/11 (page 48)	Allotments	Portfolio Holder
RN 60/11 (page 51)	Hartlepool Housing Strategy 2011-2015	Cabinet
RN 61/11 (page 53)	Selection of Preferred Developer for sites in Seaton Carew	Cabinet
RN 62/11 (page 55)	Seaton Carew Coastal Strategy Northern Management Unit Phase 2	Cabinet / Council
RN 74/11 (page 63)	Former Leathers Chemical Site	Cabinet
RN 77/11 (page 65)	Wynyard Master Plan	Cabinet
RN 78/11 (page 67)	Sustainability Policy	Portfolio Holders
RN 88/11 (page 70)	Implementation of Changes to the Common Allocations Policy Governing the Tees Valley Choice Based Lettings Scheme	Cabinet
RN 89/11 (page 72)	Former Brierton School Site	Cabinet / Council
RN 91/11 (page 76)	Property Services Proposed Budget Savings	Cabinet
RN 95/11 (page 82	Proposed Migration from the Tees Valley Food Hygiene Award Scheme to the National Food Hygiene Rating Scheme	Portfolio Holder
RN 97/11 (page 86)	Transportation and Engineering Services Proposed Budget Savings	Cabinet
RN 98/11 (page 87)	Acquisition of Assets	Cabinet / Portfolio Holder / Council

2. DECISIONS EXPECTED TO BE MADE IN DECEMBER 2011

CE 47/11 (page 12)	Customer and Support Services – Service Review	Cabinet
CE 49/11 (page 14)	Financial and Transactional Shared Services – Business Transformation 2 Programme Savings	Cabinet
CAS 97/11 (page 17)	Community Services Service reviews	Cabinet
CAS 101/11 (page 18)	Review of Children's Social Care Commissioning and 2012/13 Savings Proposal	Cabinet
CAS 107/11 (page 29)	Adult Social Care 2012/13 Savings	Cabinet
CAS 109/11 (page 32)	Support Services Savings	Cabinet
CAS 110/11 (page 33)	Home to School Transport Savings	Cabinet
CAS 111/11 (page 34)	Education Services and Out of School Activities Savings	Cabinet
RN 29/10 (page 43)	Hartlepool Domestic Violence Strategy	Cabinet

RN 68/11 (page 57)	Community Cohesion Framework	Portfolio Holder
RN 69/11 (page 59)	Flexible Support Fund	Cabinet
RN 70/11 (page 60)	Innovation Fund	Cabinet
RN 71/11 (page 61)	Families with Multiple Problems	Cabinet
RN 87/11 (page 68)	Consultation on Denominational Home to School Transport and Post 16 College Transport	Cabinet
RN 92/11 (page 77)	Asset Management Proposed Budget Savings	Cabinet
RN 93/11 (page 79)	Additional Highway Maintenance Works 2011-12	Portfolio Holder

3. DECISIONS EXPECTED TO BE MADE IN JANUARY 2011

RN 90/11 (page 74)	Mill House Site Development and Victoria Park	Cabinet / Executive Committee
RN 96/11 (page 84)	Hartlepool Voluntary and Community Sector Strategy and Compact	Cabinet

4. DECISIONS EXPECTED TO BE MADE IN FEBRUARY 2012

CE 46/11 (page 9)	Review of Community Involvement and Engagement (including LSP Review): Update on decisions taken 'in principle'	Cabinet / Council
CAS 105/11 (page 26)	Hartlepool School Admission Arrangements fir 2013/14	Portfolio Holder
RN 94/11 (page 80)	Review of Concessionary Fare Payments to Bus Operators for 2012-2013	Cabinet

TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE

A meeting of the Tees Valley Health Scrutiny Joint Committee was held on 12 September 2011.

PRESENT: Representing Middlesbrough Council:
Councillors Dryden and Mrs H Pearson

Representing Redcar & Cleveland Council:
Councillors Carling and Mrs Wall

Representing Stockton-on-Tees Borough Council:
Councillor E Cunningham (as substitute for Councillor N Wilburn),
Councillors Javed and Mrs M Womphrey.

OFFICERS: J Walsh (Hartlepool Borough Council), J Bennington and J Ord (Middlesbrough Council), M Ahmeen (Redcar & Cleveland Borough Council) and J Trainer (Stockton-on-Tees Borough Council).

APPOINTMENT – CHAIR – TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE

In a report of the Scrutiny Support Officer Members were advised that the Chairmanship of the Joint Committee had rotated amongst the five Member authorities on a yearly basis and in respect of the 2011/2012 Municipal Year it was due to be Hartlepool Borough Council.

Members were advised that on 18 July 2011 the Joint Committee's Scrutiny secretariat received notification from Hartlepool Borough Council's Health Scrutiny Forum confirming that whilst they wanted to remain members of the Joint Committee they wished to decline the position of Chair for the Municipal Year 2011/2012.

Following subsequent discussions between the Tees Valley authorities it had been agreed that a Chair be sought from Middlesbrough Council in respect of 2011/2012 and that Officers from Middlesbrough Council would provide support to the Joint Committee for this year.

AGREED as follows: -

1. That the information provided be noted.

2. That Councillor Dryden (Middlesbrough Council) be appointed as Chair of the Tees Valley Health Scrutiny Joint Committee for the Municipal Year 2011/2012.

N.B. Councillor Dryden took the Chair at this point of the meeting.

**** APOLOGIES FOR ABSENCE** were submitted on behalf of Councillors Newall and J Taylor (Darlington Borough Council), Councillors S Akers-Belcher and Griffin (Hartlepool Borough Council), Councillor Cole (Middlesbrough Council), Councillor Kay (Redcar and Cleveland Council) and Councillor N Wilburn (Stockton-on-Tees Borough Council).

DECLARATIONS OF INTEREST

Name of Member	Type of Interest	Item / Nature of Interest
Councillor Mrs Wall	Personal/Non-Prejudicial	Any matters arising relating to North East Ambulance Service NHS Trust - related to a number of employees.

TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE – SCRUTINY WORK PROGRAMME 2011/2012

The Scrutiny Support Officer submitted an introductory report on potential sources for scrutiny topics and information reports for the Joint Committee's 2011/2012 work programme.

It was acknowledged that an element of such a programme would be reactive to emerging issues from local NHS organisations especially taking into consideration the significant changes in the NHS.

The Joint Committee considered possible topics for inclusion in the scrutiny work programme. One suggested area related to the implementation of Government health reforms in particular how services that were previously planned and commissioned on a Tees wide level would continue on such a basis following the major changes. Reference was made to such services as Cancer Screening Services, Sexual Health Services, and Major Trauma Services and Cancer Services at James Cook University Hospital.

Reference was also made to ongoing activities to formulate Clinical Commissioning Groups and Health and Wellbeing Boards which were coterminous with local authority boundaries. The Joint Committee discussed the importance of how such groups related to each other with particular regard to joint commissioning arrangements across the Tees Valley and from a wider perspective across the North East.

Members were advised that towards the end of the 2010/2011 winter period the Joint Committee had considered how the local health and social care economy had dealt with the pressures associated with seasonal flu, impact on hospital admissions and how the provision of vaccines had been managed. At that time the Joint Committee had suggested examining such areas prior to the 2011/2012 winter period.

An indication was given of issues which had been raised at that time such as an initial slow take-up of the flu vaccinations and the timing of Government public health advertising campaigns to raise awareness of seasonal flu vaccines. Specific reference had been made to arrangements put in place during the period when there had been a significant increase in flu related complications, hospital admissions and a short supply of vaccines. NHS Tees had worked closely with GPs to identify the extent of current stocks of vaccine and to make sure that such supplies were moved around to ensure that they were placed where they were most needed. The Joint Committee was keen to ascertain if such arrangements would continue if proved necessary given the changes to and ultimate abolition of Primary Care Trusts. It was also suggested that information be sought regarding the role of GPs in encouraging the take up of flu vaccinations.

In terms of other suggested scrutiny topics reference was made to the Joint Committee's previous consideration of the new Out of Hours service the contract of which had recently been awarded to Northern Doctors Urgent Care. It was suggested that it might be useful for the Joint Committee to receive an update on how the service had been developed.

Members considered other possible topics of investigation such as hospital waiting times. As an initial step in the process it was suggested that each local authority examine and provide information on their respective areas for the Joint Committee's overall consideration.

The Joint Committee agreed that they should continue to receive information on scrutiny work programmes and final scrutiny reports from the constituent local authorities. Reference was made to recent reports such as the designation of James Cook University Hospital as a Major Trauma Centre by Middlesbrough Council and a report relating to Stroke Services by Darlington Borough Council.

It was considered prudent for the Joint Committee to allow a degree of flexibility within the work programme to deal with issues as and when they arose by the local NHS especially with regard to the significant changes taking place in the NHS.

Members gave initial consideration to the frequency of meetings of the Joint Committee. It was suggested that further consideration could be given to the matter but it was agreed that it would be prudent for the Joint Committee to meet within the next six weeks in order to have an opportunity to submit observations regarding arrangements currently being pursued by the local NHS in respect of the preparation for the winter period.

AGREED as follows: -

1. That it be recommended that the suggested topics for scrutiny investigation as outlined above form the basis of the Scrutiny Work Programme of the Joint Committee for the 2011/2012 Municipal Year which included:-

   (i) to deal with issues as and when they arose by the local NHS;

   (ii) preparation by the local NHS for the winter period;

   (iii) implications of NHS reforms with particular regard to joint commissioning arrangements across the Tees Valley and North East;

   (iv) hospital waiting times;

   (v) to receive an update on the Out of Hours Contract;

   (vi) to receive information on final scrutiny reports from constituent authorities.

2. That the first topic of scrutiny investigation be the preparation by the local NHS for the winter period.

3. That a further report on the Protocol for the Tees Valley Health Scrutiny Joint Committee including the appointment of a Vice-Chair be submitted to the next meeting of the Joint Committee.