HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL BOROUGH COUNCIL

Thursday 23 February 2012

at 10.00 a.m.

in Committee Room B, Civic Centre, Hartlepool.

MEMBERS: HEALTH SCRUTINY FORUM:

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

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

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

   3.1 To confirm the Minutes of the meeting held on 26 January 2012
   3.2 To confirm the Minutes of the meeting held on 9 February 2012 (to follow)

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 North Tees and Hartlepool NHS Foundation Trust – Quality Account 2012/13

(a) Covering Report – *Scrutiny Support Officer*

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

Scrutiny Investigation into Cancer Awareness and Early Diagnosis

7.2 Evidence on Smoking Cessation

(a) Covering Report – *Scrutiny Support Officer*

(b) Presentation – *Director of Fresh and Officers from the Child and Adult Services Department*

7.3 Evidence on Cancer Awareness Activities

(a) Covering Report – *Scrutiny Support Officer*

(b) Presentation – *Representatives from NHS Tees*

Public Health

7.4 Draft Hartlepool Public Health Transition Plan – *Assistant Director for Health Improvement*

Monitoring of Scrutiny Recommendations

7.5 Six Monthly Monitoring of Agreed Health Scrutiny Forum's Recommendations – *Scrutiny Support Officer*

8. **ISSUES IDENTIFIED FROM FORWARD PLAN**

No items.

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

9.1 Northern Doctors Urgent Care – Out of Hours Services – Progress Report – *Scrutiny Support Officer*

10. **REGIONAL HEALTH SCRUTINY UPDATE**

No items.

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

FOR INFORMATION: Date of Next Meeting – Thursday 5 April, 2012 commencing at 10.00 a.m. in the Civic Centre, Hartlepool.

HEALTH SCRUTINY FORUM

MINUTES

26 January 2012

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

Present:

Councillor Stephen Akers-Belcher (In the Chair);

Councillors: Marjorie James, Geoff Lilley, Arthur Preece, Linda Shields, Kaylee Sirs and Ray Wells.

Resident Representative: Ian Stewart.

Also Present: Councillor Edna Wright.

Representing North Tees and Hartlepool NHS Trust:
Mr Mat Tabaqchali, Consultant Colorectal Surgeon,
Mr Colm Hennessy, Consultant Breast Surgeon
Dr Neil Leitch, Consultant Physician
Norma Robinson, Lead Colorectal Nurse Specialist
Jan Harley, Lead Breast Nurse Specialist / Lead Cancer Nurse
Tessa FitzPatrick, Macmillan Lung Specialist Nurse
Laura McGuinness, NAEDI Cancer Awareness Project

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

55. Apologies for Absence

Councillor Griffin.

56. Declarations of Interest by Members

None.

57. Minutes of the meeting held on 17 November 2011

In reference to Minute No. 50, a Member commented that there was no reference in the minutes to the value of the land purchased by the Trust for the new hospital site. It had been quoted in the meeting as being £5m and

that this would be recoverable should the scheme not go ahead.

Subject to the comment above, the minutes were confirmed.

58. Minutes of the Joint Meeting with Children's Services Scrutiny Forum Held on 3 November 2011

In relation to Minute No. 10 Members commented that there had been no feedback in relation to the recommendation of the joint meeting "That urgent action be taken by Council in response to their motion of no confidence in the decision making of the Chief Executive, Alan Foster and Chairman, Paul Garvin and the Board of North Tees and Hartlepool Trust NHS Foundation Trust to address the concerns in relation to the removal or reduction of services from Hartlepool." The Chair commented that there would be a further report to the Forum on the issue of services at Hartlepool Hospital. In relation to the Council resolution the Chair commented that this was a full Council issue and Members should take the matter in that meeting.

The minutes of the meeting were confirmed.

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

No items.

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

No items.

61. Scrutiny Investigation into Cancer Awareness and Early Diagnosis - Evidence from North Tees and Hartlepool NHS Foundation Trust (*Scrutiny Support Officer*)

The Scrutiny Support Officer introduced representatives from the North Tees and Hartlepool NHS Foundation Trust who were present to provide detailed background information to assist the Forum's investigation into cancer awareness and early diagnosis.

Mr Mat Tabaqchali, Consultant Colorectal Surgeon, Mr Colm Hennessy, Consultant Breast Surgeon and Dr Neil Leitch, Consultant Physician were present at the meeting and gave presentations to the Forum.

Mr Tabaqchali gave an overview of the organisation of cancer services in North Tees and Hartlepool particularly for breast, lung and colorectal cancers and the various awareness and early diagnosis initiatives. Mr Tabaqchali outlined the large team that served the area on cancer treatment

and how this was part of a wider regional service base. In terms of the secondary care prospective for cancer, reference was made to the national access targets and various guidelines, the screening programmes and initiatives for early diagnosis. The health inequality agenda and the national plan for reduction in cancer mortality agenda, and the advancements in technology that were improving detection, treatment and outcomes.

On referrals for suspected cancers, Mr Tabaqchali outlined the 'two-week rule' whereby patients suspected of having a cancer were referred to a specialist for diagnosis within two-weeks of their GP's referral. There had been a 90% increase in the number of two-week referrals since 2004 and the current national target for meeting these referrals with the two-weeks was 93%, which was exceeded across all cancers by the Trust. In 2011 7154 referrals had been made with 6810 (95.2%) being seen within two weeks.

It was commented by members that the Tees Valley Joint Health Scrutiny Forum had undertaken a similar investigation when it was highlighted that screening uptake varied markedly across socio-economic groups as well as by area. There were areas of deprivation where uptake of screening was very poor and the monitoring of screening based on GP Surgeries didn't always pick up on those anomalies. Members questioned if the specialists in this field were satisfied that such differentials were being tackled. Mr Hennessy commented that there were others who could monitor and take regard of the demographics but from an operational perspective the systems were based on GP Surgeries. Mr Hennessy considered that the substantial variations in screening were something that needed to be tackled. A Member expressed their concern that the differentials in screening take up between council wards did exist though no specific action to address this seemed to be taken.

Mr Hennessy's presentation went on to outline the secondary healthcare perspective in relation to breast cancer. Mr Hennessey indicated that 1 in 9 women would develop breast cancer in their lifetime; 40,000 women each year in the UK. Breast cancer was more common in women over 50 with 8 out of 10 breast cancers occurring post menopause. However 9 out of 10 lumps investigated were not cancerous. The presentation went on to outline a series of statistics including that of the 1774 referrals during 2011 only 144 (8.5%) were cancerous. In 2011 417 new referrals were treated, the majority, 235, having come through screening.

In relation to screening uptake, Mr Hennessy indicated that across the 16 GP surgeries in Hartlepool breast cancer screening uptake was 70% with one surgery achieving an 80% uptake. However, four practices had a less than 70% uptake with one as low as 56%. Mr Hennessy stressed the importance of screening and if anything could be reinforced through this investigation it was the importance of responding to screening invitations. The message was that six minutes every three years could save your life.

Mr Tabaqchali presented a secondary health care perspective in relation to Bowel cancer. The presentation outlined the main symptoms, risk factors

and incidence of bowel cancer which revealed the cancer was more prevalent in men. One of the major factors on five-year survival rates as highlighted by Mr Tabaqchali was the stage at which the cancer was presented. In the early stages (1 and 2) five-year survival rates were quite high at 83% and 64% respectively. However, diagnosis at stages 3 and 4 reduced those rates quire significantly to 38% and 3% respectively. The figures highlighted that over half of diagnoses were for stage 3 and 4 cancers.

Mr Tabaqchali outlined statistics for the treatment of bowel cancer and the 'two-week' assessment statistics. One issue that was of concern was that the involvement in the screening programme in Hartlepool which was below the Tees Valley and national averages. Mr Tabaqchali emphasised the significant importance with involvement in screening and the early detection of bowel cancer; early detection had a huge effect on long term survival rates.

Dr Neil Leitch gave a similar presentation on lung cancer. Lung cancer was the commonest cause of cancer death in men and women and accounted for 22% of all cancer related deaths and 6% of the overall national mortality rates. Smoking was highlighted by Dr Leitch as a major cause of lung cancer with it being the cause of 90% of male and 83% of female lung cancers. Dr Leitch highlighted that while a lifelong male smoker may have a 15.9% chance of developing lung cancer during his lifetime, the improvement in those statistics was quite marked by stopping smoking, even in later life.

Dr Leitch highlighted that as with other cancers, early detection was key to five-year survival rates. Again, figures for the two-week rule were still high, but Dr Leitch indicated that as many people in the Trust area with lung cancer presented as emergency admissions which was a major cause of concern for professionals. There had been significant improvements in five year survival rates since 2004 both locally and nationally but even NICE had acknowledged that "The public needs to be better informed of the symptoms and signs that are characteristic of lung cancer, through coordinated campaigning to raise awareness". There was, however, no national screening programme.

Dr Leitch commented that the most significant way to ensure a reduction in lung cancer rates was to help people stop smoking in a positive supportive and non-blame manner; ensure children and young people did not start smoking; create a culture of a low threshold for suspicion and investigation of symptoms to bring earlier diagnosis as the earlier the diagnosis was made the better the long-term survival rates were.

During the debate and questions raised by Members and responded to by the Trust representatives, the following comments/issues were discussed –

- Breast cancer screening – while there was a call for women to attend screening, many didn't realise that the first invitation they receive wouldn't necessarily occur around their fiftieth birthday but sometime

within the three-year programme of screening. This was a concern as it was felt that some could quite easily 'slip through the net' or simply believe that not knowing was easier. Could screening not be called on a date of birth basis rather than a GP based system. Mr Hennessy commented that the programme was being adapted to address this issue by starting the screening programme at age 47, so the first call would happen between the ages of 47 and 50. The whole of the screening programme was based on a GP model and it would be a monumental upheaval to change. Mr Tabaqchali indicated that one of the benefits of the GP based system is that your invitation for screening came from somebody with whom you already had relationship.

- Had the recent PIP breast implants scandal had an affect in this area and how many women were having their implants removed/replaced? Mr Hennessy indicated that the Trust had been concerned about the use of PIP implants and as a result there were less than a handful of cases of women having PIP implants at NTHFT, with those women having already been contacted.
- It was noted that breast cancer screening was done utilising the mobile screening unit and members queried the location of the unit. The Trust representatives indicated that when in the town the unit was located at the OneLife Centre on Park Road.
- There was a concern expressed that many people did feel like there was no point to any of the health campaigns when their 'socio-economic' circumstances and the ready access to poor food and alcohol choices seemed to weigh against them. The Chair commented that such an issue, while very valid, could raise a wide-ranging debate that, in all faimess, the Trusts representatives could not respond to.
- With certain GP practices having very low referral rates for screening, was anything being done to tackle this. Mr Hennessy indicated that the PCT were aware of the data and it was an issue for them to address.
- The simple message of 'six minutes every three years may save your life' seemed to be an excellent publicity tool, why was it not used. Mr Hennessy indicated that it was a statement that had come from the staff that handled the phone calls into the Trust on cancer screening and it was their way of persuading people to attend the screening. When he had heard it, it seemed such a simple message to get across.
- Concerns were again expressed at the low turn out rates for screening, though there were further experiences reported of GPs failing to ensure all women were called for screening.
- While acknowledging the message the specialists were conveying at the meeting, there was great concern expressed that some GPs were simply not responding in the right way and sending people away who were presenting with the symptoms cancer specialists were telling them to take to their GP. Too many people almost had to fight to get a decent service.
- It was considered that screening needed to be widened to include those that had worked in high risk industries, such as mining to ensure

they were screened not just for the most obvious cancers, such as lung cancer, but those that may be a secondary effect of working in dusty atmospheres where dust may have been ingested as well as breathed in.

- Mr Tabaqchali highlighted that the screening programmes that were in place were national and had been rigorously tested before being implemented; they had excellent statistical data to back them up and testing that was conclusive. Not all cancers had such test certainty and in some cases screening could be more harmful than helpful. Mr Tabaqchali was confident, however, that new and improved screening would come forward in the future.
- It was noted that the introduction of the lower age range for breast cancer screening was part of a nationally funded pilot scheme. This funding had been subject to competitive bidding and came with very strict criteria.
- Was there not good reason for people who were presenting with one form of cancer to be screened for other secondary cancers through a full body scan. Dr Leitch indicated that all cancer patients were subject to staging scans. There were both positives and negatives to full body scans; there was an obvious radiological risk but also they could create undue anxiety for patients. Chest and abdominal scans were undertaken as necessary.
- The risks of passive smoking were highlighted as were the risks of mothers smoking during pregnancy.
- It was highlighted that the next meeting in the investigation would look at some of the campaigns that were being run and how they were affecting cancer rates.

Mr Tabaqchali thanked the Forum for the opportunity to talk about the work of the clinical teams leading on the treatment of cancer in the North Tees and Hartlepool Trust. The Chair thanked all the Trust representatives for their attendance and exceptional informative presentations and responses to Members questions. The people of Hartlepool and North Tees could feel reassured that they had such an enthusiastic and experienced cancer treatment team available to them.

Recommended

That the representatives of North Tees and Hartlepool NHS Trust be thanked for their exceptionally informative evidence in the Forum's investigation into Cancer Awareness and Early Diagnosis.

62. Consideration of progress reports/budget and policy framework documents - Proposals for Inclusion in Child and Adult Services Departmental Plan 2012/13

(*Assistant Director for Health Improvement*)

The Assistant Director for Health Improvement gave a presentation on the principal challenges the department faced during the next year and the proposals for inclusion in the departmental plan to address them. The presentation highlighted the departmental actions to address the corporate

aims to -
Improve health by reducing inequalities and improving access to services (Outcome 9),
Be healthy – children enjoy good physical and emotional health and live a healthy lifestyle (Outcome 10), and
There is reduced harm caused by drugs and alcohol misuse (Outcome 14).

Members expressed concern at some of the misinterpretations in relation to smoking and pregnancy. Young mothers in particular were being told that if they smoked during pregnancy that their baby would be small; this had a negative effect with some mothers seeing their baby as being small and advantage during birth, rather than the long-term health issues. Members felt that the message didn't seem to be getting across and this was something that needed to be urgently corrected. The Assistant Director assured Members their comments would be taken on board.

Members raised concern with the establishment of the shadow Health and Wellbeing Board particularly as clear advice was still awaited from central government on the board's responsibilities. The Board was already developing partnerships with various external bodies yet the other side of the coin, how the board's decision making would be held to account, had not been established or discussed. If a shadow 'scrutiny' arrangement was also needed, then that needed to be addressed by Members.

The Chair indicated that the Chair of the Health and Wellbeing Board should be invited to a future meeting to give an update on the progress of the Board and the matters it had discussed. Members made comment that they did not believe that the Board should be exclusively restricted to executive members and should be open to backbench membership though obviously not wishing to compromise the effectiveness of any scrutiny. The Chair indicated that he would include the concerns of members in the invitation to the Health and Wellbeing Board Chair.

Recommended

1. That the report be noted.
2. That the Chair of the Health and Wellbeing Board be invited to a future meeting to update the Forum on the work and discussions of the Board.

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

The Scrutiny Support Officer reported on items within the most recent Executive Forward Plan (January to April 2012) relating to the work of the Health Scrutiny Forum.

Members noted that there were decisions listed in the Forward Plan that related to the Health and Wellbeing Board and considered that following the debate on the previous item, that the role of scrutiny in relation to the Board was established at the earliest opportunity.

Recommended

The the report be noted.

64. Minutes From Recent Meeting Of Tees Valley Health Scrutiny Joint Committee

Minutes of the meetings of the Tees Valley Health Scrutiny Joint Committee held on 10 October and 21 November 2011 were submitted for the Forum's information.

65. Regional Health Scrutiny Update

No items.

66. Any Other Items which the Chairman Considers are Urgent

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

67. Date and Time of Next Meeting

The Chair noted that the next meeting was to be held on Thursday 9 February 2012 commencing at 10.00 a.m. The Principal Democratic Services Officer informed the meeting that the venue arranged for the meeting was the Baltic Room at the Historic Quay as no rooms were available in the Civic Centre due to the annual Environment Roundabout being held in the Civic Suite during that week.

Members did feel that a more central location for the meeting would be appropriate and following discussion agreed that the Chair and the Democratic Services Team find a more suitable venue.

As the Chair reached the agenda item of "Any Other Business", a member of the public requested the right to speak and while commenting that it was not usual practice, the Chair allowed the member of the public to speak.

The Member of the public raised concern that many people had attended today's meeting on the understanding that the issue of services being returned to the University Hospital of Hartlepool would be discussed. The member of the public commented that 16 weeks ago the council had unanimously agreed a vote of no confidence in the management of the North Tees and Hartlepool NHS Trust and questioned what had happened following that; had the Trust Board been informed, had any action been taken.

The Chair indicated that that subject had not been listed on this meeting's agenda and that services at the hospital would specifically be part of the meeting to be held on 9 February. The Council was the responsible body

in relation to the vote referred to, not this Forum. Members of the public did feel that they had been misled but the Chair was clear that the agenda for this meeting had never included the issue of the hospital and the press release on the matter clearly stated that it would be discussed at the meeting on 9 February. The Chair suggested that should the member of the public require formal clarification of what steps had been taken following the vote of no confidence, he may wish to submit a public question to the next meeting of Council.

The meeting concluded at 1.20 p.m.

CHAIR

HEALTH SCRUTINY FORUM

23 February 2011

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Support Officer

Subject: NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST – QUALITY ACCOUNT 2012/13 – COVERING REPORT

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1. PURPOSE OF REPORT

1.1 To introduce representatives from North Tees and Hartlepool NHS Foundation Trust who will be in attendance at today's meeting to discuss the Trust's Quality Account for 2012/13.

2. BACKGROUND INFORMATION

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

2.2 Members of the Health Scrutiny Forum met on 8 September 2011 where initial discussions were held in relation to the North Tees and Hartlepool NHS Foundation Trust's Quality Account for 2012/13.

2.3 At the meeting of the Health Scrutiny Forum on 6 October 2011, Members agreed three key priorities to be forwarded to the Director of Nursing and Patient Safety at North Tees and Hartlepool NHS Foundation Trust for consideration in the Trust's Quality Account 2012/13 as detailed below:-

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

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

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

2.4 Subsequently, the Director of Nursing and Patient Safety at North Tees and Hartlepool NHS Foundation Trust will be present at today's meeting to provide a presentation in relation to North Tees and Hartlepool NHS Foundation Trust's Quality Account for 2012/13.

3. RECOMMENDATIONS

3.1 That Members:-

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

(ii) Formulate a response from the Health Scrutiny Forum to be included in the North Tees and Hartlepool NHS Foundation Trust's Quality Account for 2012/13.

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

BACKGROUND PAPERS

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

(a) Minutes of the meetings of the Health Scrutiny Forum held on 8 September 2011 and 6 October 2011.

HEALTH SCRUTINY FORUM

23 February 2012

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Support Officer

Subject: EVIDENCE ON SMOKING CESSATION – COVERING REPORT

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1. PURPOSE OF REPORT

1.1 To inform Members that the Director of Fresh and officers from the Child & Adult Services Department will be in attendance at today's meeting to deliver presentations in relation to Smoking Cessation.

2. BACKGROUND INFORMATION

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

2.2 Consequently, Members will today receive presentations from the following individuals in relation to smoking cessation:-

(i) Carole Johnson, Head of Health Improvement
Providing a setting the scene presentation around tackling smoking issues in Hartlepool

(ii) Pat Marshall, Stop Smoking Service Manager
Providing details of service delivery in Hartlepool, including those services targeted at young people

(iii) Ailsa Rutter, Director of Fresh
Fresh is the UK's first dedicated regional programme for tobacco control. It was set up in 2005 to tackle the high toll of death and disease caused by smoking. Fresh provides effective leadership and expertise, developing a regional approach to help reduce the prevalence of smoking. One of their strands of work is the

implementation of regional campaigns and projects, including their most recent entitled Plain Packs Protect.

3. RECOMMENDATIONS

3.1 That Members note the content of both this report and the presentations from the representatives identified under paragraph 2.2, seeking clarification on any relevant issues from the representatives in attendance, where felt appropriate.

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

BACKGROUND PAPERS

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

(i) 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.

(ii) Fresh (2011), *Smoke Free North East*, Available from: http://www.freshne.com/ (Accessed 6 February 2012)

HEALTH SCRUTINY FORUM

23 February 2012

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Support Officer

Subject: EVIDENCE ON CANCER AWARENESS ACTIVITIES – COVERING REPORT

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1. PURPOSE OF REPORT

1.1 To inform Members that representatives from NHS Tees will be in attendance at today's meeting to deliver presentations in relation to Cancer Awareness Activities.

2. BACKGROUND INFORMATION

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

2.2 Consequently, Members will today receive presentations from the following individuals in relation to cancer awareness activities:-

(i) Laura McGuinness, Project Manager – NAEDI Cancer Awareness Project, NHS Tees
Providing an overview of the cancer awareness raising activities provided at a local and regional level.

(ii) Pete Moody, Macmillan Cancer Information and Volunteer Facilitator, NHS Tees
Macmillan Cancer Support are currently funding a two year project branded the Teesside Cancer Awareness Roadshow delivered by NHS Tees.

2.3 Members maybe interested in a study published in the British Journal of Cancer in 2009 where Dr Una Macleod argued why there was a delay in common cancer patients being seen by medical professionals:-

"The predominant risk factor for patient delay is a lack of interpretation by patients of the serious nature of their symptoms…If a symptom is atypical, or vague in nature, the risk of delayed presentation can be increased."[1]

Dr Macleod went on to cite various studies from 2002-2009 which indicated that:-

"General population surveys in the United Kingdom indicate a widespread lack of awareness of the symptoms of cancer…These low levels of symptom awareness may partly explain why the type of symptom and recognition of the seriousness of symptoms are consistent risk factors for delayed patient presentation."[1]

2.4 However, in addition to the lack of awareness of symptoms of common cancers indentified in paragraph 2.3, Dr Macleod went on to highlight that the various studies cited from 2002-2009 made the following point:-

"Equally, these surveys report that people hold negative beliefs and attitudes about the benefits of seeking medical help for cancer, which include fear, embarrassment, reluctance to bother the general practitioner and nihilism about cancer treatments."[1]

3. RECOMMENDATIONS

3.1 That Members note the content of both this report and the presentations from the representatives identified under paragraph 2.2, seeking clarification on any relevant issues from the representatives in attendance, where felt appropriate.

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

[1] McLeod, U. at al., 2009

BACKGROUND PAPERS

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

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

(ii) NHS Hartlepool (20112), *Cancer Roadshow*, Available from: http://www.hartlepool.nhs.uk/content/page.aspx?page=394 (Accessed 7 February 2012)

(iii) Macleod, U. Mitchell, ED. Burgess, C. Macdonald, S. Ramirez, AJ (2009) 'Risk factors for delayed presentation and referral of symptomatic cancer: evidence of common cancers' *British Journal of Cancer*, [Online] paper no. 101. Available from: http://www.nature.com/bjc/journal/v101/n2s/full/6605398a.html (Accessed 7 February 2012)

HEALTH SCRUTINY FORUM

23 February 2012

Report of: Acting Chief Executive

Subject: DRAFT HARTLEPOOL PUBLIC HEALTH TRANSITION PLAN

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1. INTRODUCTION

1.1 The purpose of this paper is to seek comments from the Health Scrutiny Forum on the draft Public Health Transition Plan, for transferring the statutory responsibilities for Public Health from NHS Hartlepool to Hartlepool Borough Council by April 2013.

2. BACKGROUND

2.1 The publication of 'Healthy Lives, Healthy People: Our Strategy for Public Health in England 2010' (Department of Health). Proposed radical reform of how Public Health is to be delivered in England. In summary, the proposals for the future delivery of Public Health are three fold:

i. Local Government will assume responsibility for Public Health including, strategic planning, commissioning and investment in Public Health services. This will be led by a statutory Director of Public Health accountable to the Chief Executive responsible for three key domains of Public Health including health protection; health improvement and population healthcare.

ii. Creation of National Executive Agency of the Department of Health – Public Health England who will be responsible for providing expert intelligence and health protection services.

iii. NHS Commissioning Board being responsible for public heath interventions including screening and immunisations.

3. KEY PUBLIC HEALTH POLICY UPDATE

3.1 In December 2011, a series of fact sheets regarding implementing the proposed Public Health delivery model were published covering the areas overleaf:-

- ***Public Health In Local Government***

  The Role of the Director of Public Health
  Local Government leading for Public Health
  Local Government's New Public Health Functions
  Commissioning Responsibilities
  Public Health Advice to NHS Commissioners
  Professional appraisal and support, and capacity building

- **Public Health England's Operating Model**

  Mission and values
  Functions
  Organisational design
  Status and Accountability
  Next Steps – establishing Public Health England

3.2 From the fact sheets identified under section 3.1, detailed below is a summary of their content:-

- It is intended that amendments will be brought forward in the Health and Social Care Bill that subject to Parliament, Directors of Public Health will be added to the list of statutory Chief Officers in the Local Government and Housing Act 1989. This is to ensure Directors of Public Health have appropriate status in the Local Authority.
- Directors of Public Health will be trained specialists.
- The Health and Social Care Bill will make it a statutory requirement for the Director of Public Health to produce an annual report on the health status of the town.
- Directors of Public Health will be statutory members of the Health and Well Being Board.
- Clear local political leadership will be critical to the success of improving health.
- Local Government is well placed to take a population based perspective which is at the heart of Public Health and a natural part of what Councils do.
- Local Authorities can use their new responsibilities and ring fenced resources to include health in all policies and consider the impact on health in all decisions. The Local Authority is well placed to influence the wider determinants of health including housing, economic regeneration, education, children and adult services etc.
- Local Authorities will be key partners in Health and Well Being Board alongside other new bodies including HealthWatch.
- Local Authorities will also wish to work with Clinical Commissioning Groups to provide integration across clinical pathways. The Health and Well Being Board will be critical to driving this forward.

- The Local Authority will commission services to improve health using the ring fenced Public Health resource. This investment should be based on a robust Joint Strategic Needs Assessment.
- The Health and Social Care Bill includes the power for the Secretary of State to prescribe that Local Authorities are mandated to commission the following:-

    1. Appropriate access to sexual health services;
    2. Steps are taken to protect the health of the population, in particular, giving the local authority a duty to ensure there are plans on place to protect the health of the population;
    3. Ensure NHS Commissioners receive the Public Health advice they need;
    4. National Childhood Measurement programme;
    5. NHS Health Check Assessment.

- It is now not intended that the Healthy Child Programme will be mandated before 2013. It is expected that these services will be unified within the Local Authority by 2015.
- Local Authorities will also be responsible for the following:-

    1. Tobacco control and smoking cessation services;
    2. Alcohol and drug misuse services;
    3. Public Health services for children and young people aged 5-19 years;
    4. Interventions to tackle obesity such as community lifestyle and weight management services;
    5. Locally-led nutrition initiatives;
    6. Increasing levels of physical activity in population;
    7. Public mental health services;
    8. Dental Public Health services;
    9. Accidental injury prevention;
    10. Population level interventions to reduce and prevent birth defects;
    11. Behavioural and lifestyle campaigns to prevent cancer and long term conditions;
    12. Local initiatives on workplace health;
    13. Supporting, reviewing and challenging delivery of key Public Health funded and NHS delivered services such as immunisation and screening;
    14. Local initiatives to reduce excess deaths as a result of seasonal mortality;
    15. The local authority role in dealing with health protection incidents, outbreaks and emergencies;
    16. Public Health aspects of promotion of community safety, violence, prevention and response;
    17. Public Health aspects of local initiatives top tackle social exclusion;
    18. Local initiatives that reduce Public Health impacts of environmental risks

- Local Health Resilience Forums will be created as part of the existing Local Resilience Forum infrastructure. A lead Director for this will be appointed from the NHS Commissioning Board and a lead Director of Public Health for an area will act as co-chair.
- Directors of Public Health will advise on whether screening and immunisation programmes being provided in their area met the needs of the population and if there is equitable access.
- Public Health will need to provide advice to NHS Commissioners. This advice might include Public Health intelligence and JSNA; data, epidemiology, design of monitoring and evaluation frameworks; advice of effectiveness of interventions; pathway design; health equity audit etc.
- Abortion services will remain in the NHS commissioned by clinical commissioning groups and not now the Local Authority as previously proposed.
- Commissioning of sexual assault services will rest with the NHS Commissioning Board.
- Public Health England will deliver specialist health protection services in partnership with the Local Authority; deliver an information and intelligence service; support commissioning and delivery of effective health care service and Public Health programmes; design and deliver nationwide communications and interventions.
- Public Health England will have a national office and four hubs. The four hubs will be conterminous with the four sectors of the NHS Commissioning Board and Department for Communities and Local Government Resilience hubs covering London, the South of England, Midlands and East of England and the North of England.

3.3 Further policy guidance regarding human resources and workforce, financial resources including the ring fenced Public Health budget and performance and Public Health outcomes are due to be published between January and March 2012. This guidance is critical to the implementation of the draft transition plan.

4. DRAFT TRANSITION PLAN

4.1 In order to ensure the smooth transition of the responsibility from NHS Hartlepool to Hartlepool Borough Council, it has been necessary to complete a draft transition plan (attached as **Appendix A**). This plan attempts to encapsulate at a fairly high level of detail the key actions that must be undertaken to ensure effective transition. This plan is not exhaustive and has sufficient detail to guide the work of those responsible for implementation.

4.2 The plan considers the following key themes:-

1. Policy and Strategy
2. Human Resources
3. Contracting and Procurement

4. Ring fenced Budget
5. Public Health Delivery
6. Risk, Resilience and Emergency Planning Through Transition
7. Health Protection through Transition
8. Governance through Transition
9. Infrastructure
10. NHS Commissioning Board – Public Health Transition
11. Communication and Engagement Plan through Transition

4.3 There are a number of timescales attached to the development of the Public Health Transition Plan which are detailed below:-

(i) A report on the Draft Hartlepool Public Health Transition Plan was presented to Cabinet on 23 January 2012.

(ii) Draft Hartlepool Public Health Transition Plan submitted to the Regional Director of Public Health by 27 January 2012.

(iii) A report on the final version of the Hartlepool Public Health Transition Plan is to be presented to Cabinet on 5 March 2012.

(iv) The final version of the Hartlepool Public Health Transition Plan will need to be submitted to:-

(a) the Regional Director of Public Health by 16 March 2012; and

(b) the Department of Health by 5 April 2012.

4.4 A recent letter from Professor Paul Johnson, Regional Director of Public health for the North of England highlighted the following timescales for implementing the plan.

- By the end October 2012 it is expected the substantial majority of PCTs with local authority agreement will have transferred Public Health duties to local authorities with robust governance in place for the remainder of 2012/13.
- By end December 2012 all remaining duties will be transferred.
- By end March 2013 all PCTs must have completed the formal handover of public health responsibilities to Local Authorities.

4.5 There is a regional Public Health transitions assurance board in place managed by Public Health North East as part of the Strategic Health Authority. From Hartlepool the Chief Customer Services and Workforce Officer and the Assistant Director of Health Improvement are contributing to the work of the Board.

5. RECOMMENDATIONS

5.1 That Members:-

(a) note the content of this report and the presentation, seeking clarification on any issues from the Assistant Director of Health Improvement present at today's meeting; and

(b) formulate views on the Public Health Transition Plan to be presented at the meeting of Cabinet on 5 March 2012.

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BACKGROUND PAPERS

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

(i) Department of Health (2010), *Healthy Lives, Healthy People: Our Strategy for Public Health in England*, Available from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

(ii) Department of Health (20 December 2011) *New public health system takes shape as more details published*, Available from: http://healthandcare.dh.gov.uk/public-health-system/ (Accessed 24 January 2012)

7.4
APPENDIX A

DRAFT
Public Health Transition Plan
For Hartlepool

2011-2013

Louise Wallace – November 2011

1. Introduction

1.1 The publication of 'Healthy People, Healthy Lives: Our Vision for Public Health in England 2010' (Department of Health) proposed radical reform of the future delivery of public health in England. This white paper proposed new responsibilities for Local Government for improving health and resources to enable this to happen. It also proposed responsibilities for the NHS Commissioning Board for public health interventions including screening and immunisations. The paper signalled the creation of a new Executive Agency 'Public Health England' with public health responsibilities in including health protection and public health intelligence and knowledge.

1.2 This new system for public health is aimed at being integrated across all of the various parts but with a strong focus on localism, with Local Government playing a leading role, with public health teams led by a Director of Public Health.

1.3 Implementing the new system is a complex process and one that must be completed by April 2013. Therefore, it is essential to have a local transition plan that describes the key issues and actions that must be undertaken to ensure a smooth transition from the old system to the new system.

1.4 This transition plan is jointly owned between NHS Hartlepool as the statutory body currently responsible for public health and Hartlepool Borough Council who by 2013 will be responsible for public health. Joint ownership of this plan is essential, as it is imperative that there is robust governance, due diligence and accountability arrangements in place throughout the transition year 2012/13. This plan identifies what needs to be done; by when and who is responsible for ensuring progress is made and actions delivered.

1.5 This transition plan must be agreed with NHS Hartlepool and Hartlepool Borough Council Executive in draft form by the end of January 2012. This agreement must be in place as by this date a draft plan must be submitted to the Regional Director of Public Health (RDPH). The RDPH has responsibility for assuring the transition across the Strategic Health Authority clusters and approving each areas public health transition plans.

1.6 The creation of the Health and Well Being Board by 2013 was also a key feature of the public health white paper. This Board will also want to ensure the public health transition plan reflects the work of the Board and the Joint Strategic Needs assessment for Hartlepool.

Hartlepool
Public Health Transition Plan

Key Theme – Policy and Strategy

Key Issue	Actions	Timescale	Lead Officer	Progress
Publication of Healthy People Healthy Lives White Public Health Paper - Consultation 30th November – 31st March Publication of public health outcomes framework for consultation Publication of funding and commissioning of public health	Brief Corporate Management Team	December 2010	Assistant Director of Health Improvement	Complete
	Brief Cabinet	January 2011	Assistant Director of Health Improvement	Complete
	Establish cross departmental Assistant Director Transition Steering Group	January 2011	Assistant Director of Health Improvement	Complete
	Respond to White paper before 31st March	31st March 2011	Assistant Director of Health Improvement And Portfolio Holder for Public Health	Complete

Key Issue	Actions	Timescale	Lead Officer	Progress
Cross reference proposed public health outcomes framework	Consider framework alongside corporate outcomes framework (s)	End of February 2011	Policy Officer and Assistant Director of Health Improvement	Complete
Contribute to Regional Public Health Transition Group and Regional Health and Well Being Board Workstream	Ensure Hartlepool is represented regionally on transitions steering group	Ongoing	Assistant Director of Health Improvement	Underway and Hartlepool regularly feeds issues into group via Peter Kelly
Health and Well Being Partnership functioning in shadow form	Expression of interest submitted to be a pathfinder.	April 2011	Assistant Director of Health Improvement and assistant Director of Adult Social Care	Pathfinder status confimed
Establish shadow Health and Well Being Board		March 2012	Assistant Director of Health Improvement	Agreement secured through Cabinet to establish Board and 1st meeting took place n 10th October 2011 with elected Mayor to Chair

Key Issue	Actions	Timescale	Lead Officer	Progress
Ensure Public Health representation in GP Consortia for Hartlepool	Secure a place on the emerging GP Consortia Board	April 2011 / 12	Assistant Director of Health Improvement	Assistant Director of Health for Health Improvement is a voting member of Hartlepool Clinical Commissioning Group (CCG) for Hartlepool. Key public health issues such as immunisations, cancer and alcohol issues have already been debated by the CCG. There is representation from the CCG on shadow Health and Well Being Board.
Joint Strategic Needs Assessment and Public Health Intelligence	Refresh JSNA for 2011 and then for 2012 and 2013 when it becomes the responsibility of the Local Authority	October 2011 October 2012 October 2013	Assistant Director of Health Improvement	Underway and is a key task of shadow Health and Well Being Board.

7.4
APPENDIX A

Key Issue	Actions	Timescale	Lead Officer	Progress
Develop a draft Health and Well Being Strategy through Health and Well Being Board	Identify a team and process for writing strategy on behalf of board	April 2012	Assistant Director of Health Improvement	Underway

Human Resources

Key Issue	Actions	Timescale	Lead Officer	Progress
Publication of the Public Health Human Resources Concordat	Consider the Human resources Concordat in NHS Hartlepool and Hartlepool Borough Council (HBC) and identify issues for staff.	January 2012	Chief Customer and workforce Officer (HBC) and Director of Corporate Affairs (NHS Hartlepool)	HR Concordat published and work ongoing
Cabinet to consider options for appointing a Director of Public Health	Cabinet paper with options to be discussed and agreed by Cabinet.	5th December 2011	Acting Chief Executive	Complete
Recruitment of Director of Public Health	Job description to be developed and submitted to Faculty of Public Health for approval. Job advertised through NHS Hartlepool.	December 2011	Acting Chief Executive	Job description completed and submitted to faculty of Public Health

Key Issue	Actions	Timescale	Lead Officer	Progress
	Panel to be appointed. Interview candidates.	March 2012	Acting Chief Executive	Job to be advertised and panel appointed
Existing Public Health Staff	Transfer public health staff working base to Civic Centre	February 2011	Assistant Director of Health Improvement	Complete
	Undertake 1-1 interviews with all staff and assign them into groups as required by NHS HR	February 2011	Assistant Director of Health Improvement	Complete
	Consider implications of HR guidance for staff in relation to TUPE, terms and conditions, consultation and discussions with staff side and unions.	April 2012	Assistant Director of Health Improvement with Chief Customer and workforce Officer (HBC) and Director of Corporate Affairs (NHS Hartlepool)	This is dependent on national HR framework for public health / NHS staff and affordability.

Ring Fenced Budget

Key Issue	Actions	Timescale	Lead Officer	Progress
Publication of shadow public health ring fenced allocations to local authorities	Ensure investment programme for this resource is consistent with overall financial strategy of the Local Authority.	January 2012	Acting Chief Executive, Chief Finance Officer	HBC has contributed to the mapping exercise of actual 2010 / 11 spend as part of a national exercise to assist the DOH in identifying formulae and budget for each area. Shadow budget expected 2012/13
	Develop plans to invest this resource through the Health and Well Being Board to deliver the Health and Well Being Strategy	April 2012	Assistant Director of Health Improvement	Key task of shadow health and well being board is to develop Health and Well Being Strategy including plans for investment in services.

Contracting and Procurement

Key Issue	Actions	Timescale	Lead Officer	Progress
Identify contracting and procurement issues associated with services transferring to Local Authority responsibility in appendix 1.	Undertake a stocktake of all contracts, service level agreements and memorandum of understanding in place for all public health services as outlined in appendix 1 for 2011/12.	December 2011	PCT Public Health Contracts Manager Deputy Director of Procurement PCT	Underway and being led by PCT.
	Identify key leads for each of the contracts, service level agreements and memorandum of understanding from HBC and PCT during 2012 transitional year and beyond.	March 2012	Assistant Director of Health improvement / Assistant Director of Procurement	

Key Issue	**Actions**	**Timescale**	**Lead Officer**	**Progress**
	Prepare a legacy document of all programmes, schemes, services and activities commissioned with public health resources for 2011/12. This document will outline the services or activity, levels of investment and outcomes delivered to inform Local Authority of the legacy relating to this investment.	October 2012	Assistant Director of Health improvement	

Public Health Delivery

Key Issue	Actions	Timescale	Lead Officer	Progress
Identify services that can be shared with neighbouring authorities to maximise economies of scale for public health.	Participate in the prepare of a paper for the Tees Valley Chief Executives regarding in principle sharing arrangements of public health functions across Tees.	November 2011	Acting Chief Executive / Assistant Director of Adult Social Care	Complete
	Present to cabinet wider public health functions that could be shared across Tees of Tees Valley. List is appendix 2.	5th December 2011	Acting Chief Executive	Complete
	Present to cabinet wider public health functions that could be shared across Tees of Tees Valley. List is appendix	5th December 2011	Acting Chief Executive	Complete

	2.			
Key Issue	**Actions**	**Timescale**	**Lead Officer**	**Progress**
	Identify a lead Local Authority to host these functions.	February 2012	Acting chief Executive supported by assistant Director of Health Improvement	
	Agree a service specification and costings model and service level agreement for these functions.	October 2012	Acting Chief Executive supported by assistant Director of Health Improvement	
	If Hartlepool is not the lead authority hosting these functions, ensure the lead Authority considers and acts on all human resource issues relating to staff.	October 2012	Acting Chief Executive supported by assistant Director of Health Improvement / Director of Corporate Affairs (PCT)	
Integrate Public Health into the management structure of the Local	Identify the span of control and management functions	March 2012		

Authority.	and arrangements of			
Key Issue	**Actions**	**Timescale**	**Lead Officer**	**Progress**
	public heath as a Corporate function within the Local Authority.	March 2013	Acting Chief Executive	
Core Public Health Offer to Clinical Commissioning groups	Identify and agree the core public health offer to clinical commissioning groups including the local public health team in Hartlepool and shared functions across Tees / Tees Valley	October 2012	Tees Executive Director of Public Health / Assistant Director of Health Improvement / Chair of Clinical Commissioning Group	

Risk, Resilience and Emergency Planning Through Transition

Key Issue	Actions	Timescale	Lead Officer	Progress
Public Health representation on Local Resilience Forum (LRF)	Assistant Director of Health improvement (Hartlepool) to represent NHS Tees on LRF during 2012/13 for all emergency planning health issues.	Until April 2013	Assistant Director of Health Improvement (Hartlepool)	Ongoing
	Participate in the creation of Local Health Resilience Forum sub group of the LRF.	April 2013	Assistant Director of Health Improvement (Hartlepool)	Ongoing
Maintain NHS Emergency planning arrangements and business continuity	NHS Hartlepool will continue to host the emergency planning manager and prepare	April 2013	Assistant Director of Health Improvement (Hartlepool)	Ongoing

Key Issue	Actions	Timescale	Lead Officer	Progress
	plans to comply with the Civil Contingency Act 2004 until national guidance is produced indicating how this duty is to be discharged post PCT.	April 2013	Assistant Director of Health Improvement (Hartlepool)	Ongoing

Health Protection Through Transition

Key Issue	Actions	Timescale	Lead Officer	Progress
Maintain strong relationships with the Health protection Agency as their functions migrate to Public Health England	Ensure regular dialogue with the Unit Director of the HPA with HBC.	Ongoing	Assistant director of Heath Improvement and Unit Director of HPA	
	Ensure the Local Authority Cabinet and Health and Well Being Board are briefed on the importance of health protection and identify it as a key strategic	December 2011	Assistant Director of Health Improvement	HPA presentation to Health and well Being Board regarding transition and importance of health protection. Agreement has been secured to make immunisation uptake a key public health priority to

				address in 2012.
Key Issue	**Actions**	**Timescale**	**Lead Officer**	**Progress**
	priority for public health and the Health and well Being Strategy.	April 2013	Assistant Director of Health Improvement	

Governance Through Transition

Key Issue	Actions	Timescale	Lead Officer	Progress
Agree a governance process to ensure due diligence for all aspects of public health transferring to the local authority (contracts, staff indemnity, incident reporting, risk sharing agreements scheme of delegation, clinical governance etc.)	Scope issues with the Chief solicitor and the Director of Corporate Affairs for the PCT and agree a process and plan to mitigate risks.	March 2012	Chief Solicitor / PCT Director of Corporate Affairs	
	Identify any information governance issues as public health transfers to the Local Authority. This might be paper based or electronic information	July 2012	Chief Solicitor / PCT Director of Corporate Affairs	

	(Caldicott Guardian and information controller issues).			

Infrastructure

Key Issue	Actions	Timescale	Lead Officer	Progress
Access to HBC IT for Public Health staff	Ensure all public health staff have access to HBC IT and email accounts	February 2011	Assistant Director of Health Improvement	Complete
Asset register and transfer of assets	Identify all PCT assets currently used by public health staff and identify how these assets will be returned or utilised in future.	March 2012	Head of IT PCT	

Communication and Engagement Plan through Transition

Key Issue	Actions	Timescale	Lead Officer	Progress
Develop a joint communication plan regarding public health transition with HBC and NHS Hartlepool	Ensure the plan meets needs of staff through transition	Ongoing until April 2013	Head of communications HBC and Head of Communications PCT	
	Ensure the plan communicates a range of partners on a frequent basis e.g.: with Health and Well Being Board, community and voluntary sector providers, LINX or emerging health Watch, Clinical Commissioning Group	Ongoing until April 2013	Head of communications HBC and Head of Communications PCT	

7.4
APPENDIX A

NHS Commissioning Board – Public Health Transition (Local Level)

Key Issue	Actions	Timescale	Lead Officer	Progress
Clarity regarding critical public health functions including immunisation screening and infection control through transition.	Work with the Regional Public Health team to identify and agree a transition plan for those public health services transferring to the responsibility of the NHS commissioning board.	October 2012	Assistant Director of Health Improvement	Regional work on screening is underway.

Appendix 1

Public Health Functions Transferring from Primary Care Trusts to Local Authorities

1. Introduction

1.1 The publication of 'Healthy People, Healthy Lives: Our Vision for Public Health in England 2010' (Department of Health) described mandated functions that will transfer to the responsibility of the Local Authority.

'The Health and Social Care Bill allows the Secretary of State to prescribe that certain services should be commissioned or provided by local authorities, and certain steps taken. *Healthy Lives, Healthy People: update and way forward* set out why and how the Government intends to use these powers. We said:

"Wherever possible, we wish to transfer responsibility and power to the local level, allowing local services to be shaped to meet local needs. But there are some circumstances where a greater degree of uniformity is required. With this in mind, the Health and Social Care Bill allows the Secretary of State to prescribe that certain services should be commissioned or provided by local authorities, and certain steps taken. We consulted on which services should be prescribed in this way. Our decisions have been guided by the following principles. We will require local authorities to deliver or commission particular services where:

- *services need to be provided in a universal fashion if they are to be provided at all (this is particularly relevant to health protection, because if certain health protection services are not provided in a universal fashion, or not provided at all, there may be risks to population health and wellbeing);*
- *the Secretary of State is already under a legal duty to provide a certain service, but in practice intends to delegate this function to local authorities. Mandation will ensure that these obligations are met;*

- *certain steps that are critical to the effective running of the new public health system.*

"Reflecting on the consultation responses and following the above principles, we plan to prescribe that local authorities deliver the following services or steps:

- *appropriate access to sexual health services;*
- *steps to be taken to protect the health of the population, in particular, giving the Director of Public Health a duty to ensure there are plans in place to protect the health of the population;*
- *ensuring NHS commissioners receive the public health advice they need;*
- *the National Child Measurement Programme;*
- *NHS Health Check assessment;*
- *elements of the Healthy Child Programme."* [paragraphs 2.19-2.20]

It can be seen from the extract above that mandation is not intended to identify some services as more important than others. We expect all local authorities to tackle the key local health improvement issues, but their strategies will be determined by local needs rather than central diktat. Rather the issue is that in some areas greater uniformity is required. Below we provide more detail on each of the above areas. We plan to lay draft regulations in [mid 2012] before making final regulations later that year.

Public health topic	Proposed activity to be funded from Public Health budget
Sexual health	Testing and treatment of sexually transmitted infections, fully integrated termination of pregnancy services, all outreach and preventative work
Immunisation against infectious disease	School immunisation programmes, such as HPV.
Seasonal mortality	Local initiatives to reduce hospital admissions and seasonal excess deaths
Accidental injury prevention	Local initiatives such as falls prevention and reducing childhood injuries

Public mental health	Mental health promotion, mental illness prevention and suicide prevention
Nutrition	Locally led initiatives
Physical activity	Local programmes to reduce inactivity; influencing town planning such as the design of built environment and physical activities role in the management / prevention of long tram conditions
Obesity programmes	Local programmes to prevent and treat obesity, e.g. delivering the National Child Measurement programme; commissioning of weight management services
Drug misuse	Drug misuse services, prevention and treatment
Alcohol misuse	Alcohol misuse services, prevention and treatment
Tobacco control	Tobacco control local activity, including stop smoking services, prevention activity, enforcement and awareness campaigns
NHS Health check	Assessment and lifestyle interventions
Health at work	Local initiatives on workplace health and responsibility deal
Prevention and early presentation	Behavioural/ lifestyle campaigns/ services to prevent cancer, long term conditions, campaigns to prompt early diagnosis
Community safety and violence prevention and response	Specialist domestic violence services that provide counselling and support services for victims of violence including sexual violence
Social exclusion	Support for families with multiple problems, such as intensive family based interventions
Dental Public Health	Targeting oral health promotion strategies to those in greatest need.

Appendix 2 – Extract from Cabinet Paper 5th December 2011 Public Health – Future Options.

1. What is already shared across Tees for Public Health and what could be shared across Local Authorities in future?

Public Health is currently hosted within the NHS through the Primary Care Trust (PCTs). The 4 PCTs across Tees work on a shared management arrangement. The following public health functions are provided to support the 4 locality public health teams:

- Public health intelligence
- Infection control
- Emergency planning (including flu pandemic)
- Screening
- Immunisations
- Seasonal flu
- Dental public health
- Research
- Health equity audit
- Health needs assessments
- Oral health needs assessment
- Health impact assessment
- Cancer –early detection and awareness
- Cardiovascular disease
- Sexual health
- Commissioning obesity services
- Respiratory disease
- Long term conditions
- Public health input into funding

2 What Can be Done on a Supra Local Authority Basis (Beyond Tees Valley?)

2.1 There are also public health services that are currently commissioned or resources to participate in are committed to on a much wider scale than just the Tees Local Authorities. This includes the following:

FRESH – regional Tobacco Office
BALANCE – regional alcohol office
Regional Maternity Service Office
Public Health North East Intelligence North East (PHINE)
Better Health Fairer Health Strategy – Regional Action Groups
School of Public Health
Academic Public Health – FUSE

HEALTH SCRUTINY FORUM

23 February 2012

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Support Officer

Subject: SIX MONTHLY MONITORING OF AGREED HEALTH SCRUTINY FORUM'S RECOMMENDATIONS

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1. PURPOSE OF REPORT

1.1 To provide Members with the six monthly progress made on the delivery of the agreed scrutiny recommendations of this Forum.

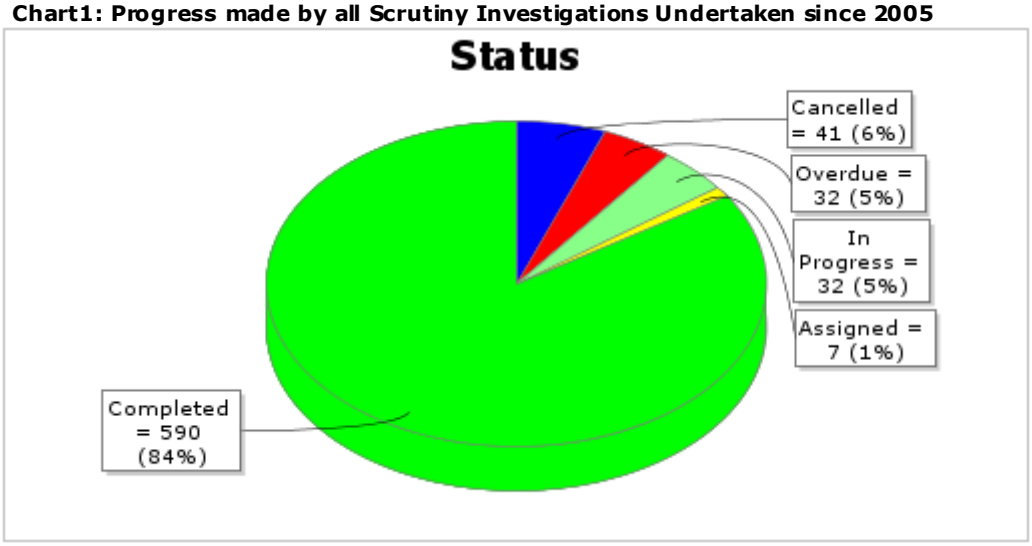
2. BACKGROUND INFORMATION

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

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

2.3 In accordance with the agreed procedure, this report provides for Members details of progress made against each of the investigations undertaken by the Forum. **Chart1** overleaf is the overall progress made by all scrutiny forums since 2005 and **Appendix A** provides a detailed explanation of progress made against each scrutiny recommendation agreed by this Forum since the last six monthly monitoring report presented in August 2011.

Chart1: Progress made by all Scrutiny Investigations Undertaken since 2005



3. RECOMMENDATIONS

3.1 That Members:-

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

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

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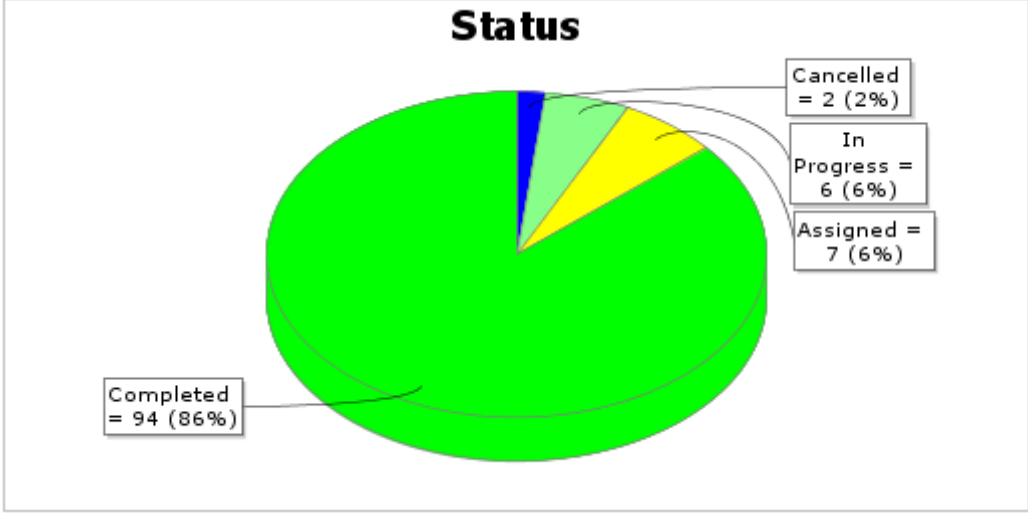
BACKGROUND PAPERS

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

Health Scrutiny Forum - All

Generated on: 10 February 2012



Year 2008/09
Investigation Reaching Families in Need

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
SCR-HSF/1a That the local authority take the lead in providing a co-ordinated leadership approach across the different	SCR-HSF/1a/i	The government has provided guidance regarding a "Think Family" initiative that we are developing in Hartlepool. This initiative will support this recommendation	Ann Breward; John Robinson	01-Mar-2011	01-Mar-2013	10-Jan-2012 The Early Intervention Strategy has been agreed by Cabinet and is now entering its final development stage before implementation	73%	In Progress

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
providers in order to facilitate a systematic approach to tackling health inequalities in the town.		and will endeavour to lead a culture change in the way that our services are designed.				05-Oct-2011 Think Family forms the basis of the new Early Intervention Strategy that is currently going through a consultation process.	
						08-Jul-2011 This work is currently being led by the Early Intervention Grant development group made up of senior children's services officers.	
						30-Mar-2011 Hartlepool is about to enter a period of service redisign that will be underpinned by Think Family. This process will enable the continued focus on whole family prevention and early intervention through the Early Intervention Grant.	
						08-Mar-2011 We continue to develop the Think Family approach when working with families that have multiple needs. We are using this approach with a number of families who require intensive interagency support.	
						12-Jan-2011 We	

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

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					Family Services continuie to make progress operationally and strategicall although at the current time there is not a requirement for a high level steering group. Partners from all sectors are involved in services that are operating in a way that puts the family at the centre of their work. Services for children and adults are being explored through the Young Carers Pathfinder and the Team Around processes. A Prevention/think family strategy is currently being prepared.	
					23-Feb-2010 Think Family Co-ordinator is now in post. Directors of Child and Adult Services is chair of the 'Think Family Steering Group'. Cross organisation social inclusion group is also in place to steer operationals aspects.	
SCR-HSF/1b That subject to the	SCR-HSF/1b The Think Family Reforms will be reported	Ann Breward; John Robinson	01-Mar-2011	01-Mar-2013	10-Jan-2012 The Early Intervention	05% In Progress

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
implementation of recommendation 1a, the local authority, acting as strategic leader, enter into formal arrangements with partner organisations (i.e. Police, PCT, FT, Housing Hartlepool and the Voluntary Sector).	through the Children's Trust that includes all major stakeholders in this process.				Strategy has been agreed by Cabinet and is now entering its final development stage before implementation. The Children's Trust are fully engaged in this process.	
					05-Oct-2011 The Children's Trust Partnership is fully involved in the development of the Early Intervention Strategy and is receiving regular reports as part of the pathway through local authority process.	
					08-Jul-2011 The work on the team around the household project is still in development and being led by the senior officers.	
					08-Mar-2011 A strategic group is actively engaged in indentifying elements of multi-agency practice, including the FIP, that can from the basis of future work with the most complex families.	
					12-Jan-2011 The second draft of the prevention strtaegy	

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

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					2011.	
					06-Apr-2010 The Think Family Coordinator is working with the Parenting Commissioner to develop a Vision Statement that will be put before the Children's Trust Board for discussion and agreement in June 2010. This will form the basis of an integrated strategy that delivers a ThinK Family approach across services.	
					23-Feb-2010 Expected to achieve target.	

Year 2009/10
Investigation Alcohol Abuse - Prevention and Treatment

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
SCR-HSF/3e/ii The current delivery model is made sustainable and the ability to increase the capacity of providers, whilst maintaining the current high standard, is	SCR-HSF/3e/ii	NHS Hartlepool Board considered the recommendations of the investigation at the board meeting in July. It was acknowledged by the PCT Board that alcohol and the funding of treatment services is a key priority. Officers will continue to work to	Louise Wallace	31-Mar-2011	31-Mar-2012	08-Mar-2011 NHS Hartlepool Board agreed in January 2011 that alcohol treatment and prevention services should be a priority. Currently in the process of identifying a supporting budget to secure funding for	CK	Assigned

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
prioritised.		identify resources on a recurring basis through the QIPP programme, particularly as it is recognised that there is a significant pressure on hospital services from alcohol related harm.				2011/12 resource.		
SCR-HSF/3f/i Address the problem of why people exhibiting risky behaviour in terms of alcohol don't utilise their GP as their first point of contact	SCR-HSF/3f/i	Work is ongoing to develop the GP Locally Enhanced Service (LES) to ensure GPs are able to offer effective and appropriate services for people in primary care. The LES has been drafted and is now in the process of being consulted on.	Louise Wallace	31-Mar-2011	31-Mar-2012	09-Jan-2012 Discussions are ongoing with the Clinical Commissioning Group regarding alcohol treatment pathways and investment in services. 12-Oct-2011 Discussions are ongoing with the Clinical Commissioning Group regarding sustainable funding for primary care interventions. 06-Jul-2011 This work is ongoing due to financial constraints. 08-Mar-2011 LES is currently being consulted upon as part of the gradual 'hand-over' from NHS Hartlepool to the GP Consortia.	75%	In Progress
SCR-HSF/3h In promoting safe, sensible drinking, that the Council be	SCR-HSF/3h	Securing Purple Flag status would be challenging and is an aspiration at this time	Ian Harrison	30-Sep-2011	30-Sep-2012	10-Feb-2012 New due date (08/09/12) - The Purple Flag Award is dependent	70%	In Progress

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
encouraged to evaluate any opportunities to work towards recognising the Town Centre as a Purple Flag zone.		considering the current level and baseline. Improvements would include not only the participation of licensees but also consideration of the wider night time economy environment which does need significant investment. There is however a tiered development plan in place to work towards this award. This includes more positive engagement with the trade to develop higher standards of customer care; more consideration of safe routes home and closer working with town centre management. One of the first stages is the voluntary adoption of voluntary codes by operators and moving to the introduction of the Best Bar None scheme. There will also be a review of the impact of the Transport Interchange.				upon the commitment of a range of private businesses - licensees. The trading environment is extremely difficult at present and this is making licensees more reluctant to commit to initiatives. Work is ongoing to improve and develop relationships within the trade but progress will continue to be slow until some of the internal relationships within the trade improve to a degree where they can work together. 08-Feb-2012 Work is continuing in January 2012 but internal difficulties within the licensing trade have affected the progress of voluntary initiatives such as Purple Flag. A new, rival, town centre only, licensees group began in October 2011 in an attempt to move a positive agenda forward and this was supported by both the Council and Police - however, the chairman has been moved by his employer to another	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					pub out of town and this has halted its progress. Street Pastors continue to work very well and additional funding is being sought to continue the taxi marshalling scheme for a further year. Positive work has also been carried out using the Courts to ban individuals from the Town Centre when they have been involved in alcohol fuelled violence and disorder.	
					07-Mar-2011 Marshalled taxi rank continues to operate on Saturday nights. A second Best Bar None meeting was held on 1st March but attendance was, once again, poor. One licensee has agreed to help promote the scheme but after discussions with Durham City council (whose BBN scheme won a national award in 2009) it would appear that significant Council resources will be required to promote and establish the scheme (DCC quoted	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					20 hours per week for first 3 months). Efforts will be made to secure private sector sponsorship but the success of this will be dependant upon obtaining more interest from the licensees themselves. Work is ongoing. Work has also begun on establishing a Street Pastor scheme with a meeting taking place involving SHP, Police, Council and Hartlepool Churches Together. A Steering Group has been formed and it is hoped Street Pastors will be operating later this year. Other steps taken include improving the street lighting in Lucan Street, erecting alley gates to the alleyways between Victoria Road and Lucan Street and Lucan Street and Middleton Lane (These alleys were used as late night short cuts but often resulted in assault, urinating etc), Taxi marshalling continues and a Taxi Shelter will be erected in	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					Church Street to assist with this. 18-Jan-2011 Best Bar None Scheme has been discussed on two occasions at Hartlepool Licensees Assn meetings and one specific BBN meeting has taken place. Interest in the scheme is slowly developing. Marshalled taxi rank has been operating in Church Street since October and is set to continue for 2011.	

Year 2010/11
Investigation Connected Care

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
SCR-HSF/5b That once recommendation (a) is completed, Connected Care is rolled-out to other communities in Hartlepool	SCR-HSF/5b	Discussions to be undertaken with local areas to ascertain if developing the connected care model in their areas would be a positive development. If this is the case then agreement on how this will be facilitated in each area and who will be involved is required. This may be different in different areas of the town as per the model	Jill Harrison; Geraldine Martin	31-Mar-2013	31-Mar-2013	04-Jan-2012 The development of the Who Cares (NE) Board to include representatives from the North and Central areas (elected members, residents and voluntary sector representatives) will ensure that there is an ongoing dialogue with local communities. 03-Jan-2012 Who	30% In Progress

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
		of connected care development. It is hoped that the CIC Who Cares (NE) may facilitate this dialogue with residents and community groups in the different areas.				Cares NE now has the funding in place to roll out the SAILS model and the handyperson service across the town. Work is ongoing to ensure there is an effective dialogue between Who Cares NE and residents and other organisations in the central and north parts of the town to so that the shape of services reflect local communities' needs.		
SCR-HSF/5b/i That once recommendation (a) is completed, Connected Care is rolled-out to other communities in Hartlepool:- (i) Ensuring that the necessary governance structure is in place.	SCR-HSF/5b/i	In each area a robust governance structure will be developed that has a local project group to steer and drive the developments and to ensure a truly local focus is developed. Also representatives from the central and north area projects will be part of the development of a town wide Who Cares (NE) Partnership Group to ensure the CIC develops as a true town wide entity.	Geraldine Martin	30-Sep-2011	31-Mar-2013	06-Feb-2012 Due date extended to March 2013 as a result of contract awarded being held up from April - October 2011. 03-Jan-2012 Connected Care is now being rolled out across the town and the Board membership has representation on it from both the Central and North areas of the borough. Development workers are liaising with residents from the new areas to ensure that services develop in a localised way to respond to local	CW	Assigned

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
						need.		
SCR-HSF/5b/ii That once recommendation (a) is completed, Connected Care is rolled-out to other communities in Hartlepool:- (ii) Identifying the needs of the individual community from residents and ensuring the delivery of a bespoke service.	SCR-HSF/5b/ii	Each local area will develop and complete its own audit to identify how a connected care approach will inform the development of models that meet local needs. Who Cares (NE) can facilitate audits in other areas if required. At the request of local people in Burbank, Who Cares (NE) has already begun to work with local residents and organisations to complete a community audit in Burbank.	Geraldine Martin	30-Sep-2012	30-Sep-2012	03-Jan-2012 Burbank audit has been completed and local residents' views taken into account when developingl services local to the central area of Hartlepool. Similar work is being developed for the north.	CX	Assigned
SCR-HSF/5b/iii That once recommendation (a) is completed, Connected Care is rolled-out to other communities in Hartlepool:- (iii) Ensuring that partnership arrangements are in place for current service providers.	SCR-HSF/5b/iii	The success of the connected care model is based on bringing together existing services and community organisations within local communities to reduce duplication and encourage partnership approaches. Who Cares (NE) can facilitate this development in other areas to ensure that there is local ownership and that despoke services are developed, tailored to local needs. It would be a requirement within any contract linked to connected care that this approach to partnership	Geraldine Martin	31-Mar-2013	31-Mar-2013	03-Jan-2012 Who Cares NE has brought together a number of partners to represent the North and Central areas of the town and sit on the CIC Board. The Board is committed to partnership working and local services that reflect local needs. This requirment has been written into the contract and wil be monitored.	CX	Assigned

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
		is followed.						
SCR-HSF/5b/iv That once recommendation (a) is completed, Connected Care is rolled-out to other communities in Hartlepool:- (iv) That a feasibility study is carried out into support for the Connected Care roll-out through the transfer of staff.	SCR-HSF/5b/iv	Monitoring the development of the model across Hartlepool will determine whether the outcomes justify the transfer of resources in the future.	Jill Harrison; Geraldine Martin	31-Mar-2013	31-Mar-2013	04-Jan-2012 The connected care model is currently funded from a range of sources until March 2013 at a total cost of £340k p.a - this includes care navigation, the SAIL service and the Handyperson Service. Funding sources include PCT Funding for Social Care (£120k), PCT Reablement Funding (£120k), PCT base budget (£50k) and HBC base budget (£50k). The longer term viability of commissioning the model across Hartlepool will be determined by the outcomes achieved between November 2011 and March 2013 and the continuation of funding beyond that date.	75%	In Progress
						03-Jan-2012 A range of data is being collected to monitor and evaluate outcomes as the model is rolled out across the town. The multi agency advisory group will be tracking		

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
						progress and receiving a bi-monthly report from Who Cares NE. The Health and Wellbeing Board will be kept informed as to progress.		
SCR-HSF/5c/i That following the completion of the work being undertaken by the LSE:- (i) That the findings are shared with the Health Scrutiny Forum.	SCR-HSF/5c/i	Research findings from LSE will be presented to Health Scrutiny Forum.	Geraldine Martin	31-Aug-2012	31-Aug-2012	03-Jan-2012 -- enter new status update -- Research findings will be fed back to Scrutiny members once the data has been collected and evaluated by LSE .	CX	Assigned
SCR-HSF/5c/ii That following the completion of the work being undertaken by the LSE:- (ii) That where evidence demonstrates the financial benefits of Connected Care, those organisations benefitting from early intervention by Connected Care.	SCR-HSF/5c/ii	Positive outcomes highlighted in the LSC research will be used to encourage all agencies that benefit from the preventative / early intervention approach to contribute to the ongoing delivery of services via a connected care model.	Geraldine Martin	30-Sep-2012	30-Sep-2012	03-Jan-2012 -- enter new status update - LSE and Who Cares (NE) have had preliminary discussions as to the data needed to be collected etc with a further meeting scheduled early in the new year. 03-Jan-2012 -- enter new status update --	CX	Assigned
SCR-HSF/5d That in order to ensure the safety of Connected Care Navigators and as part of a multi-disciplinary	SCR-HSF/5d	Work has already commenced to explore how staff delivery prevention and early intervention services can have access to the Care First system and	Trevor Smith	31-Dec-2012	31-Dec-2012		CX	Assigned

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
approach to meeting the needs of individuals, that a feasibility study be undertaken into Navigators accessing Care First, Rio, EPR.		the Employee Protection Register (EPR).					

Year 2008/09
Investigation Reaching Families in Need

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
SCR-HSF/1c That the FIP Project be expanded in light of its effectiveness thus far in targeting hard to reach families.	SCR-HSF/1c	The Family Intervention Project (FIP) is currently being developed as an integrated part of the Team around the School initiative. This service has been designed to enable new services to be bolted onto it and to adopt the FIP approach to assertive support.	Ann Breward; John Robinson	01-Dec-2011	01-Dec-2011	10-Jan-2012 FIP is now an integral part of services. 08-Jul-2011 The FIP continues to get national focus and in Hartlepool we continue to develop the FIP to complement other work programmes. 08-Mar-2011 Like most services the FIP has taken a cut in funding for 2011/12. This has given the impetus to partners to engage in a process of redesign that will focus even more on those families at the more complex end of the	100% Completed

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					spectrum.	
					12-Jan-2011 The FIP service continues to be effective and is leading on our integrated services for families. The coalition government has put the intensive interventions agenda at the forefront of its strategy for families with multiple needs. The resources available to provide services in the future are curently under discussion.	
					27-Sep-2010 The Family Intervention Project continues to provide a range of services through the team around the primary school process. The service is currently involved in developing intensive packages of support for children on the cusp of care or those that may require external placements. Service development will be impacted upon by the government spending review.	
					06-Jul-2010 The government has removed the funding	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					ring fence on this programme and has consequently dropped its montoring responsibilities. This will enable Hartlepool to further develop the Family Intervention project as an integral part of the team around the school approach.We will continue to use this funding to explore tyhe development of direct support to targeted families. The Housing FIP is in a similar position and will be developed in line with other preventative services.	
					06-Apr-2010 In March 2010 Hartlepool was succesful in a bid to develop a Housing Challenge Family Intervention Project with Partners from Housing Hartlepool, NDC and Belle Vue Centre. This project will bring an additional £87,000 into the town and will link with the Team Around the School Initiative that concentrates on housing in the Belle Vue area.	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						23-Feb-2010 Service continues to develop with further opportunites being offered by government. Housing worker and 3 seperated parent workers have joined the team.	
SCR-HSF/1g That in order to strengthen links and communication routes between agencies, the establishment of a co-ordinated, single point of contact for the referral of information and referrals from any source be explored.	SCR-HSF/1g	We will explore current communication routes being developed by community safety, the Team Around the School Initiative and Family Information Service to further this action and provide a report to the Children's Trust and Cabinet.	Ann Breward; John Robinson	01-Mar-2011	01-Dec-2011	10-Jan-2012 Ecaf will be implemented after testing in January and all key partners have agreed to participate. The Early Intervention Strategy includes plans to develop an information Hub that will include the learning from the successful implementation of the CAF service.	100% Completed
						08-Jul-2011 The Common Assessment Team will start a pilot in August and will model new practice linked to the early intervention service and the Duty Team.	
						30-Mar-2011 As part of the initial redesign that takes into account this action the CAF Coordinator will lead a small team as part of the Prevention Service to	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					provide a single pathway for all families requiring an intervention. This will be a pilot in 2011/12.	
					08-Mar-2011 The new funding context has resulted in the need to redesign prevention services and this will take place during 2011. The need for a single entry system still has to be realised.	
					12-Jan-2011 Thinking continues to change around the opportunities to get this process right and in place. As a consequence of budget constraints services are being refocussed. The second draft of the prevention strategy has been circulated for comment and if accepted will get us closer to this aim but this is unlikely to be realised within this financial year.	
					27-Sep-2010 The prevention strategy is in its second draft and is on track for full implementation by March 2011. The issue of a single point	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					of contact is not yet realised although a single point of referral is getting closer as a consequence of the team around process.	
					06-Jul-2010 After a development meeting to discuss the reintroduction of the Hartlepool Intervention Panel those present expressed the belief that this was not a system that is currently required the work including the circle of adults was seen as sufficient. We will return to this if needed.	
					06-Jul-2010 The Team around the school process is refining referral routes operationally but needs to be cemented through policy and procedure The development of the Team Around the School processes will continue as the focus of a new preventative strategy that will be written during 2010/11	
					06-Apr-2010 The	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						Parenting Commissioner has reinstigated the Hartlepool Intervention Panel to support the development of this work. The panel is made up of senior managers that have strategic and operational responsibilities who are in a position to make decisions regarding gaps in service, resource issues and "stuck cases" that are creating major concerns.	
						23-Feb-2010 Initially this process is to be looked at by the Family Intervention Project Steering Group. A YCAP database is being developed and a police officer has joined the TAPs team to look at some of the issues.	
SCR-HSF/1h That the feasibility of introducing a similar way of gathering and sharing data in Hartlepool, as has been implemented	SCR-HSF/1h	We will investigate this issue as part of the development of the Common Assessment Framework linked in with the Children's Trust, the Local Safeguarding Children	Ann Breward; John Robinson	01-Mar-2011	01-Dec-2011	10-Jan-2012 Ecaf will be implemented after testing in January and all key partners have agreed to participate. The Early Intervention Strategy includes plans to	100% Completed

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
by Westminster Council (i.e. a Multi-Agency Information Desk) be explored.	Board and the Safer Hartlepool Partnership. These developments will need to take account of the current sub regional agreements that are in place.				develop an information Hub that will include the learning from the successful implementation of the CAF service.	
					08-Jul-2011 The Common Assessment Team will start a pilot in August and will model new practice linked to the early intervention service and the Duty Team.	
					30-Mar-2011 The new service being led by the CAF Coordinator (May 2011) will enable Hartlepool to further explore the issue of multi agency information sharing.	
					08-Mar-2011 It is now highly unlikely that we have the structures that will enable Hartlepool to replicate the Westminster model. In the redesign of services there is an intention to develop a new assessment process that may enable us to move towards a similar process.	
					12-Jan-2011 A recent	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					audit of CAF has shown that assessments are of variable quality and that as a system more progress needs to be made before it can be seen as fully integrated. There has been some delay with ECAF and it is still not cirtain that the system will be adopted in Hartlepool. A decision will be made on this soon. Currently due to budget constraints and service redesign across partners we are not in a position to develop a Westminster model in Hartlepool although it remains a model that practitioners are keen on.	
					27-Sep-2010 The CAF Coordinator has recently reported to the Children's Trust and the Safeguarding board regarding progress in development. The ECAF system is soon to go live and it is expected that this system will support better quality assessments and easier access.	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					Hartlepool partners have not yet agreed a process based on the Westminster family recovery model although there are now several individual cases where the process of one information coordinator is in operation. This process will be monitored to ensure any learning is not lost.	
					06-Jul-2010 The CAF Coordinator is currently taking a quality audit of CAF that will result in new policy and guidance. This audit will be completd by October 2010.	
					06-Apr-2010 The CAF Coordinator is currently providing training for staff across agencies to support the development of this process. We are currently developing new monitoring systems based on family outcomes rather than numbers of CAFs completed. This shows that we are entering a	

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

Year 2009/10
Investigation Alcohol Abuse - Prevention and Treatment

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
SCR-HSF/3c/ii Looks to pool resources in the treatment and prevention of alcohol related problems	SCR-HSF/3c/ii	The terms of reference for the Strategy Group and the self assessment/improvement plan confirm a commitment to pool and maximise resources for more effective responses. This will be influenced however by the Governments announcement on funding allocations and governance structures e.g. GP Commissioning and the abolition of Primary Care Trusts, the	Michelle Chester; Chris Hart	30-Apr-2011	30-Apr-2012	01-Feb-2012 Alcohol, drug and offending budgets integrated and managed through joint substance misuse Commissioning Group	100% Completed
						13-Oct-2011 Review of Safer Hartlepool Partnership structures confirmed terms of reference and activity of Substance Misuse Commissioning Group and Alcohol Strategy Group. Investment for drug services	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
	detail of which is not likely to be known until January 2011.				increased for 2011/12 with general advice that llocation will continue at similar levels for 2012/13.Resources for alcohol limited and Total Place exercise planned for Q3/4. In addition discussion initiated with GP Consortia in advance of proposed NHS changes to structures, finance and commissioning responsibilities.	
					12-Jul-2011 Funding from PCT has been confirmed as recurrent and within the NHS changes should continue to be available in future years. QUIPP initiative is expected to illustrate business case for future resources and models of treatment. Hartlepool Alcohol Strategy Group mapping and scoping services and investment with plans to negotiate with PCT and evolving GP Consortia for future years investment. Discussion also intended with other key responsible	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					authorities re investment. National Treatment Agency and Balance North East taking lead to map and scope alcohol services r.egionally to build case for Public Health England debate	
					18-Apr-2011 PCT funding for alcohol community treatment confirmed 29th March 2011. No increase in previous years level of funding which will lead to capacity issues and waiting lists. PCT have confirmed QUIPP monies for 12 months to improve pathways and process with the intention of reducing hospital admissions. Safer Hartlepool Partnership grant aid will allow offender alcohol project to run and a proportion of drug pooled treatmentmonies has been used to enhance community treatment and offender programmes. SHP Alcohol Strategy Group have considered the level of resources and will be discussing	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
					investment with PCT Chief Executive and other partners.The governments proposals to NHS changes including GP Consortia role and budgets fo commissioning services are to pause pending further consultation. Guidance and frameworks may not be available until 2012 at the earliest.	
					03-Mar-2011 On 1/3/11 no decision had been made by the PCT on budget allocations for 2011/12. The decision is expected towards the end of March 2011. Changes to the guidance relating to the allocation of funding for drugs treatment from Dept of Health, indicate that a small proportion of funding can now be utilised for individuals who have significant problem associated with alcohol misuse.	
					24-Jan-2011 There is commitment from PCT to provide 'invest to save' budget re	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						hospital admissions, but still awaiting confirmation of local treatment budgets, although it is anticipated this will be forthcoming.	
SCR-HSF/3e/i The funding of alcohol treatment and prevention services is ring-fenced and mirrors illegal drug treatment and prevention	SCR-HSF/3e/i	NHS Hartlepool Board considered the recommendations of the investigation at the board meeting in July. It was acknowledged by the PCT Board that alcohol and the funding of treatment services is a key priority. Officers will continue to work to identify resources on a recurring basis through the QIPP programme, particularly as it is recognised that there is a significant pressure on hospital services from alcohol related harm.	Louise Wallace	31-Mar-2011	31-Mar-2012	09-Jan-2012 Action complete 12-Oct-2011 The NHS Hartlepool funded QIPP scheme is now being delivered to reduce emergency admissions. This is in keeping with the Alcohol Strategy overseen by the Alcohol Strategy Group. 06-Jul-2011 A meeting between the Chair of NHS Hartlepool, Chief Executive of NHS Hartlepool and Lead Member for the Alcohol Strategy Group with the intention of gaining high level support for this issue has been arranged. The PCT has invested in an alcohol scheme with an aim of reducing emergency admissions to hospital as part of the QIPP Programme.	100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						08-Mar-2011 NHS Hartlepool Board agreed in January 2011 that alcohol treatment and prevention services should be a priority. Currently in the process of identifying a supporting budget to secure funding for 2011/12 resource.	
SCR-HSF/3f/ii Ensure that all GP practices are trained in terms of brief interventions	SCR-HSF/3f/ii	Any training issues are expected to be identified through this process. This LES will ensure that GPs are a first point of contact as they will be actively engaging with patients who have hazardous and harmful drinking behaviours.	Louise Wallace	31-Mar-2011	31-Mar-2012	09-Jan-2012 Action complete 12-Oct-2011 Brief interventions training is ongoing as part of the QIPP programme across primary and social care. 06-Jul-2011 This issue is ongoing due to financial constraints. 08-Mar-2011 LES is currently being consulted upon as part of the gradual 'hand-over' from NHS Hartlepool to the GP Consortia.	100% Completed

Year 2010/11
Investigation Connected Care

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
SCR-HSF/5a That a strategy is devised to identify those communities within Hartlepool who may benefit from the delivery of the Connected Care model.	SCR-HSF/5a/i	The external evaluation for the delivery and impact of connected care has been very positive. Ongoing funding is in place via both the Council and the PCT for the development of care navigation services (which were originally planned for the Owton Ward). It is proposed to use this funding for a further two years to enable services to be developed in other communities using the connected care model of community audits and bringing together existing community groups to deliver seamless services.	Jill Harrison; Geraldine Martin	31-Mar-2013	31-Mar-2013	03-Jan-2012 Who Cares (NE) has now received the additional 2 years funding to enable the SAILS and handyperson services to be developed across the town. Who Cares is working closely with local partners from the North and Central areas of town to ensure a localised response in the way the services are shaped in each area.	100% Completed
SCR-HSF/5a That a strategy is devised to identify those communities within Hartlepool who may benefit from the delivery of the Connected Care model.	SCR-HSF/5a/ii	As part of the reablement plan delivery the PCT and LA have agreed that a range of low level health and social care services can be provided as part of the connected care model of service delivery. It was therefore agreed to commission services across the town that provide low level support and prevention to maintain people within their own communities (including	Jill Harrison; Phil Hornsby	31-Jul-2013	31-Jul-2013	04-Jan-2012 The Supported Access to Independent Living (SAIL) service has been commissioned from 1 November 2011 to provide a range of low level services across Hartlepool in line with the connected care / care navigation model. Services include the handyperson service, home visiting, welfare notices, luncheon clubs and social	100% Completed

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
	welfare notices, luncheon clubs, handy person service, fuel poverty advice and a home visiting service) for two years from April 2011. It is envisaged that this in the first instance this may involve all local organisations in coordinating these type of services in the medium term.				activities. Who Cares (NE) is the overarching organisation holding the contract and is working with other local organisations to co-ordinate services and avoid duplication. The Board of Who Cares (NE) now includes representatives from the North and Central areas of the town (elected members, voluntary sector group representatives and residents) to ensure that a local focus is maintained.	

HEALTH SCRUTINY FORUM

23 February 2011

Report of: Scrutiny Support Officer

Subject: NORTHERN DOCTORS URGENT CARE – OUT OF HOURS SERVICES – PROGRESS REPORT

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1. PURPOSE OF REPORT

1.1 To present to Members details of the progress report complied by Northern Doctors Urgent Care Ltd (NDUC) into Out of Hours Services across the Tees Valley.

2. BACKGROUND INFORMATION

2.1 At the meeting of the Forum held on 26 January 2012, an issue was raised in relation to a meeting of the Tees Valley Health Scrutiny Joint Committee (TVHSJC) held on 21 November 2011, at which the Members of the TVHSJC received a progress report complied by NDUC into Out of Hours Services across the Tees Valley.

2.2 Therefore, attached as to this report are details of the presentation provided by NDUC at the TVHSJC meeting of 21 November 2011 as below:-

(i) Appendix A – Transcript of evidence provided to TVHSJC
(ii) Appendix B – Details of the survey undertaken with patients
(iii) Appendix C – Breakdown of the cases received by NDUC at the Hartlepool

3. RECOMMENDATIONS

3.1 That Members note the content of this report and the NDUC report (attached as **Appendix A**) indicating if any further action is required.

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

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

(a) Minutes of the meeting of the Health Scrutiny Forum held on 26 January 2012.

(b) Minutes of the meeting of the Tees Valley Health Scrutiny Joint Committee held on 21 November 2011.

I have been asked by the Tees Valley Health Scrutiny Joint Committee to complete a review of the services provided by NDUC in the Teesside area. This report will be presented to the above committee on Monday 21st November 2011 at the Town Hall, Middlesbrough.

NDUC Teesside service details

The service in the Hartlepool area went live at 18.00hrs on 1st November 2010 and at 18.00hrs on 1st February 2011 for the remainder of the Teesside area, i.e. Redcar & Cleveland, Middlesbrough and Stockton. I have been asked to review the service so far.

Until 1st February, the call centre was run from our base at Northumberland House in Newcastle. From the inception of the whole Teesside service, the call centre has been based locally in Crutes House, Teesdale Business Park, Thornaby. From here basic demographics are taken by our specially trained call handlers. Calls are allocated using our clinically validated urgency criteria. Triaging clinicians are GPs, as well as nurses who have been trained to use a computer support tool underpinned by critical thinking. Depending on the urgency of the patient's condition, calls may be allocated as an immediate 999 referral; as an urgent case for clinical triage, in which case they will expect to receive a call back from the clinician within 20 minutes, or as a routine call in which they will expect a call back within an

hour. Following this triage, the call may be concluded with telephone advice only, i.e. self care, etc; as a home visit, or as a face to face consultation with a GP at one of our urgent care centres. All our face to face consultations are undertaken by a general practitioner. After every contact with NDUC, full safety netting advice is always given, either by the call handler or by the clinician, advising the patient [or carer] to ring the service immediately if they notice a change in the patient's condition, or if they are worried in any way.

You may remember that when I last met with you I spoke about the National Quality Requirements or NQRs. These are the nationally defined targets that we are obliged to attain, and mean that we should see urgent categories of patients face to face within 2 hours and the more routine patients within 6 hours. However, the commissioners for your contract have requested that NDUC undertakes what they define as Local Quality Requirements. This requires patients with urgent problems to be seen face to face within 90 minutes and patients with more routine problems within 4 hours.

Currently NDUC operates urgent care centres from several bases spread right across the area. These are in Redcar, Guisborough, Eston Health Centre in the Low Grange Health Village, Resolution at North Ormesby Health Village, Tithebarn in Stockton and the One Life Centre in Hartlepool. We also operate out of the consulting rooms in Crutes House.

I have included a basic table taken from the template that we send monthly to our commissioners. This shows our call volumes over the past nine months. We have dealt with between 5,500-7,000 cases per month for the Teesside area which will probably equate to just over 70,000 cases per year. On average around 33 % calls resulted in telephone advice, i.e. self-care advice etc, whilst around 25 % patients were seen in centres and about 15% patients were visited at home. The remaining cases were passed over to

the district nurses, resulted in a 999 response or were referred to A&E or directly to hospital for admission where clinically appropriate.

I have reviewed our activity over the past month across the whole area, which is entirely representative of our achievements, and can confirm that we are 100% compliant with regard to telephone advice for both urgent and routine calls. Similarly, if we look at the urgent face to face consultations, whether they are home visits or centre visits, we are proud to say that we saw 99% of the patients within the national targets. However, we admit that we are finding it a challenge to see all urgent patients within the 90 minute time window set by commissioners as part of the local quality requirements. In October we saw 92% of urgent patients within the 90 minute period. Often the reason for not achieving this target is because of extraneous factors such as traffic levels or even a football match. Again we saw 94% of routine patients within the four hour time frame. We are currently working on strategies to improve this compliance against the local quality requirements of the tighter time frame, without having to reduce the home visiting rate.

October 2011

	Breach	Compliant	Total	%
TRU	**5**	3165	3170	**100**
TRR	**7**	608	615	**99**
F2F R	**9**	1488	1497	**99**
F2F U	**6**	440	446	**99**
LQR 1	**17**	206	223	**92**
LQR 3	**86**	1411	1497	**94**

I have reviewed the complaints from the whole Teesside area since February. The governance team sits independently of the clinical and operational teams and investigates all concerns in a totally unbiased manner. We investigated 37 complaints out of the 52,333 cases we dealt

with in your area. These mostly related to attitudes of staff or perceived waits for visits. However, a proportion of these investigated complaints were not upheld. All responses are sent to Tees Client Services for independent review, and all are reported monthly to our commissioners for further detailed evaluation if necessary. Each quarter we present and discuss all complaints with our commissioners.

What is NDUC's view on how the Tees Out of Hours service has gone so far?

We have reviewed our service both internally and with reference to external sources.

Challenges

Staff

As you are aware NDUC took over the out of hours contract from Primecare. The people issues associated with the transfer of North Tees & Hartlepool NHS Trust and Primecare from 1 November 2010 and 1 February 2011 respectively has proved to be very challenging, requiring significant amounts of management time to be spent to identify, develop and implement solutions. All of these concerns have been successfully addressed.

NDUC incurred significant costs and management time associated with the recruitment of GPs for the Teesside GP OOH Contract. NDUC initially took over the majority of GPs who had previously provided support to Primecare. However, following a recruitment campaign over the past few months we have successfully introduced new GPs to the service.

Alongside the requirement to familiarise the GPs with NDUC's procedures and new telephone and IT systems, it was immediately necessary to address and resolve performance issues with some of the practices and quality of service being delivered by these individuals.

GP recruitment is ongoing for Teesside with regular induction and shadowing sessions scheduled to all recruits. Similarly, refresher training sessions and workshops have been successfully implemented so that clinicians are kept fully informed of all changes. All GPs are reviewed as part of our rolling call review programme. This means once GPs had commenced working with NDUC, we immediately reviewed at least 4 of their telephone triage calls entirely randomly. From this we were able to analyse the qualities and competencies of those doctors who are new to us. We were then able to identify any learning needs, as well as individually highlight quality doctors. Any clinicians who did not attain our standards were either invited in to meet with our clinical executive, or were not employed. NDUC made an executive decision around 3 years ago not to employ agency doctors, and all doctors working for NDUC are 'local' doctors.

On a very positive note, we have been approached by several local quality GPs who have heard of the philosophy of our organisation and are interested in working for us.

Logistics

The first week or so was spent in understanding the geographical area. Unfortunately, some the ex Primecare staff though local, had covered other regions for their company and we had to familiarise them with their locality. However, all new staff that we have appointed are local. We are proud that our in-depth training programmes have created a wealth of local knowledge now available to us.

Patient demand

Similarly, we have made considerable efforts to understand local patient demand and address patients' needs. We have noticed that Teesside patients have very high expectations and can be slightly more demanding and impatient than those in the North area. Therefore, we have risen to the challenge, and as you have seen from the statistics previously presented, we generally satisfy these expectations.

Dental cases

However, we note that out of hours dental calls remain very high. NDUC provides the call handling and dental nurse triage for these patients. The callers to this service have often long standing and very complex dental problems and many are not registered with their own in hour dentists. They therefore contact the service in time of dental crisis.

Hartlepool One Life Centre

We are currently experiencing challenges regarding the One Life Centre and the integrated model of care that has been introduced in Hartlepool. Some issues have been exacerbated by the closure of the A&E department at Hartlepool Hospital, some of which have been reported to the Hartlepool Mail. It is apparent to us that Hartlepool residents struggle to understand what each of the services does and how they all fit together. NDUC has always been very clear that it does not operate a walk in centre and that all patients must be triaged by telephone before further appropriate care is given. I understand that efforts have been made by the commissioners to disseminate clarifying communications to all local service users. However, just to reiterate, the service that NDUC delivers at the One Life Centre complies with our contract, with most patients being seen within the required time frames. Once they have arrived, very few patients have to wait for their appointment.

Urgent care centres

As you are aware we currently can utilise urgent care centres in Redcar, Guisborough, the Eston Grange Health Centre in the Low Grange Health Village, Resolution at North Ormesby Health Village, Tithebarn in Stockton and the One Life Centre in Hartlepool. We also operate out of the consulting rooms in Crutes House. However, in practice, we have rarely used the urgent care centre based in Guisborough and Tithebarn. We will of course provide transport to and from the centres where necessary.

External challenges

The key challenge which faces NDUC in line with other providers in the health economy concerns improving efficiency within a very tight budget. NDUC therefore needs to meet its challenging targets without impacting adversely on quality or performance. Clinical safety is obviously paramount.

Another challenge is that of integrating with our co-providers. We have worked hard and are continuing to develop strong and productive links with the palliative care teams, the various district nurse groups and the safeguarding agencies. We have worked very productively with our in hours GP colleagues and have developed good working relationships with them.

A large challenge which to some extent is outside our control is that of public engagement with our potential patients. I understand that the commissioners have a winter health campaign which should clarify which service is the most appropriate.

One of the most significant challenges for NDUC is the changing commissioning landscape. We have significantly felt the loss of key commissioning staff, with many of whom we have developed close and

productive working relationships. The contract is now managed by the North East Primary Care Services Agency based in Sunderland.

A challenge for all NHS organisations is compliance with the government's new requirements. The Department of Health has issued its expectations regarding information governance requirements. Each NHS organisation has been required to complete a very comprehensive 'toolkit' regarding their compliance. Part of this involves each staff member annually undergoing an extensive, though absolutely necessary, internal training programme which has proved to be very time consuming.

Currently NDUC is also completing its application process as part of registration with the Care Quality Commission. This will mean that it must evidence the elements required by the Commission by its registration date in April 2012. We are well on our way towards full compliance with these requirements

Reponses to challenges

Generally

Generally, the perception from internal and external sources is that the service has gone well. We have had positive feedback from the GPs who currently work for us. They appreciate the fact that we are more structured, they like the way we operate and the criteria we use to allocate visits. They positively acknowledge the fact that we are locally run from a local operating centre, and we employ local responses to issues rather than the more centralist approach that had been often previously used. Many GPs have commented on the friendly nature of the organisation and that they appreciate that many of the administrative and management staff from Newcastle often work at Crutes House, thus facilitating an integrated approach to the service.

Local integration

Additionally, we have worked hard over the past nine months to develop close links with our in hours GP colleagues. Both services fully recognise the importance and benefits of close integration in patient care so that care quality is seamless. We have taken on board some proposals that the in hours GPs have made and thence improved the passage of information between services. One of these suggestions involve our governance team ringing each GP practice first thing the next working day and informing them personally of their patients who have died during our period of operation.

NDUC has benefited by being incorporated into the active local urgent care network. Monthly meetings take place to discuss common interests and concerns.

As you are possibly aware NDUC currently does not have access to the national Summary Care Records system. Therefore, we have worked extremely hard in raising the profile of our internal special patients register with all our in hours colleagues. Relevant additional information may be passed on to us regarding those patients which any GP practice, nursing service or safeguarding service such as those run by child protection, judges would benefit from us holding and making available to our clinicians. We have now introduced an electronic system where each practice inputs and manages their own special patients, initially very supported by our administrative staff who provide a helpdesk. This has been well received. We are currently rolling this method out with the various district nurse and palliative care teams so that we have a greater understanding of individual patient care needs throughout the whole area covered by NDUC.

We have worked hard to forge links with the local palliative care and district nurse communities, both in hours and in the out of hours period. Our clinical services manager and operations manager regularly meet with

these groups. Our integration has allowed us to jointly explore learning from cases and this has meant that we have jointly been able to improve some elements of patient care in the area, for example the death verification process. We now provide the on call clinical service for the Butterwick Hospice.

We are working hard to develop a strong working relationship with the Safeguarding leads, with regard to Child protection and also safeguarding adults [POVA].

All consultations are passed to GP practices next working day. Any urgent cases are flagged up and passed independently by the governance team to the patient's own GP the next working day for closer scrutiny and attention.

All patients who are unregistered or visitors are automatically passed through to a clinician the next working day for review and follow up according to clinical need. This means we check the patient's demographics on the NHS spine and pass on to the correct recipient accordingly. This ensures that patients do not fall through the cracks and are followed up by their own GP. As we discussed last time, we have a surprising number of such patients to review on a daily basis.

Similarly, where a patient has contacted the service several times over a short period, we contact the patient's own GP to highlight our concerns and perhaps set up a joint meeting to identify ways of best managing the patient. We have contacted local GPs since we took over the service on many occasions for this.

A&E

We have initiated an email conduit so that A&E staff may request an investigation into the reasons for a patient's referral. We will then feedback our findings to the referring staff concerned.

Internal service improvements

Having monitored and assessed the implementation of the service over the past few months, NDUC believes that patients will benefit from 'call blending'. This means that although we operate a local call centre in Stockton and another based in Newcastle, that all calls from patients will go into a central queue and for each call the clinician will operate a cab-rank rule, i.e. they will take the next call from the queue. The benefits of this are that there is a build up of greater local knowledge and familiarity of processes for all clinicians; it gives a balanced method of operating as each area can support the other, and thus it will improve patient care and patient satisfaction with the service. However, of necessity this must be supported by excellent governance arrangements and up to date local information. We have spent a great deal of time producing our well regarded Clinicians' Desk Top Guidelines which comprehensively, yet succinctly provide contemporaneous information and checked contact details for all our clinical and nursing staff. These Guidelines are updated quarterly, or on an ad hoc basis if changes within the local health care sector occur, such as the closure of Hartlepool A&E.

NDUC recognises that it is ideally placed to arrange training workshops and teaching sessions on current topics, often by external experts, to all our GPs. These are exceptionally popular and the information gained in these fora is usually disseminated back to the GPs own practices, thus potentially benefiting an even larger cohort of patients.

As with all ongoing services, NDUC continues to monitor its activities. We have a robust incident reporting system which flags up issues that our eyes and ears on the ground, i.e. our call handlers, our drivers and our GPs identify. All of these incidents are investigated, a response produced, feedback given where appropriate and changes implemented where necessary. Over the past year we have investigated around 500 such

incidents throughout the organisation. We are proud that we have such an open blame-free culture with staff questioning and wanting improve the service.

Access to the service

NDUC is aware that it must make reasonable adjustments to accessing the service for people who may not be able to communicate clearly though the telephone triage system. This may be because of hearing impairment, because of language problems, learning disabilities or who are very distressed. We have therefore met several times with members of the deaf and hard of hearing community to mutually attempt to design a service that is fit for purpose. On the back of these discussions, NDUC now provides a text phone [0300 123 1932], but is also looking at providing a platform for a video translation service. We have also made contacts with persons representing recognised local BSL interpreters, which may be used in face to face situations. NDUC is additionally investigating the safe, both electronically and operationally safe use of email and other on-line access.

NDUC provides access to language line and interpreting services, whilst we have staff development strategies to achieve a culturally sensitive and aware staff group.

We provide taxi transportation to and from the various centres for those patients who have no other means of transport. We have arranged SLAs (service level agreements) with three local taxi companies and we regularly meet with them to confirm that they are still compliant with the agreed level of service. This also includes the provision of wheelchair access vehicles. We closely monitor taxi usage on a monthly basis. As an organisation, we have had no issues with the running of this service.

Communications with patients

Our marketing strategy appears to have been targeted appropriately and thereby fairly successful and well received – with most patients calling the right number, at the right time for the right reasons. As indicated, further work needs to be undertaken by the local commissioners to clarify the services available at the One Life Centre to reduce the confusion patients are obviously feeling.

We have been very active in public engagement. We have attended various patient forums and LINKs groups to offer information and receive feedback so that we can further develop the service. Once again the offer is here to visit our operations hub in Crutes House Stockton at your convenience.

Service user feedback

This can be broken down into the quarterly surveys, complaints, compliments, some incidents and the feedback we receive from visiting groups such as LINKs or a charity. The responses we have received from the surveys have been disappointing to date. We undertook a formal quarterly survey in April and again in July and both times we had a poor response rate. Therefore, in October we decided to hit each area with a very large number of questionnaires in the hope that we would get a reasonable response rate. These results are due back to us at the end of November. We have reviewed other means of contacting patients and have discounted telephone questionnaires because of the issues surrounding patient confidentiality. We would like a greater input so that we can tailor our service in conjunction with local patient requirements and have thus developed an on-line questionnaire.

However, reviewing the complaints already mentioned, it would appear from the volume and the subject of the complaints, that we need, and have

indeed addressed, attitudinal problems and perceived waits for a face to face consultation. Nonetheless, it is important to note that we have dealt with over 52,000 cases in your area and have had 37 complaints, some of which have not been upheld. Even so we are not complacent, and we have learned from some of the issues that patients have been concerned about. For example, we are currently reviewing the joint community provision for mental health. We are also working hard with all GPs as well as specific GPs to improve their knowledge of palliative care issues. We host regular workshops for all our GPs which are facilitated by local palliative care consultants and palliative care nurses and are proving to be amazingly popular.

Winter pressures

NDUC starts preparing for winter in July. We have a dynamic forecasting model which applies to the clinical as well the operational aspects of our service. Therefore, each shift will be staffed up according to our forecasts. With reference to the Christmas and New Year Holiday period, we have based our forecasts on scientific factors as well as empiricism, but we know that we will be extremely busy. We also have to factor in other external issues such as a possible flu or widespread diarrhoea and vomiting outbreak. We have reviewed our activity for the holiday period when Christmas last fell on a Sunday which was in 2005 and have factored this in when planning our staffing levels.

Over the past months we have steadily developed our links with our co-providers in health, social and the local councils. Our commissioners have arranged several desk top exercises across all our patches with scenarios set for each agency to work though both independently and collectively. These are a superb way of working through likely situations as well as allowing excellent day-day working relationships to develop.

Since November 1st all primary and secondary care providers have reported their clinical statistics to the commissioners and the Strategic Health Authority. This allows the commissioners to have an early notification of areas experiencing a potentially increased level of activity. If the case load increases, we utilise our commissioner approved multi-agency escalation process which allows us to balance our resources. We are therefore also able to target specific areas that require additional support. However, any decision that affects the overall running of the service is immediately shared with the designated commissioner on call.

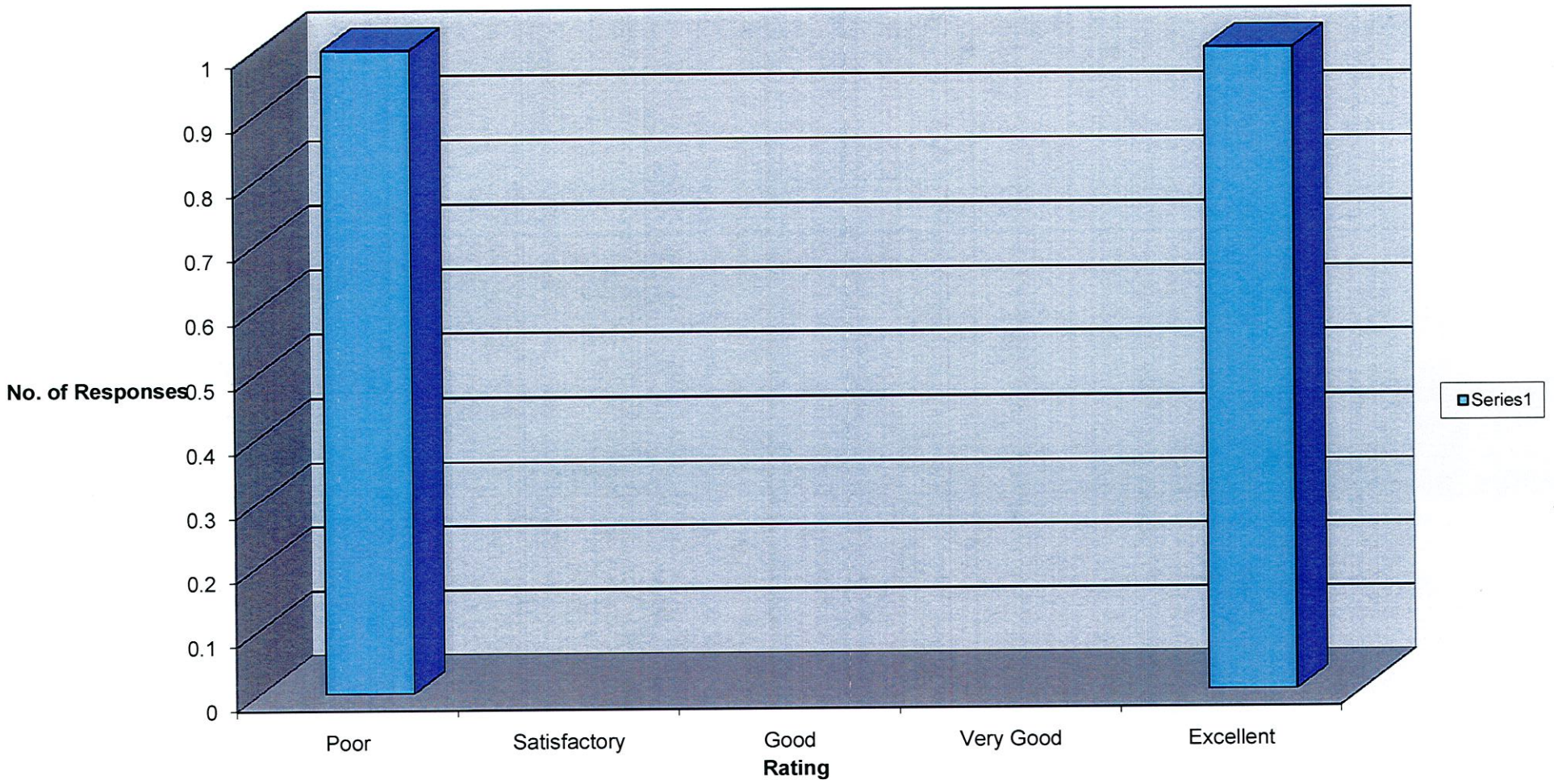
If the weather is bad we apply our Severe Weather Contingency Plan. This involves optimising our activity so that the best level of care can be delivered. This may mean perhaps temporarily switching the activity of one centre to one that is more readily accessible to everyone. We have purchased a number of Land Rover 4 X 4s to allow us to undertake some of the more inaccessible visits. Additionally, we still will be using the services of 4X4 Response North East. We are assured that our taxi companies are equipped to deal with poor weather. We have developed links with the local councils' roads and highways maintenance services to arrange for areas around centres to be gritted when possible.

Over times of severe weather and over the holiday period, each agency participates in a daily prearranged conference call facilitated by the commissioners. This gives each provider the opportunity to highlight current issues, discuss any themes that are developing and if one area is experiencing a spike in activity, there may be opportunities for a co-provider to be able to assist to help them. For example, between last Christmas and the New Year, one of the hospitals in the North area experienced a considerable increase in A&E activity. It was identified that some of the activity was more primary care than true A&E work. NDUC was able to support this A&E for several days by providing a GP to work alongside the A&E staff and deal with the GP appropriate cases.

In conclusion, I hope that I have been able to reassure you that the efforts that we have initiated, together with our organisational work ethic will allow NDUC to respond to both anticipated and unheralded challenges in a timely, safe and appropriate manner.

Karen Taylor
Head of Governance
NDUC
17th November 2011

Hartlepool COMPLETE RESULTS JULY 2011



HARTLEPOOL ALL RESULTS

Jul-11

1. About your first contact with this service

a. Your satisfaction with the time it took for your call to be answered

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	1			1		2
0.00%	50.00%	0.00%	0.00%	50.00%	0.00%	100%

1a	Total Number of Respondents	2
	% of Patients Classing Service as "Excellent" or "Good"	50.00%
	% of Patients Classing Service as "Satisfactory" or Better	100.00%
	% of Patients Classing Service as "Poor"	0.00%

b. How you were treated on the phone

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	1			1		2
0.00%	50.00%	0.00%	0.00%	50.00%	0.00%	100.00%

1b	Total Number of Respondents	2
	% of Patients Classing Service as "Excellent" or "Good"	50.00%
	% of Patients Classing Service as "Satisfactory" or Better	100.00%
	% of Patients Classing Service as "Poor"	0.00%

2. About the Health Professional (who called you back on the phone)

a Your satisfaction with the time it took for a health professional to speak to you

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	1			1		2
0.00%	50.00%	0.00%	0.00%	50.00%	0.00%	100.00%

2a	Total Number of Respondents	2
	% of Patients Classing Service as "Excellent" or "Good"	50.00%
	% of Patients Classing Service as "Satisfactory" or Better	100.00%
	% of Patients Classing Service as "Poor"	0.00%

b. The understanding of why you were seeking help

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	1			1		2
0.00%	50.00%	0.00%	0.00%	50.00%	0.00%	100.00%

2b	Total Number of Respondents	2
	% of Patients Classing Service as "Excellent" or "Good"	50.00%
	% of Patients Classing Service as "Satisfactory" or Better	100.00%
	% of Patients Classing Service as "Poor"	0.00%

3. About the consultation that you had with the health professional (this may have been over the phone or face to face)

a. The Health professional's explanation of things to you

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	1		1			2
0.00%	50.00%	0.00%	50.00%	0.00%	0.00%	100.00%

3a	Total Number of Respondents	2
	% of Patients Classing Service as "Excellent" or "Good"	50.00%
	% of Patients Classing Service as "Satisfactory" or Better	100.00%
	% of Patients Classing Service as "Poor"	0.00%

b.The extent to which you felt reassured by the health professional

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
		1	1			2
0.00%	0.00%	50.00%	50.00%	0.00%	0.00%	100.00%

3b	Total Number of Respondents	2
	% of Patients Classing Service as "Excellent" or "Good"	100.00%
	% of Patients Classing Service as "Satisfactory" or Better	100.00%
	% of Patients Classing Service as "Poor"	0.00%

c. The ease of getting any necessary medicines

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	1	1				2
0.00%	50.00%	50.00%	0.00%	0.00%	0.00%	100.00%

3c	Total Number of Respondents	2
	% of Patients Classing Service as "Excellent" or "Good"	50.00%
	% of Patients Classing Service as "Satisfactory" or Better	100.00%
	% of Patients Classing Service as "Poor"	0.00%

4. How easy was it to get to the treatment centre?

Very Easy	Quite Easy	Not at all Easy	No Ans	total
1		1		2

50.00%	0.00%	50.00%	0.00%		100.00%

5. Finally please rate

a. The advice given about what to do next

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
1			1			2
50.00%	0.00%	0.00%	50.00%	0.00%	0.00%	100.00%

b. Your overall satisfaction with the help given you

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
1				1		2
50.00%	0.00%	0.00%	0.00%	50.00%	0.00%	100.00%

5a	Total Number of Respondents	2
	% of Patients Classing Service as "Excellent" or "Good"	50.00%
	% of Patients Classing Service as "Satisfactory" or Better	50.00%
	% of Patients Classing Service as "Poor"	50.00%

5b	Total Number of Respondents	2
	% of Patients Classing Service as "Excellent" or "Good"	50.00%
	% of Patients Classing Service as "Satisfactory" or Better	50.00%
	% of Patients Classing Service as "Poor"	50.00%

6. Are you?

Male	Female	No Ans	total
1	1		2
50.00%	50.00%	0.00%	100.00%

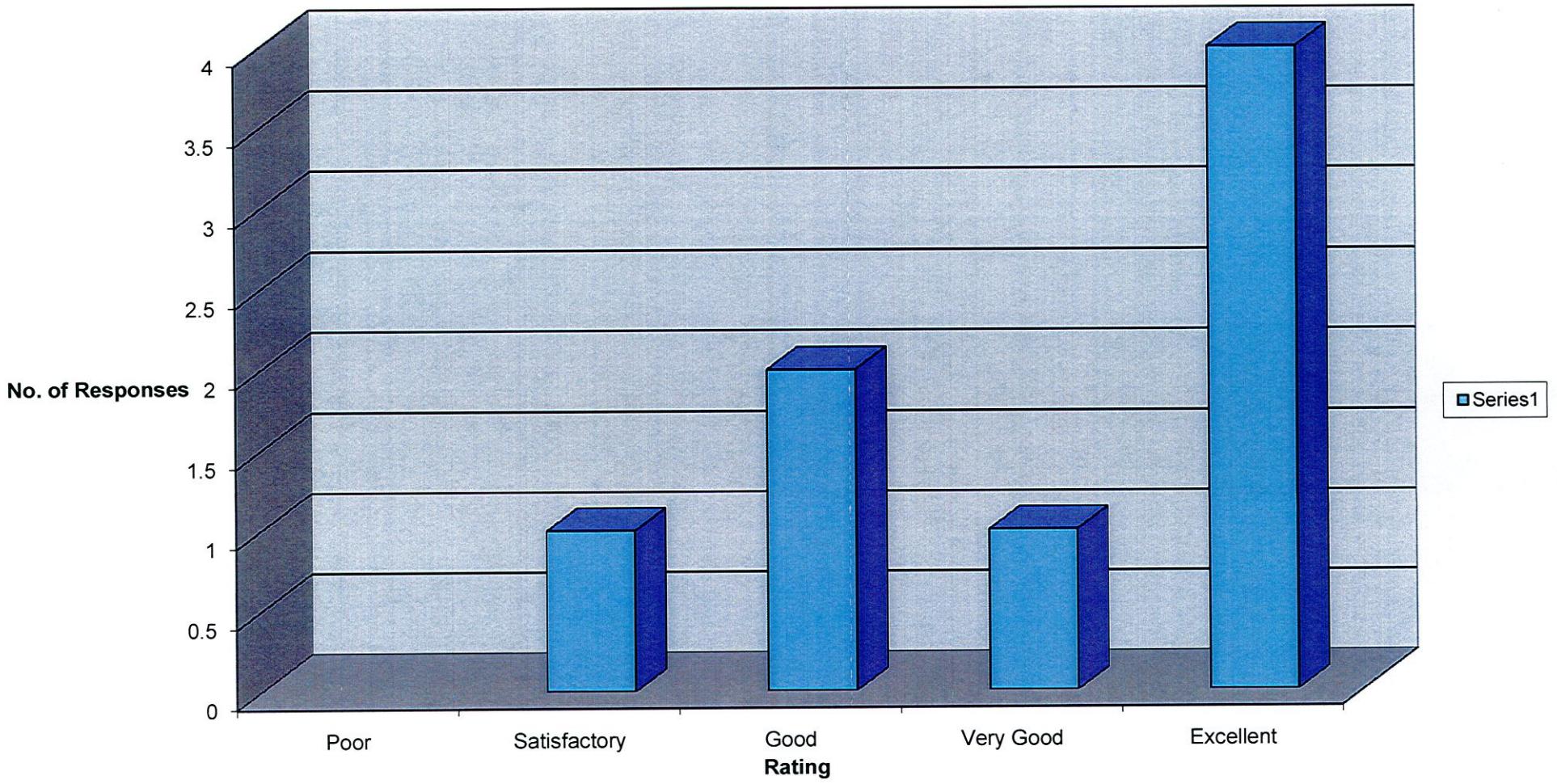
7. How old are you in Years

Under 12	12-15 years	16-24 years	25 - 60 years	Over 60 year:	No Ans	total
				2		2
0.00%	0.00%	0.00%	0.00%	100.00%	0.00%	100.00%

8. What ethnic group do you belong to?

White	Mixed	Black/Black British	Chinese	Asian/Asian I	Other Ethn	No Ans	total
2							2
100.00%	#DIV/0!	#DIV/0!	#DIV/0!				100.00%

MIDDLESBROUGH COMPLETE RESULTS JULY 2011



MIDDLESBROUGH ALL RESULTS

1. About your first contact with this service

a. Your satisfaction with the time it took for your call to be answered

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	1	3	3	5		12
0.00%	8.33%	25.00%	25.00%	41.67%	0.00%	100%

1a Total Number of Respondents	12
% of Patients Classing Service as "Excellent" or "Good"	91.67%
% of Patients Classing Service as "Satisfactory" or Better	100.00%
% of Patients Classing Service as "Poor"	0.00%

b. How you were treated on the phone

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	1	3	2	6		12
0.00%	8.33%	25.00%	16.67%	50.00%	0.00%	100.00%

1b Total Number of Respondents	12
% of Patients Classing Service as "Excellent" or "Good"	91.67%
% of Patients Classing Service as "Satisfactory" or Better	100.00%
% of Patients Classing Service as "Poor"	0.00%

2. About the Health Professional (who called you back on the phone)

a Your satisfaction with the time it took for a health professional to speak to you

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	1	1	4	6		12
0.00%	8.33%	8.33%	33.33%	50.00%	0.00%	100.00%

2a Total Number of Respondents	12
% of Patients Classing Service as "Excellent" or "Good"	91.67%
% of Patients Classing Service as "Satisfactory" or Better	100.00%
% of Patients Classing Service as "Poor"	0.00%

b. The understanding of why you were seeking help

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	0		5	6		11
0.00%	0.00%	0.00%	45.45%	54.55%	0.00%	100.00%

2b Total Number of Respondents	11
% of Patients Classing Service as "Excellent" or "Good"	100.00%
% of Patients Classing Service as "Satisfactory" or Better	100.00%
% of Patients Classing Service as "Poor"	0.00%

3. About the consultation that you had with the health professional (this may have been over the phone or face to face)

a. The Health professional's explanation of things to you

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	1	1	3	6		11
0.00%	9.09%	9.09%	27.27%	54.55%	0.00%	100.00%

3a Total Number of Respondents	11
% of Patients Classing Service as "Excellent" or "Good"	90.91%
% of Patients Classing Service as "Satisfactory" or Better	100.00%
% of Patients Classing Service as "Poor"	0.00%

b.The extent to which you felt reassured by the health professional

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	1	3	1	6		11
0.00%	9.09%	27.27%	9.09%	54.55%	0.00%	100.00%

3b Total Number of Respondents	11
% of Patients Classing Service as "Excellent" or "Good"	90.91%
% of Patients Classing Service as "Satisfactory" or Better	100.00%
% of Patients Classing Service as "Poor"	0.00%

c. The ease of getting any necessary medicines

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	0	2	1	7	1	11
0.00%	0.00%	18.18%	9.09%	63.64%	9.09%	100.00%

3c Total Number of Respondents	10
% of Patients Classing Service as "Excellent" or "Good"	100.00%
% of Patients Classing Service as "Satisfactory" or Better	100.00%
% of Patients Classing Service as "Poor"	0.00%

4. How easy was it to get to the treatment centre?

Very Easy	Quite Easy	Not at all Easy	No Ans	total
2	1		8	11

18.18%	9.09%	0.00%	72.73%		100.00%

5. Finally please rate

a. The advice given about what to do next

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
		4	2	2	3	11
0.00%	0.00%	36.36%	18.18%	18.18%	27.27%	100.00%

b. Your overall satisfaction with the help given you

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	1	2	1	4	3	11
0.00%	9.09%	18.18%	9.09%	36.36%	27.27%	100.00%

5a	Total Number of Respondents	8
	% of Patients Classing Service as "Excellent" or "Good"	100.00%
	% of Patients Classing Service as "Satisfactory" or Better	100.00%
	% of Patients Classing Service as "Poor"	0.00%

5b	Total Number of Respondents	8
	% of Patients Classing Service as "Excellent" or "Good"	87.50%
	% of Patients Classing Service as "Satisfactory" or Better	100.00%
	% of Patients Classing Service as "Poor"	0.00%

6. Are you?

Male	Female	No Ans	total
3	8		11
27.27%	72.73%	0.00%	100.00%

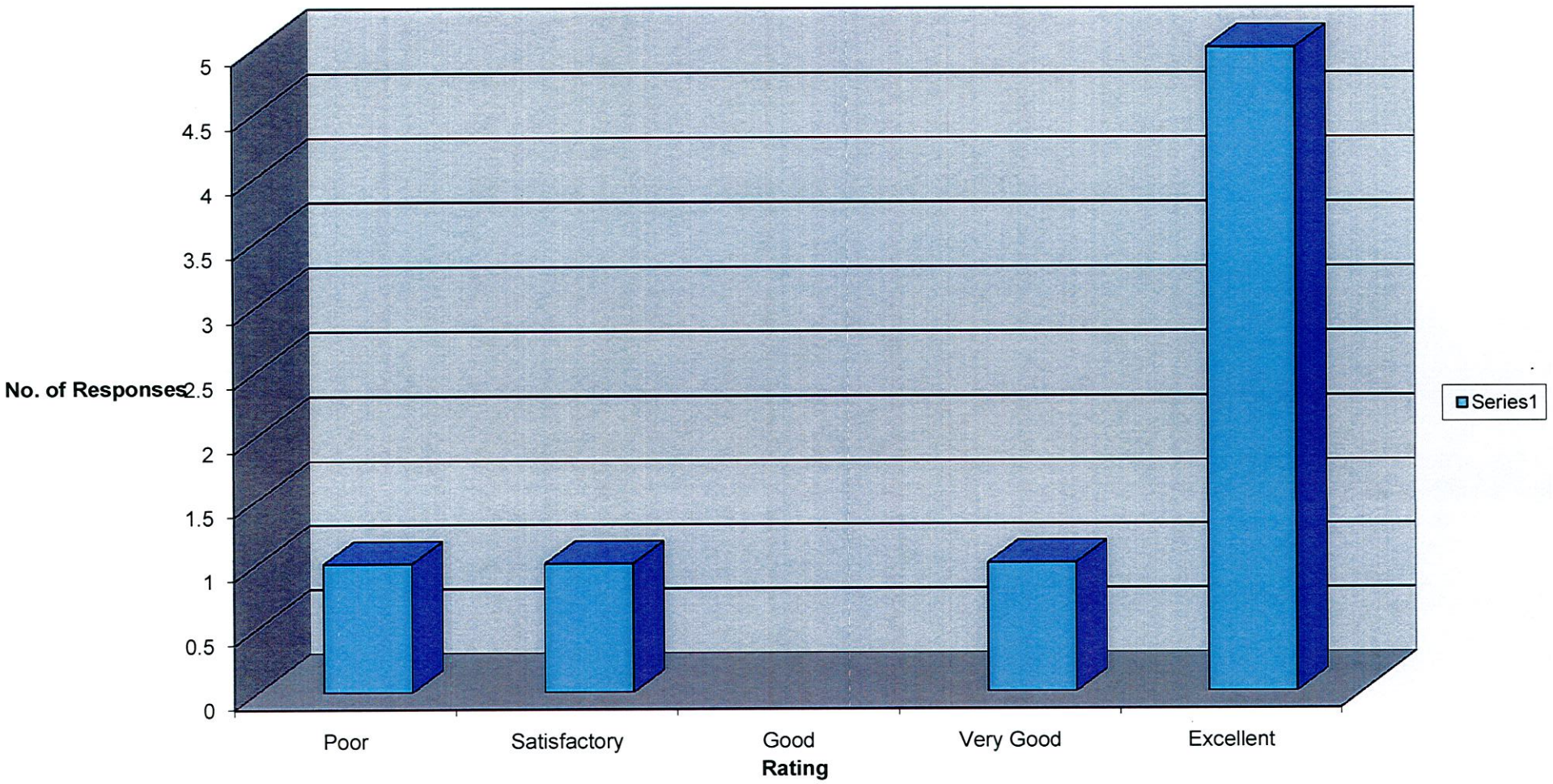
7. How old are you in Years

Under 12	12-15 years	16-24 years	25 - 60 years	Over 60 years	No Ans	total
			6	5		11
0.00%	0.00%	0.00%	54.55%	45.45%	0.00%	100.00%

8. What ethnic group do you belong to?

White	Mixed	Black/Black British	Chinese	Asian/Asian I	Other Ethn	No Ans	total
11							11
100.00%	#DIV/0!	#DIV/0!	#DIV/0!				100.00%

REDCAR & CLEVELAND COMPLETE RESULTS JULY 2011



REDCAR & CLEVELAND ALL RESULTS

1. About your first contact with this service

a. Your satisfaction with the time it took for your call to be answered

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
		2	4	6		12
0.00%	0.00%	16.67%	33.33%	50.00%	0.00%	100%

1a Total Number of Respondents	12
% of Patients Classing Service as "Excellent" or "Good"	100.00%
% of Patients Classing Service as "Satisfactory" or Better	100.00%
% of Patients Classing Service as "Poor"	0.00%

b. How you were treated on the phone

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
		1	5	6		12
0.00%	0.00%	8.33%	41.67%	50.00%	0.00%	100.00%

1b Total Number of Respondents	12
% of Patients Classing Service as "Excellent" or "Good"	100.00%
% of Patients Classing Service as "Satisfactory" or Better	100.00%
% of Patients Classing Service as "Poor"	0.00%

2. About the Health Professional (who called you back on the phone)

a Your satisfaction with the time it took for a health professional to speak to you

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
		1	6	5		12
0.00%	0.00%	8.33%	50.00%	41.67%	0.00%	100.00%

2a Total Number of Respondents	12
% of Patients Classing Service as "Excellent" or "Good"	100.00%
% of Patients Classing Service as "Satisfactory" or Better	100.00%
% of Patients Classing Service as "Poor"	0.00%

b. The understanding of why you were seeking help

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	1	1	4	6		12
0.00%	8.33%	8.33%	33.33%	50.00%	0.00%	100.00%

2b Total Number of Respondents	12
% of Patients Classing Service as "Excellent" or "Good"	91.67%
% of Patients Classing Service as "Satisfactory" or Better	100.00%
% of Patients Classing Service as "Poor"	0.00%

3. About the consultation that you had with the health professional (this may have been over the phone or face to face)

a. The Health professional's explanation of things to you

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	3		5	4		12
0.00%	25.00%	0.00%	41.67%	33.33%	0.00%	100.00%

3a Total Number of Respondents	12
% of Patients Classing Service as "Excellent" or "Good"	75.00%
% of Patients Classing Service as "Satisfactory" or Better	100.00%
% of Patients Classing Service as "Poor"	0.00%

b.The extent to which you felt reassured by the health professional

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	3	1	3	4	1	12
0.00%	25.00%	8.33%	25.00%	33.33%	8.33%	100.00%

3b Total Number of Respondents	11
% of Patients Classing Service as "Excellent" or "Good"	72.73%
% of Patients Classing Service as "Satisfactory" or Better	100.00%
% of Patients Classing Service as "Poor"	0.00%

c. The ease of getting any necessary medicines

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	2	1	2	5	2	12
0.00%	16.67%	8.33%	16.67%	41.67%	16.67%	100.00%

3c Total Number of Respondents	10
% of Patients Classing Service as "Excellent" or "Good"	80.00%
% of Patients Classing Service as "Satisfactory" or Better	100.00%
% of Patients Classing Service as "Poor"	0.00%

4. How easy was it to get to the treatment centre?

Very Easy	Quite Easy	Not at all Easy	No Ans	total
4	5		3	12

33.33%	41.67%	0.00%	25.00%		100.00%

5. Finally please rate

a. The advice given about what to do next

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
1	2	1	3	2	3	12
8.33%	16.67%	8.33%	25.00%	16.67%	25.00%	100.00%

b. Your overall satisfaction with the help given you

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
1	1		1	5	4	12
8.33%	8.33%	0.00%	8.33%	41.67%	33.33%	100.00%

6. Are you?

Male	Female	No Ans	total
6	6		12
50.00%	50.00%	0.00%	100.00%

7. How old are you in Years

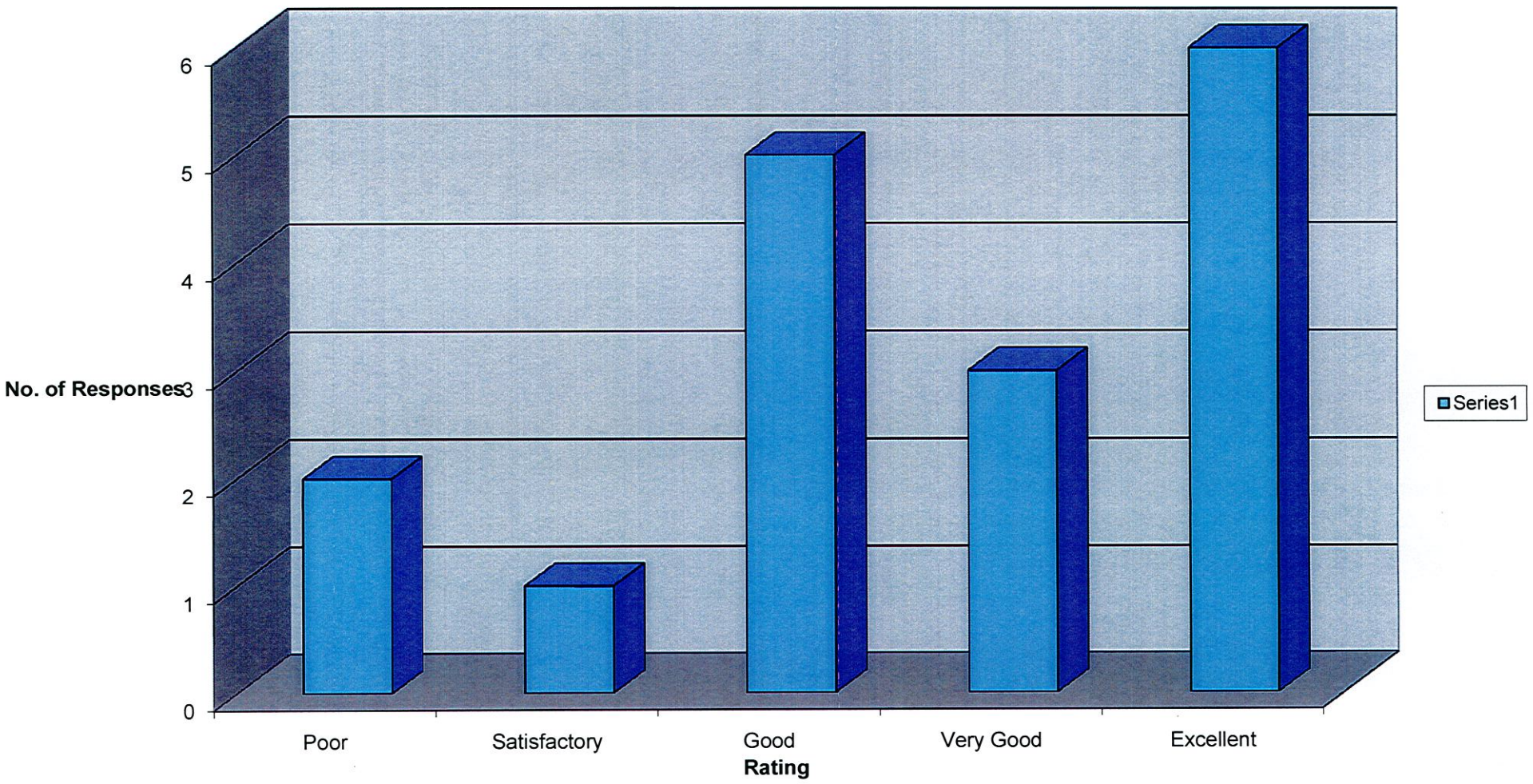
Under 12	12-15 years	16-24 years	25 - 60 years	Over 60 year:	No Ans	total
2		1	7	2		12
16.67%	0.00%	8.33%	58.33%	16.67%	0.00%	100.00%

8. What ethnic group do you belong to?

White	Mixed	Black/Black British	Chinese	Asian/Asian I	Other Ethn	No Ans	total
12							12
#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	#DIV/0!

5a	Total Number of Respondents	9
	% of Patients Classing Service as "Excellent" or "Good"	66.67%
	% of Patients Classing Service as "Satisfactory" or Better	88.89%
	% of Patients Classing Service as "Poor"	11.11%
5b	Total Number of Respondents	8
	% of Patients Classing Service as "Excellent" or "Good"	75.00%
	% of Patients Classing Service as "Satisfactory" or Better	87.50%
	% of Patients Classing Service as "Poor"	12.50%

STOCKTON COMPLETE RESULTS JULY 2011



STOCKTON ALL RESULTS

1. About your first contact with this service

a. Your satisfaction with the time it took for your call to be answered

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	1	6	6	8		21
0.00%	4.76%	28.57%	28.57%	38.10%	0.00%	100%

b. How you were treated on the phone

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	1	4	10	6		21
0.00%	4.76%	19.05%	47.62%	28.57%	0.00%	100.00%

2. About the Health Professional (who called you back on the phone)

a Your satisfaction with the time it took for a health professional to speak to you

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
	3	4	9	5		21
0.00%	14.29%	19.05%	42.86%	23.81%	0.00%	100.00%

b. The understanding of why you were seeking help

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
1		5	7	8		21
4.76%	0.00%	23.81%	33.33%	38.10%	0.00%	100.00%

3. About the consultation that you had with the health professional (this may have been over the phone or face to face)

a. The Health professional's explanation of things to you

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
2	3	3	5	8		21
9.52%	14.29%	14.29%	23.81%	38.10%	0.00%	100.00%

b.The extent to which you felt reassured by the health professional

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
3	2	5	2	8	1	21
14.29%	9.52%	23.81%	9.52%	38.10%	4.76%	100.00%

c. The ease of getting any necessary medicines

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
2	3	5	2	6	3	21
9.52%	14.29%	23.81%	9.52%	28.57%	14.29%	100.00%

4. How easy was it to get to the treatment centre?

Very Easy	Quite Easy	Not at all Easy	No Ans	total
8	2		11	21

1a	Total Number of Respondents	21
	% of Patients Classing Service as "Excellent" or "Good"	95.24%
	% of Patients Classing Service as "Satisfactory" or Better	100.00%
	% of Patients Classing Service as "Poor"	0.00%
1b	Total Number of Respondents	21
	% of Patients Classing Service as "Excellent" or "Good"	95.24%
	% of Patients Classing Service as "Satisfactory" or Better	100.00%
	% of Patients Classing Service as "Poor"	0.00%
2a	Total Number of Respondents	21
	% of Patients Classing Service as "Excellent" or "Good"	85.71%
	% of Patients Classing Service as "Satisfactory" or Better	100.00%
	% of Patients Classing Service as "Poor"	0.00%
2b	Total Number of Respondents	21
	% of Patients Classing Service as "Excellent" or "Good"	95.24%
	% of Patients Classing Service as "Satisfactory" or Better	95.24%
	% of Patients Classing Service as "Poor"	4.76%
3a	Total Number of Respondents	21
	% of Patients Classing Service as "Excellent" or "Good"	76.19%
	% of Patients Classing Service as "Satisfactory" or Better	90.48%
	% of Patients Classing Service as "Poor"	9.52%
3b	Total Number of Respondents	20
	% of Patients Classing Service as "Excellent" or "Good"	75.00%
	% of Patients Classing Service as "Satisfactory" or Better	85.00%
	% of Patients Classing Service as "Poor"	15.00%
3c	Total Number of Respondents	18
	% of Patients Classing Service as "Excellent" or "Good"	72.22%
	% of Patients Classing Service as "Satisfactory" or Better	88.89%
	% of Patients Classing Service as "Poor"	11.11%

38.10%	9.52%	0.00%	52.38%		100.00%

5. Finally please rate

a. The advice given about what to do next

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
2	2	4	4	5	4	21
9.52%	9.52%	19.05%	19.05%	23.81%	19.05%	100.00%

b. Your overall satisfaction with the help given you

Poor	Satisfactory	Good	Very Good	Excellent	No Ans	total
2	1	5	3	6	4	21
9.52%	4.76%	23.81%	14.29%	28.57%	19.05%	100.00%

6. Are you?

Male	Female	No Ans	total
12	9		21
57.14%	42.86%	0.00%	100.00%

7. How old are you in Years

Under 12	12-15 years	16-24 years	25 - 60 years	Over 60 year:	No Ans	total
2		1	7	11		21
9.52%	0.00%	4.76%	33.33%	52.38%	0.00%	100.00%

8. What ethnic group do you belong to?

White	Mixed	Black/Black British	Chinese	Asian/Asian I	Other Ethn	No Ans	total
21							21
100.00%	#DIV/0!	#DIV/0!	#DIV/0!				100.00%

5a	Total Number of Respondents	17
	% of Patients Classing Service as "Excellent" or "Good"	76.47%
	% of Patients Classing Service as "Satisfactory" or Better	88.24%
	% of Patients Classing Service as "Poor"	11.76%
5b	Total Number of Respondents	17
	% of Patients Classing Service as "Excellent" or "Good"	82.35%
	% of Patients Classing Service as "Satisfactory" or Better	88.24%
	% of Patients Classing Service as "Poor"	11.76%

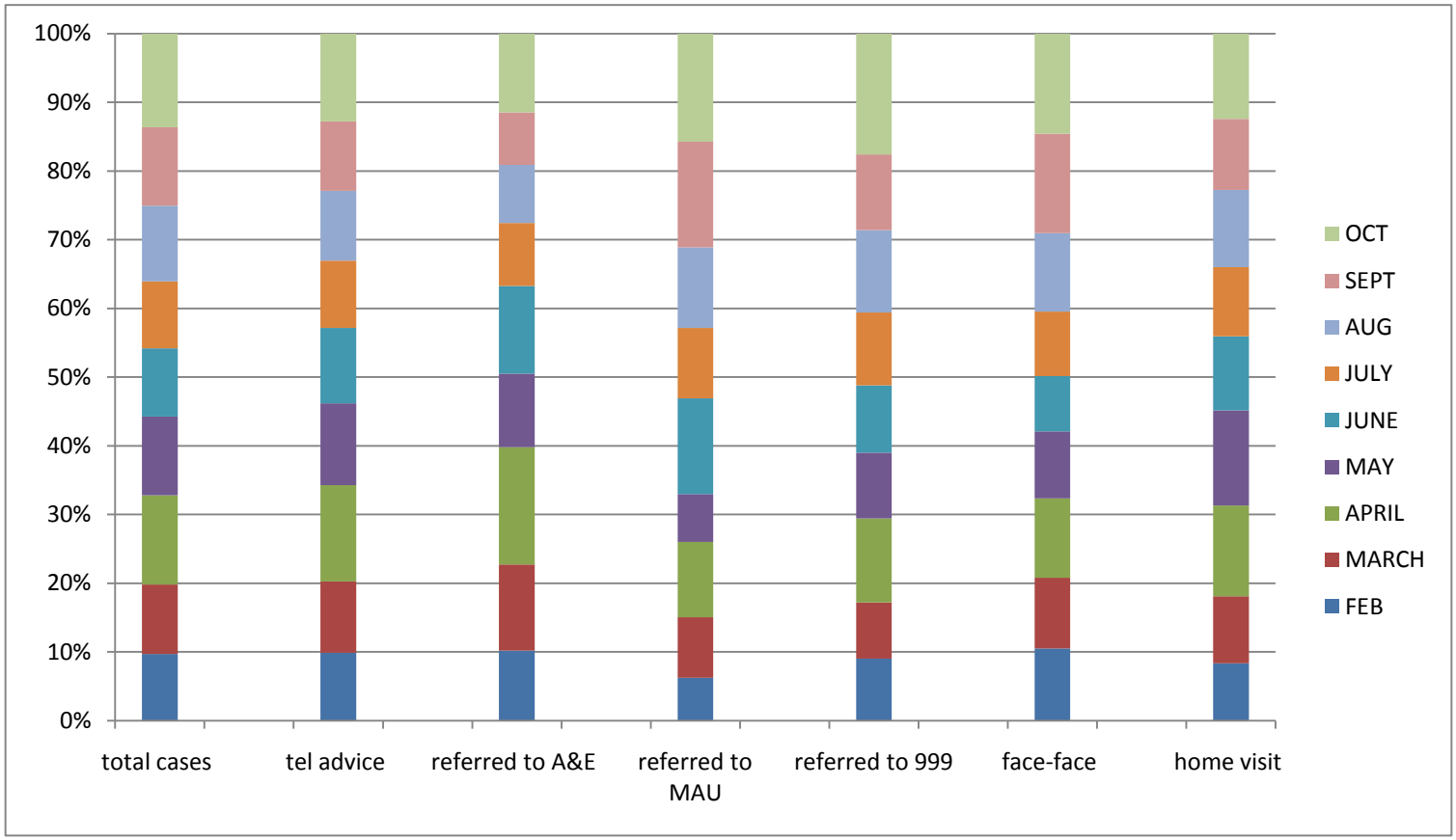
Breakdown of cases for Hartlepool. Data taken from the KPIs reported monthly to commissioners.

Period of activity reviewed February - October 2011

	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT
total cases	532	557	713	628	548	535	604	628	749
tel advice	221	232	313	266	245	219	227	226	286
referred to A&E	40	49	67	42	50	36	33	30	45
referred to MAU	17	24	30	19	38	28	32	42	43
referred to 999	45	41	61	48	49	53	60	55	88
face-face	150	147	165	139	115	134	163	207	208
home visit	93	108	147	154	120	112	125	115	138
referred to district nurses	5	12	11	5	6	5	16	13	8

Breakdown of cases for Hartlepool. Data taken from the KPIs reported monthly to commissioners.

Period of activity reviewed February - October 2011



NDUC DETAILS FEBRUARY 2011 - OCTOBER 2011 TEESSIDE ONLY

[Statistics taken from the data presented monthly to the commissioners]

2011	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT
TOTAL CASES	5452	5613	7084	6414	5350	5831	5442	5090	6057
TEL ADVICE	1860	1972	2513	2276	1772	1859	1772	1534	1852
TO 999	372	375	414	391	341	391	357	350	421
CV	1356	1318	1485	1312	1049	1155	1079	1134	1257
HV	806	795	963	941	808	941	856	810	913
REFER TO DISTRICT NURSE	526	607	819	709	749	813	768	690	904
DENTAL TRIAGE	446	502	822	722	596	646	620	552	688
COMPLAINTS	6	5	3	3	5	5	4	2	4
COMPLIMENTS	2	11	0	0	0	0	0	5	4