HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL BOROUGH COUNCIL

Thursday 5 April 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 9 February 2012 (to follow)
   3.2 To confirm the minutes of the meeting held on 23 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 Hartlepool LINk Update

(a) Covering Report – *Scrutiny Support Officer*

(b) Presentation on Hartlepool's Local HealthWatch – *Hartlepool LINk Co-ordinator*

(c) Verbal Update on Cancer Patient Survey – *Hartlepool LINk Development Officer*

7.2 Female Life Expectancy in Hartlepool

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

(b) Presentation – *Assistant Director for Health Improvement*

Scrutiny Investigation into Cancer Awareness and Early Diagnosis

7.3 Information on Second Hand Smoke – *Scrutiny Support Officer*

7.4 Information from Tees, Esk and Wear Valleys NHS Foundation Trust – *Scrutiny Support Officer*

7.5 Draft Final Report – *Chair of the Health Scrutiny Forum*

8. **ISSUES IDENTIFIED FROM FORWARD PLAN**

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

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

9.1 Minutes of the meeting held on 30 January 2012

10. **REGIONAL HEALTH SCRUTINY UPDATE**

No items.

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

HEALTH SCRUTINY FORUM

MINUTES

9 February 2012

The meeting commenced at 10.00 a.m. at Hartlepool College of Further Education, Hartlepool

Present:

Councillor Stephen Akers-Belcher (In the Chair);

Councillors: Geoff Lilley, Arthur Preece, Linda Shields and Ray Wells.

Resident Representative: Ian Stewart.

Also Present: In accordance with Council Procedure Rule 4.2;
Councillor Sarah Maness as substitute for Councillor Marjorie James.
Councillors Alison Lilley, Brenda Loynes and Edna Wright.

Councillors Robin Todd and Jean Chaplow and Mr Stephen Gwillym, Durham County Council.

North Tees and Hartlepool NHS Foundation Trust: -
Carole Langrick (Deputy CE / Director of Strategic Development),
Julie Gillon (Director of Operations and Performance),
Rowena Dean (General Manager Elective Care Services),
Sue Piggott (General Manager, Medicine and Emergency Care),
Julie Parkes (Assistant Director Clinical Support and Therapies),
Linda Bantoft (Head of Business Support)
Chris Ward (Consultant Physician),
Deepak Dwarakanath (Associate Medical Director),
Chris Tulloch (Clinical Director, Orthopaedics),

NHS Tees: -
Ali Wilson (Director of Commissioning and System Development (North)),
Joanne Dobson (Assistant Director Health Systems Development)
Sarah Clasper (Head of Communication and Involvement),

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

68. Apologies for Absence

Councillors Griffin and James.

69. Declarations of Interest by Members

None.

70. Minutes of the meeting held on 26 January 2012

Deferred.

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

No items.

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

No items.

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

No items.

74. North Tees and Hartlepool NHS Foundation Trust's Service Delivery Proposals (*Scrutiny Support Officer*)

The Scrutiny Support Officer introduced representatives from North Tees and Hartlepool NHS Foundation Trust who were present to brief the forum on developments to service delivery affecting the University Hospital of Hartlepool (UHH).

Deputy Chief Executive, Carole Langrick, opened the presentation indicating that the Trust had developed a range of service enhancements to demonstrate the Trusts' commitment to developing services in Hartlepool. The Deputy Chief Executive highlighted that the changes were enhancements to current provision and not turning the clock back and reinstating Accident and Emergency provision at Hartlepool.

Through the presentation, representatives of the Trust outlined the services that were being enhanced at Hartlepool which were broadly as follows: -

The majority of flexible cystoscopy procedures carried out in the Trust are performed at University Hospital North Tees (UHNT). From September 2012 it was proposed that additional provision will be made from UHH. The result is that up to 500 patients per year from Hartlepool and East Durham will be able to choose to have their procedure closer to home.

Orthopaedic hand surgery is provided primarily at UHNT, however from January 2012 an additional two theatre sessions a week have been provided at UHH. The result is that over 300 patients per year from Hartlepool and East Durham will be able to choose to have their hand procedure closer to home.

The Rutherford Morrison Unit at UHH will be exclusively an endoscopy suite comprising three endoscopy rooms which will eliminate single sex issues. Works will be complete by September 2012. Result is an additional 1,500 endoscopies being carried out at UHH.

The Trust has been improving cardiology provision at UHH and all cardiology services are being relocated to a single purpose built area within UHH, bringing together the cardiac diagnostics unit, cardiology outpatient clinics and elective cardioversion procedures to improve quality and efficiency for patients from Hartlepool and East Durham. The unit is expected to be completed by May 2012 and will provide facilities in Hartlepool for 80 cardioversions.

A purpose built unit is being developed within the main hospital site at UHH will provide a one stop assessment service aimed at reducing admissions / readmissions to hospital for elderly patients. The unit is expected to be operational from April 2012.

The Community Renaissance Project was outlined detailing how integrated multi professional teams would manage the health care needs of people with long term conditions and complex needs in their own home.

Therapy services would be realigned around the needs of the local population through relocation of services into a community base and through the provision of more flexible appointments evenings and weekends. There would be improved alignment with other services to achieve one-stop models, e.g. podiatry / orthotics / audiology – one stop models.

Following the presentation, the Chair opened the meeting for questions, including from the public present. The areas questioned and debated by the meeting were, briefly, as follows: -

- Cystoscopy services operated on a hub and spoke arrangement from James Cook Hospital. The services outlined were an enhancement to the current provision but not a realignment of the service.
- The three rooms for endoscopy services would meet the national requirements for separate single sex wards.
- Concern was expressed at the moving of the rehabilitation service from its current building into the old A&E ward. Trust representatives indicated that the current building was in a poor state of repair and would be demolished. The new unit would improve services and access for the elderly. The decision was based on the needs of the service, not the buildings. It was indicated that the site once cleared would be used for car parking.

- The stroke service was for patients of all ages. The service provided at UHNT was one of the best in the country and this addition would enhance the services. The original location suggested within the UHH was not the old A&E area but the professionals considered that it was not the best location for patients. When they reviewed what was available, the old A&E area was chosen as having the best access for the predominantly elderly patients that used the unit and access to rapid clinical intervention services.
- In responding to questions on costs, the Trust's Deputy Chief Executive indicated that senior medical staff including consultants who would be needed to undertake the work would be doing so at UHH. This was being done within the cost packet of providing those services now. There would be some capital costs for improvements but revenue was within the costs. As part of the medium and long term strategy the Trust was looking to build up the services that it expected to be here when the new hospital comes into service. Many of these services may stay here even when the new hospital opens. Essentially, only the very ill would go to the new hospital. These service changes were not a 'Plan B' but part of the journey we are on.
- On the transfer of the bladder clinic to UHH, it was questioned as to how much clinic time that equated to. The Trust indicated that an average clinical session was three and a half hours and initially one clinic session would transfer to UHH with that being increased in time to two sessions.
- The improved services to children and families were described as a response to service user comments and would include an increased number of health visitors, a greater integration of child care professionals and a single point of access. The Chair commented that it would be valuable to have a six month update on these services.
- It was understood that once the finance became available and the new hospital was built, the hospitals at North Tees and Hartlepool would close. Members sought some timescales on this happening. There was general concern among the public that while happy to see some improvement to the current services, they wished to see A&E return as many did not have any faith in the services provided at the OneLife Centre. The Trust indicated that the timescales were out of their hands and totally dependent on central government. The issues around A&E had been aired on numerous occasions.
- It was commented that communication could be improved on all sides. The Chair agreed that good communication was essential and there was much that could be done to improve matters.
- A member of the public commented that they felt they had been victimised for raising complaints when much could be learnt and improved through responding to complaints positively. The Chair commented that in his experience the Trust did see complaints positively.
- Issues of access to services was raised. Public transport, particularly for those in the South Durham area was poor and the distances to the new hospital site and UHNT made access difficult. People would prefer to see the services moved back to the hospital. The hospital was one of the biggest employers in Hartlepool yet the Trust had a

'plan B' to move all the services to UHNT if the new hospital wasn't approved.

- Some did welcome the changes proposed as positive and welcomed the increased access for local people.
- Reference was made to the vote of no confidence made by the council in the Trust Board. The public perception of the services offered through the OneLife Centre was poor and even professionals were expressing their concerns with paramedics refusing to take fracture cases to the OneLife Centre as the necessary staff were never on duty. The Trust representatives indicated that they were unaware of these concerns being expressed by staff and indicated that their feedback had been positive.
- Concern was expressed as to why the rehabilitation unit which was only built in 1976 had fallen into such poor repair that it was now being demolished and the services moved into the old A&E area. Why had the building not been maintained properly. Trust representatives indicated that clinicians had looked at available alternatives on the site and had chosen the old A&E location as providing the best option for the relocation of the stroke and rehabilitation services. It was a clinicians decision.
- A Member of the Forum welcomed the proposals the Trust had announced at the meeting. In relation to the communication with the public, the Member commented that he had attended the Steering Group meetings on the A&E service and had raised his concerns at those meetings but there were still improvements needed.
- A Member of the public indicated that they understood that when the new hospital was built the two existing sites would close and the local services would be based at the OneLife Centre. If these services were to be based at the OneLife Centre, why were they not moved there now to save moving them twice or did this reflect the lack of faith the Trust also had in the OneLife Centre. The Trust's Deputy Chief Executive indicated that while the Trust had the hospital site and its facilities it would continue to use them. The Trust would also continue to work with the Primary Care Trust (PCT) who owns the OneLife Centre.

At the conclusion of the discussion, the Chair thanked the Trust representatives for their attendance and very helpful and informative input into the meeting.

Recommended

That the comments be noted and that the North Tees and Hartlepool NHS Foundation Trust and NHS Tees representatives be thanked for their attendance.

75. Draft Hartlepool Public Health Transition Plan (*Assistant Director for Health Improvement*)

The Chair requested that the report be deferred as consideration of this matter had been referred a Working Group established by the Scrutiny Coordinating Committee.

Recommended

That the report be deferred.

76. 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.

Recommended

That the report be noted.

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

The minutes of the meeting of Tees Valley Health Scrutiny Joint Committee held on 19 December 2011 were submitted for the Forum's information.

A Member indicated that at the last meeting of the Tees Valley Health Scrutiny Joint Committee representatives of the North East Ambulance Service had been present. The Chair informed the meeting that he had requested that the Ambulance Service attend a forthcoming meeting to discuss the service changes for Hartlepool.

The meeting concluded at 12.20 p.m.

CHAIR

HEALTH SCRUTINY FORUM

MINUTES

23 February 2012

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

Present:

Councillor Stephen Akers-Belcher (In the Chair);

Councillors Sheila Griffin, Marjorie James, Geoff Lilley, Jean Robinson, Linda Shields and Ray Wells.

Also Present: In accordance with Council Procedure Rule 4.2; Councillor Carl Richardson as substitute for Councillor Kaylee Sirs.
Councillor Edna Wright.

Sue Smith (Director of Nursing and Patient Safety, North Tees and Hartlepool NHS Foundation Trust)
Barbara Carr, (Assistant Director of Nursing North Tees and Hartlepool NHS Foundation Trust)
Laura McGuinness (Project Manager – NAEDI Cancer Awareness Project, NHS Tees),
Aisal Rutter (Director, Fresh),
Pat Marshall (Stop Smoking Service Manager),
Peter Moody (Macmillan Cancer Information and Volunteer Facilitator, NHS Tees)

Officers: Louise Wallace, Assistant Director, Health Improvement
Carole Johnson, Head of Health Improvement
James Walsh, Scrutiny Support Officer
David Cosgrove, Democratic Services Team

78. Apologies for Absence

Councillor Kaylee Sirs

79. Declarations of Interest by Members

None.

80. Minutes of the meeting held on 26 January and 9 February 2012

26 January 2012 - Confirmed.
9 February 2012 – deferred.

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

No items.

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

No items.

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

No items.

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

Sue Smith, Director of Nursing and Patient Safety, North Tees and Hartlepool NHS Foundation Trust (NTHNHST) and Barbara Carr, Assistant Director of Nursing NTHNHST, updated the forum on the development of the 2012/13 Quality Account for the Trust. The presentation also included an update on the 2011/12 Quality Account.

In relation to the 2011/12 Quality Account progress, it was reported that patient mortality remained below the national average (HSMR 94) with cardiac arrests reduced. Sepsis rates were also lower than average. The improvements in documentation and communication were delivering excellent results and in relation to patient experience it was highlighted that the 'Carers Diary' was having a significant and positive impact. An area of ongoing concern was the rates of C-difficile infection which were still considered to be too high but were on track to improve.

In relation to the priorities for 2012/13 the forum was informed of the stakeholder feedback from the earlier stage of consultation which included the following: -

1. Patient Safety – Mortality, Infection Control and Monitoring patient safety; early warning scores.
2. Effectiveness of Care – Communication and Discharge arrangements.
3. Patient Experience – Dementia, Nutrition and End of Life Care.

The presentation also set out the dates for the remaining elements of the consultation and decision process before forwarding the submitting the audited quality account and annual report to Monitor at the end of May. It was also intended that the Quality Account would be easier to read than previously to make it a more accessible document.

The Chair commented that in terms of being easy to read, the important information needed to remain so suggested that some kind of simplified overview or executive summary may help.

Members noted the comments in relation to the potential for the development of an early warning test for dementia suffers and welcomed this as a huge step forward and commented that there were lots of opportunities for this to be rolled out into the community in the various places that health care professionals met the public, particularly the over 50 age group. The NTHNHST representatives indicated that the test was only aspirational at the moment and if brought forward would be nurse led initially.

A Member queried the amount of compensation spent by the Trust on patient complaints. It was accepted that in such a large organisation things would occasionally go wrong but it was considered that it would be valuable to compare this with other Trusts. Patient discharge was also a cause for concern with the times for patients to be discharged often drifting quite significantly through a day. There was also concern expressed by the public at needing to return to their GP for further referrals when they were already under the care of a hospital specialist.

The Trust commented that all the data produced by them was validated by PWC (Price Waterhouse Cooper). Discharge times were sometimes an issue but when a benchmarking exercise had been undertaken the Trust was generally doing quite well. On referrals, the Trust commented that this was one of the anomalies of the system but unless the referral came from a GP into the hospital service, the Trust didn't get paid for that patient referral.

On compensation, the Trust commented that there was no real value in carrying out such comparisons as cases frequently took a number of years to resolve. All such cases were covered by insurance and the real value of the complaints in the first case was what could be learned from them for future patient care.

As part of the patient experience the Chair considered that out of hours care and treatment may be a valuable area for the Quality Accounts to examine. Performance on complaints was also an area highlighted by Members. The Trust commented that most were referred through PALs (Patient Advice and Liaison) though an increasing number were picked up at source.

Recommended

1. That the Trust representatives be thanked for their helpful update report to the Forum.
2. That Members comments and the timetable for the completion of the Quality Account be noted.

85. Scrutiny Investigation into Cancer Awareness and Early Diagnosis - Evidence on Smoking Cessation

(*Scrutiny Support Officer*)

Carole Johnson, Head of Health Improvement and Pat Marshall, Stop Smoking Service Manager (NTHNHST) gave presentations to the Forum on Smoking and Tobacco Control and the Stockton and Hartlepool Stop Smoking Service. Aisal Rutter, Fresh – Smoke Free North East, also gave a presentation outlining the work of Fresh in Hartlepool and the region highlighting some of the marketing tactics of the cigarette industry in attracting young smokers.

The Chair thanked the representatives for their very hard hitting presentations. Members welcomed the information on the smoking cessation services in Hartlepool and that it was one of the most successful programmes in the country. Members asked how the messages were being given to young people on the massive implications of smoking. It was indicated that the messages on smoking were starting to be given to year 7 pupils though through theatre groups rather than lecturing. The messages needed to be given to children at this age as that was the group that were being targeted as 'early adopters' for smoking.

Members discussed the pros and cons of the plain packet campaign, particularly in light of the packaging that was displayed at the meeting, much of which was designed either not to look like normal cigarette packets or to appeal to young women. Aisal Rutter stated that the campaign was not aimed at current smokers as they were already addicted. The campaigns of the Stop Smoking Service were there to break their addiction and help them through that process. Plain Packets were aimed a deterring the new young smokers; protecting them from becoming the new generation of addicts. The tobacco industry was fighting against their introduction hard but this had to be seen as a battle that had to be won. The Forum debated the issue and agreed unanimously to throw its weight behind the campaign for plain packaging. The Chair thanked Members for this support and requested that Officers forward this to the Health and Wellbeing Board indicating that the Forum saw this as an essential part of the protection of the health of the young people of Hartlepool.

On smoking cessation services Members supported the programme of support and groups available to people to help them quit smoking in Hartlepool. Members suggested that extending the smoking cessation services into workplaces may be of value and utilising the on site Nurses at larger industrial sites may be an additional way to reach men in particular.

The Assistant Director commented that smoking and its consequential health problems were still the number one public health issue. Through the new Health and Wellbeing legislation the service was non-mandatory. Delivering such services on our own would be difficult; Fresh for example were currently commissioned on a North east regional basis.

The Chair commented that he had concerns that the Mental Health Services often created barriers for patients stopping smoking; "it's a bad time to do that as well" was an argument he considered needed to be tackled head on with mental health professionals. The Chair proposed that he write to the Mental Health Trust to seek that they review their support to helping patients to quit.

In closing the debate, the Chair again thanked the presenters for their highly valuable and informative input into the Forum's investigation. The information given strengthened the need to protect the health of young people and this Forum fully supported the work being undertaken by the Trust, the Smoking Cessation Service and Fresh.

Recommended

1. That the representatives of the Trust the Stockton and Hartlepool Smoking Cessation Service and Fresh be thanked for their very helpful and informative presentations to the Forum.
2. That Members comments be noted.
3. That the Shadow Health and Wellbeing Board be informed of this Forum's support for the campaign for the introduction of plain packaging for tobacco products in the UK and seek their support for the campaign.

86. Scrutiny Investigation into Cancer Awareness and Early Diagnosis - Evidence on Cancer Awareness Activities (*Scrutiny Support Officer*)

Laura McGuinness, Cancer Awareness and early Diagnosis Project Manager, gave a presentation outlining the work of NHS Hartlepool on cancer awareness and early diagnosis, the Hartlepool Cancer Awareness Measure (CAM) and the National Awareness and early Diagnosis Project (NAEDI). The Project manager highlighted that GP feedback had been excellent with all Hartlepool GP Practice being involved. The campaign was now going national following the impact that it had had in this region.

Peter Moody, MacMillan Cancer Information and Volunteer Facilitator outlined the role that MacMillan was playing in the area in partnership with NHS Tees and how the charity was reaching out to engage with the community through road-shows that aimed to highlight the common signs and symptoms of cancer, how lifestyle factors affected cancer risk and the NHS Screening Programmes that were available.

Members commented that NAEDI and MacMillan should consider

extending the road-shows into work places to reach those that were often hard to reach through other programmes. Laura McGuinness commented that visiting workplaces had played a huge part in developing these programmes and workplaces would be included in the road-shows, though it had to be noted that they only launched the programme last week.

The Chair welcomed the presentations and commented that the road-shows were a very positive way of reaching the community and suggested that MacMillan may wish to include some of the various community events that were held around the town during the summer as a way to get these positive messages into families.

Recommended

1. That the Cancer Awareness and early Diagnosis Project Manager and MacMillan Cancer Information and Volunteer Facilitator be thanked for their very helpful and informative presentations to the Forum.
2. That Members comments be noted.

87. Draft Hartlepool Public Health Transition Plan

(*Assistant Director for Health Improvement*)

The Assistant Director, Health Improvement, presented the Draft Hartlepool Public Health Transition Plan for the Forum's consideration. The final plan would be submitted to Cabinet on 5 March including Scrutiny comments and then to the Regional Director of Public Health by 16 March and the Department of Health by 5 April.

The Chair of the Scrutiny Coordinating Committee indicated that the Committee had agreed that the Chair of this Forum should respond on behalf of Scrutiny on the draft plan. This was supported by the Members of the Forum. The Chair of the Scrutiny Coordinating Committee also commented that one of the important t issues that had been discussed with the Acting Chief Executive was the appointment of the appropriate Officer at the earliest opportunity. There would be three representatives of Hartlepool on the external panel; the Chair of the Shadow Health and Wellbeing Board, the 'Health' Portfolio Holder and the Chair of the Health Scrutiny Forum.

The Chair commented that his response to the draft plan to be submitted to cabinet would echo the comments made by Members expressed during previous meetings and discussions on the plan.

Recommended

1. That the Draft Hartlepool Public Health Transition Plan be noted.
2. That the Chair of the Forum be delegated authority to submit Scrutiny's comments on the draft plan to Cabinet.

88. Six Monthly Monitoring of Agreed Health Scrutiny Forum's Recommendations (*Scrutiny Support Officer*)

The Scrutiny Support Officer reported the six monthly progress made on the delivery of the agreed scrutiny recommendations of the Forum. The report showed that 84% of the Forum's recommendations had been completed, with a further 1% assigned and 5% in progress. The report highlighted that 5% of recommendations were overdue and only 6% had been cancelled. Full details were set out in the appendix to the report.

Recommended

That the report be noted.

89. Issues identified from the Forward Plan

No items.

90. Feedback From Recent Meetings of Tees Valley Health Scrutiny Joint Committee - Northern Doctors Urgent Care – Out of Hours Services – Progress Report (*Scrutiny Support Officer*)

The Scrutiny Support Officer presented for Members information a progress report compiled by Northern Doctors Urgent Care Limited (NDUC) into Out of Hours Services across the Tees Valley. The progress report had been presented to the Tees Valley Health Scrutiny Joint Committee on 21 November 2011.

The Chair considered that the Forum needed to feedback the issues of communication in relation to the Hartlepool OneLife Centre that were a source of concern for Members. A Member commented that there was still much public confusion as out of hours the centre did not provide the walk-in service it claimed as people had to phone to go through a telephone triage system first before being told at which health venue they should attend.

Recommended

That the Chair of the Forum contact NHS Hartlepool to invite them to a future meeting of the Forum to discuss the operational issues connected to One Life Hartlepool.

91. Regional Health Scrutiny Update

No Items.

92. Date and Time of Next Meeting

In confirming the date and time of the next meeting as 10.00 a.m. on Thursday 5 April 2012, the Chair indicated that he had written to the Mayor as Chair of the Shadow Health and Wellbeing Board and the North East Ambulance Service seeking their attendance at the meeting.

The meeting concluded at 12.30 p.m.

CHAIR

HEALTH SCRUTINY FORUM

05 April 2012

Report of: Scrutiny Support Officer

Subject: HARTLEPOOL LINk UPDATE – COVERING REPORT

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1. PURPOSE OF THE REPORT

1.1 To introduce representatives from Hartlepool LINk who will be present at today's meeting to provide an update on LINk activity during the 2011/12 Municipal Year.

2. BACKGROUND INFORMATION

2.1 Continuing the development of strong working / communication links between Hartlepool LINk and the Health Scrutiny Forum, a request has been received from the LINk Co-ordinator, to provide an update on the following areas:-

(i) Presentation on the development of Hartlepool's Local HealthWatch; and

(ii) Verbal update on cancer patient survey undertaken by Hartlepool LINk.

3. RECOMMENDATION

3.1 That Members note the content of this report and the presentation, seeking clarification on any issues from the representatives from Hartlepool LINk present at today's meeting.

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

BACKGROUND PAPERS

No background papers were used in the preparation of this report

HEALTH SCRUTINY FORUM

05 April 2012

Report of: Scrutiny Support Officer

Subject: FEMALE LIFE EXPECTANCY IN HARTLEPOOL – COVERING REPORT

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1. PURPOSE OF REPORT

1.1 To introduce the Assistant Director for Health Improvement, who will be present at today's meeting to provide an update in terms of Female Life Expectancy in Hartlepool.

2. BACKGROUND INFORMATION

2.1 The publication of the Health Profile for Hartlepool in 2009 highlighted that female life expectancy in the Town equated to the worst in England, this generated significant media interest; nationally through the Radio 4 programme 'Woman's Hour' and locally via the Evening Gazette and Hartlepool Mail newspapers.

2.2 On the 6 October 2009 the Health Scrutiny Forum received a report by the Acting Director of Health Improvement into Female Life Expectancy in Hartlepool. Members agreed at the meeting of 6 October 2010:-

"That the Forum [will continue] to monitor the issue of health inequalities in the town and on doing this receive an update report on an annual basis focussing on those specific wards causing concerns in relation to life expectancy of women."

2.3 Subsequently the Assistant Director for Health Improvement will be in attendance today to provide a presentation to Members in relation to the issue of Female Life Expectancy in Hartlepool. **Table1** overleaf provides a comparison between the Health Profile for Hartlepool in 2009, 2010 and 2011 in relation to female life expectancy:-

Table1: Comparison of Average Female Life Expectancy (in years) in Hartlepool to National Averages.

Year	Average Female Life Expectancy in Hartlepool	Average Female Life Expectancy in England	Worst Average Female Life Expectancy in England
2009[1]	78.1	81.1	78.1
2010[2]	79.0	82.0	78.8
2011[3]	79.8	82.3	79.1

3. RECOMMENDATIONS

3.1 That Members note the content of this report and the presentation by the Assistant Director for Health Improvement, seeking clarification on any relevant issues 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:-

(a) Minutes of the Health Scrutiny Forum held on 6 October 2009

(b) The Association of Public Health Observatories (2009), *Health Profile 2009 Hartlepool*, Available from http://www.apho.org.uk/default.aspx?QN=HP_METADATA&AreaID=50333 (Accessed 8 November 2010)

(c) The Association of Public Health Observatories (2010), *Health Profile 2010 Hartlepool*, Available from http://www.apho.org.uk/default.aspx?QN=HP_METADATA&AreaID=50333 (Accessed 8 November 2010)

(d) The Association of Public Health Observatories (2011), Health Profile 2011 Hartlepool, Available from http://www.apho.org.uk/default.aspx?QN=HP_METADATA&AreaID=50333 (Accessed 12 March 2012)

[1] APHO, 2009
[2] APHO, 2010
[3] APHO, 2011

HEALTH SCRUTINY FORUM

05 April 2012

Report of: Scrutiny Support Officer

Subject: INFORMATION ON SECOND HAND SMOKE

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1. PURPOSE OF REPORT

1.1 To present to Members information from ASH on second hand smoke.

2. BACKGROUND INFORMATION

2.1 At the meeting of the Forum held on 26 January 2012, an issue was raised during the investigation into 'Cancer Awareness and Early Diagnosis' about the effects of passive smoking.

2.2 Therefore, attached as **Appendix A** to this report is a factsheet from the organisation ASH (Action on Smoking and Health) detailing various sources of evidence on the effects of second hand smoke.

3. RECOMMENDATIONS

3.1 That Members note the content of this report and the ASH fact sheet attached as **Appendix A**.

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

BACKGROUND PAPERS

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

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

June 2011

- Introduction
- What's in the smoke?
- The health effects of secondhand smoke.
- Deaths from SHS
- The risks to children
- Legal protection
- Public opinion about secondhand Smoke
- HPublicH opinion about smokefree legislation
- Health impact of smokefree laws

ash fact sheets
action on smoking and health

Secondhand smoke

www.ash.org.uk enquiries@ash.org.uk Telephone: 020 7739 5902

Introduction

This fact sheet summarises the health impact of secondhand smoke on adults and children. For more detailed information see: ASH Research Report: Secondhand Smoke and ASH Research Report: Secondhand Smoke - the impact on children

Breathing in other people's cigarette smoke is called passive, involuntary or secondhand smoking. Secondhand smoke, also called "environmental tobacco smoke", comprises "sidestream" smoke from the burning tip of the cigarette and "mainstream" smoke which is smoke that has been inhaled and then exhaled by the smoker.

The United States Environmental Protection Agency (EPA) classifies environmental tobacco smoke as a Class A (known human) carcinogen alongside asbestos, arsenic, benzene and radon gas. [1] According to the British Medical Association there is no safe level of exposure to secondhand smoke.[2]

What's in the smoke?

Tobacco smoke contains over 4000 chemicals in the form of particles and gases.[1] Many potentially toxic gases are present in higher concentrations in sidestream smoke than in mainstream smoke and nearly 85% of the smoke in a room results from sidestream smoke.[3] The particulate phase includes tar (itself composed of many chemicals), nicotine, benzene and benzo(a)pyrene. The gas phase includes carbon monoxide, ammonia, dimethylnitrosamine, formaldehyde, hydrogen cyanide and acrolein. Some of these have marked irritant properties and some 60 are known or suspected carcinogens (cancer causing substances).

For further information on tobacco smoke see: ASH Fact Sheet: What's in a Cigarette

The health effects of breathing in secondhand smoke

Immediate effects of exposure to secondhand smoke include eye irritation, headache, cough, sore throat, dizziness and nausea. Adults with asthma can experience a significant decline in lung function when exposed, while new cases of asthma may be induced in children whose parents smoke. Short term exposure to tobacco smoke also has a measurable effect on the heart in non-smokers.[4]

In the longer term, passive smokers suffer an increased risk of a range of

smoking-related diseases. The International Agency for Research on Cancer (IARC), convened by the World Health Organization, conducted a review of evidence on second-hand smoke and cancer in 2002 and found that *"the evidence is sufficient to conclude that involuntary smoking is a cause of lung cancer in never smokers".* The report concludes that exposure to other people's smoke increases the risk of lung cancer in non-smokers by 20-30 per cent and coronary heart disease by 25-35 per cent. [5]

The health effects of breathing in secondhand smoke (continued)

These findings were confirmed in the UK by the Government-appointed Scientific Committee on Tobacco and Health (SCOTH) whose 2004 report found that passive smoking is a cause of lung cancer and ischaemic heart disease in adult non-smokers, and a cause of respiratory disease, cot death, middle ear infections and asthma attacks in children.[6] The Committee reported a "*causal effect of exposure to secondhand smoke on the risks of lung cancer, ischaemic heart disease and a strong link to adverse effects in children"*, and found that secondhand smoke *"represents a substantial public health hazard."*

The 2006 US Surgeon General report concurs with the BMA that there is no safe level of exposure to secondhand smoke and furthermore concludes that "*the scientific evidence is now indisputable: secondhand smoke is not a mere annoyance. It is a serious health hazard that leads to disease and premature death in children and nonsmoking adults."* [7]

- The SCOTH report estimates that non-smokers exposed to secondhand smoke have a 24% increased risk of lung cancer and a 25% increased risk of heart disease.[8] The Institute of Medicine in the United States confirms that exposure to secondhand smoke is a cause of heart disease in non-smokers.[9] Other estimates have found an increased risk of heart disease between 25-35%.[10]
- The effects of passive smoke exposure on the heart can be rapid.[11] A Japanese study has shown that just 30 minutes of exposure to environmental tobacco smoke by healthy non-smokers can have a measurable impact on coronary blood flow.[12]
- A study published in the British Medical Journal suggests that previous studies of the effects of passive smoking on the risk of heart disease may have underestimated the risk. Researchers found that non-smokers exposed to secondhand smoke and with detectable cotinine levels had a 50-60% increased risk of heart disease.[13]
- A 2009 study on the impact of secondhand smoke exposure on obstructive lung disease concluded that *"SHS has a substantive role in causing chronic respiratory disease. Exposure to as little as 1 hour of SHS can cause an acute decline in lung function; longer-term exposure can induce asthma, excessive decline in lung function, and possibly COPD."*[14]
- SHS exposure has been associated with a 40%increased risk of developing cervical tumours (cervical neoplasia).[15]
- A 2010 IARC update on the link between exposure to SHS and cancer reports limited evidence showing an association between exposure and cancers of the larynx and pharynx.[16] Exposure to secondhand smoke has also been linked with bladder,[17] leukaemia, nasal and breast cancer. [18] [19] However, the epidemiological studies of these cancers and SHS exposure are currently limited.
- There is some evidence to suggest an association between passive

smoking and the risk of acute stroke [20] [21] while a recent systematic review concluded that there is evidence of a "strong, consistent and dose-dependent association between exposure to secondhand smoke and risk of stroke".[22]

- Some research has suggested a link between exposure to secondhand smoke and breast cancer.[23] However, a large UK prospective study (the Million Women study) found no association between breast cancer and passive exposure to tobacco smoke among nonsmoking women either in childhood or in later life.[24]
- A 2010 study found an association between exposure to SHS and tuberculosis.[25] In addition to this, non-smokers exposed to secondhand smoke were reported to be significantly more susceptible to infectious diseases in general including community acquired pneumonia and invasive pneumococcal disease.[26]
- The first study to identify an association between exposure to secondhand smoke and the development of peripheral arterial occlusive disease (PAOD) has been published. PAOD is a surrogate marker for coronary artery disease.[27]
- There is some new evidence to suggest that exposure to secondhand smoke may be associated with depression in never-smokers.[28] These are new findings and further research is needed.
- A study published in Diabetes Care in February 2011 suggests an independent association between exposure to secondhand smoke and the development of Type 2 Diabetes in women.[29] Again, this is a new study with further research necessary to determine whether there is a causal link.

For further information regarding the health risks of exposure to secondhand smoke for adults see the 'Going smoke-free' report by the Royal College of Physicians.[30]

Deaths from secondhand smoke

Whilst the relative health risks from passive smoking are small in comparison to risks from active smoking, the overall health impact is large because the diseases are common.[31]

It has been estimated that domestic exposure to secondhand smoke in the UK causes around 2,700 deaths in people aged 20-63 and a further 8,000 deaths a year among people aged 65 years and older.[32]

In 2005, the California Environmental Protection Agency used population estimates in the US to show the number of annual estimated deaths from SHS exposure. For non-smokers the Agency estimated that:

- around 3,400 Americans died from lung cancer (ranging from 3,423 to 8,866)
- 46,000 died from cardiac-related illness (range of 22,700 to 69,600)
- 430 children died from sudden infant death syndrome (SIDS). [33]

The risks to children

In 2010 The Royal College of Physicians published a landmark report entitled "Passive Smoking and Children". The report acknowledges the importance of smokefree legislation in reducing exposure to secondhand smoke in the workplace but points out that the principle source of exposure for non-smokers is in the home and that children are especially at risk.[34]

The authors conclude that *"passive smoking in the home is a major hazard to the health of the millions of children in the UK who live with smokers*" [35] and that *"passive smoking is a significant cause of morbidity and mortality in babies and children*." [36]

The report affirms that a child exposed to SHS has an increased risk of asthma, lower respiratory infections, bronchitis, middle ear disease, bacterial meningitis and sudden infant death syndrome, as well as general reduced respiratory function (cough, wheezes).[37] These disorders generate over 300,000 UK GP consultations and about 9,500 hospital admissions every year, costing the NHS about £23.3 million. [38]

- A review published by the World Health Organization in 1999 found that passive smoking is a cause of bronchitis, pneumonia, coughing and wheezing, asthma attacks, middle ear infection, cot death, and possibly cardiovascular and neurobiological impairment in children.[39]
- A study published by the American Academy of Pediatrics in 2009 confirmed earlier findings that "secondhand tobacco smoke (SHS) exposure of children and their families causes significant morbidity and mortality," citing strong evidence showing an association of SHS exposure in children with respiratory illnesses, middle-ear infections, tonsillectomy and adenoidectomy, cough, asthma and asthma exacerbations, hospitalizations and sudden infant death syndrome. According to the study, SHS has also been associated with the exacerbatation of many chronic illnesses such as sickle cell disease.[40]
- Passive smoking increases the risk of lower respiratory tract infections such as bronchitis, pneumonia and bronchiolitis in children. One study found that in households where both parents smoke, young children have a 72% increased risk of respiratory illnesses.[41] Passive smoking causes a reduction in lung function and increased severity in the symptoms of asthma in children, and is a risk factor for new cases of asthma in children.[42] [43]
- A study in Sweden revealed that parents who smoke are greatly increasing their child's risk of developing several types of cancer. Similar risks for exposure by mothers and fathers smoking were found for lung cancer (71%), and throat cancer (45%). There was an 8-fold increased risk of developing nasal cancer (nasal adenoid cystic carcinoma) by exposure to SHS from either parent during childhood.[44]
- Infants of parents who smoke are more likely to be admitted to hospital for bronchitis and pneumonia in the first year of life.[45] Passive smoking during childhood predisposes children to developing chronic obstructive airway disease and cancer as adults.[45]
- Exposure to tobacco smoke may impair olfactory function in children. A Canadian study found that passive smoking reduced children's ability to detect a wide variety of odours compared with children raised in non-smoking households.[46]
- Passive smoking may also affect children's mental development. A US study found deficits in reading and reasoning skills among children even at low levels of smoke exposure.[47] There is also some evidence to suggest that exposure to secondhand smoke can lead to increased school absenteeism.[48] [49]
- A report by the British Medical Association found that suggestive evidence that exposure to SHS causes childhood cancer (in

particular brain cancer and lymphoma) and meningitis. It can also lead to cancer in adulthood and the initiation and progression of cardiovascular disease.[52]

- A study published in 2009 found an association between childhood exposure to SHS and emphysema in adulthood. The findings suggest that the lungs may not recover completely from the effects of early-life exposure.[50]

In 2000, it was estimated that almost half of all children in the UK were exposed to tobacco smoke at home.[51] By early 2007 this figure had dropped to 40%[52] and a recent study in Scotland found that children's exposure to secondhand smoke has continued to fall since the introduction of smokefree legislation.[53] The proportion of children living in smokefree homes has risen from 21% in 1996 to 37% in 2007.[54] Nevertheless, secondhand smoke in the home remains the principal source of exposure for children.

The full Royal College of Physicians report "Children and Passive Smoking" is available for purchase or download.

For related information see:

ASH Fact Sheet on Secondhand Smoke in the Home
ASH Fact Sheet on Smoking, Sex and Reproduction
ASH Fact Sheet Information Smoking in Cars

Legal protection from exposure to secondhand smoke

Since the implementation of the smokefree provisions of the Health Act in 2007, smoking in all enclosed public places and workplaces is prohibited across the United Kingdom.

For further information see:

ASH Fact Sheet Information on Smokefree Legislation
Smokefree England
Clearing the Air Scotland
Smoking Ban Wales
Space to Breathe for Northern Ireland
Smokefree England Regulations
The Smoke-free (Premises and Enforcement) Regulations 2006

Public opinion about secondhand smoke

There are high levels of awareness about the health risks of SHS. Around 80% of adults in the UK believe that a non-smoker's risk of lung cancer, bronchitis and asthma is increased by SHS exposure. Slightly fewer (76%) are aware that SHS increases the risk of heart disease.[55]

The most recent edition of the annual Government survey on public opinion about smoking, "Smoking-related behaviours and attitudes", found that:

- Around 62% of non smokers dislike people smoking around them.
- Women who did not smoke were more likely to mind others smoking near them than men who did not smoke (64% compared with 59%).
- Those who have never smoked regularly were more likely to mind people smoking near them than ex-regular smokers (67% and 53% respectively).
- People do not like the smell of cigarettes (65%); or the smell of smoke on clothes (53%). 51% also reported adverse health reactions due to SHS

including that: it affects their breathing; makes them cough; gets in their eyes and makes them feel sick. [56]

Awareness about the impact of secondhand smoke on children is variable:

- 92% of adults are aware that exposure to SHS increases a child's risk of chest infections and 86% are aware of an increased risk of asthma.
- People are less likely to be aware of the risks associated with cot deaths (58% thought there was an increased risk) but only 35% believed there was an increased risk of ear infections in children living with a smoker. [57]

Public opinion about smokefree legislation

There is strong support for smokefree legislation which has been growing steadily in recent years:

- In 2005, prior to the introduction of smokefree legislation, a YouGov poll commissioned by ASH and Cancer Research UK found that 71% of respondents would support a law to make workplaces smokefree.[58]
- The Department of Health carried out a survey in 2008 which found that 76% of respondents supported smokefree legislation in England.[59]
- The 2008/9 edition of the Office of National Statistics "Smoking-related behaviour and attitudes" found that 85% of respondents supported restrictions on smoking at work, 93% in restaurants, 91% for indoor shopping centres, 94% for indoor sport and leisure centres. 75% of those interviewed supported the ban on smoking in pubs.[60]
- Monthly surveys conducted on behalf of the Government since the ban was implemented have revealed that 98% of businesses are compliant with the law and 81% believe the legislation is a "good idea".[61]
- A MRUK survey carried out on behalf of the Scottish government in 2006 found that 91% of non-smokers supported smokefree legislation.[62]
- Surveys suggest there is strong support for the introduction of a law banning smoking in cars with children.[63]
- Research in the US has found that young adults who lived in smokefree homes as children are much more likely to prefer to live in smokefree accommodation once they leave home.[64]

The health impact of smokefree laws

There is consistent evidence to show that in countries where comprehensive smokefree legislation has been implemented, reductions in secondhand smoke exposure of between 80% and 90% have been recorded.[65]

In addition to improved respiratory function, there has been a notable decline in admissions to hospital for heart attack. There is a growing body of evidence to show that incidences of myocardial infarction (heart attack) fall following the introduction of smokefree legislation.[66] [67] [68] [69] One review of recent studies found an overall decrease in acute myocardial infarction of 17%.[70]

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ash action on smoking and health

HEALTH SCRUTINY FORUM

05 April 2012

Report of: Scrutiny Support Officer

Subject: INFORMATION FROM TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST

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1. PURPOSE OF REPORT

1.1 To present to Members information from Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) on stop smoking services for people under the care of the Mental Health Trust.

2. BACKGROUND INFORMATION

2.1 At the meeting of the Forum held on 23 February 2012, an issue was raised during the investigation into 'Cancer Awareness and Early Diagnosis' about the policy of the TEWV towards stop smoking services for people under the care of the Mental Health Trust. Following the meeting of 23 February 2012, the Chair wrote to TEWV and a copy of the letter is attached as **Appendix A** to this report.

2.2 Subsequently the Director of Operations – Tees at TEWV responded in writing and this response is attached as **Appendix B**, along with a copy of TEWV's Smoking Policy; attached as **Appendix C**.

3. RECOMMENDATIONS

3.1 That Members note the content of this report, the correspondence and evidence attached as **Appendices A, B and C**.

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

BACKGROUND PAPERS

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

(a) Minutes of the meeting of the Health Scrutiny Forum held on 23 February 2012.

7.4
Appendix A

Councillor Stephen Akers-Belcher (Chair, Health Scrutiny Forum)
101 Westbrooke Avenue
Hartlepool
TS25 5HY

Mr David Brown
Service Director
Tees Esk and Wear Valleys NHS Foundation Trust

[SENT BY EMAIL]

23 February 2012

Dear David,

Re: Stop Smoking Services

The Health Scrutiny Forum in Hartlepool is currently carrying out a scrutiny inquiry into Cancer Awareness and Early Diagnosis and focussing part of its investigation on smoking cessation services.

Evidence was presented to the Health Scrutiny Forum this morning (23 February 2012) from the Stockton and Hartlepool Stop Smoking Service which detailed some of the targeted support they undertook. It was noted by the Forum that for all the Stop Smoking Service function was targeted at people with mental health difficulties, this was not reflected as a priority by the Mental Health Trust.

Therefore, as Chair of the Health Scrutiny Forum, I would appreciate if you could confirm, in writing, TEWV's position in relation to the promotion of Stop Smoking Services during the assessment of patients.

Yours sincerely

Councillor Stephen Akers-Belcher
CHAIR OF THE HEALTH SCRUTINY FORUM

7.4
Appendix B

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

The Dales
163 Durham Road
Stockton on Tees
TS19 0EA

Tel: 01642 358912
Email: david.brown@tewv.nhs.uk

DB/Sh

22 March 2012

Councillor Stephen Akers-Belcher
(Chair, Health Scrutiny Forum)
101 Westbrooke Avenue
Hartlepool
TS25 5HY

Dear Councillor Akers-Belcher,

Thank you for your letter of 23 February. I have sought information from the services in Hartlepool and can offer the following comments.

For older people, lifestyle questions are part of the comprehensive assessment that is carried out with patients and part of the education programme focuses on healthy choices, especially in relation to reducing the risk of vascular dementia and would therefore include reducing or stopping smoking. Within the Dementia Care Pathway there is a discussion and signposting element relating to health promotion as an intervention essential for all, therefore stop smoking services would be recommended at this stage.

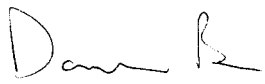
It is a similar picture in the Adult services. The Trust has in place lifestyle, wellbeing and physical assessments and reviews all clients or patients in services, this provides the opportunity to intervene and support people who choose to stop or reduce smoking. There are identified and trained staff providing assessment and smoking cessation activity using evidence based tools. The community teams refer to the local smoking cessation clinics, for example the one at Asda. We recognise that the issue of smoking cessation is a particularly challenging one which we take seriously and this is reflected in the assessment and treatment phase of care.

I think the above is reflected in the Trust's Smoking Policy which focuses more on a smoke free environment but also references what I have described above.

I hope that this clarifies the position in relation to the promotion of stop smoking services during the assessment of patients.

Best wishes.

Yours sincerely,



David Brown
Director of Operations – Tees

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Policy Number: **CORP/0002/v4**

Issue/Version No.: **4**

Smoke Free Policy for Tees, Esk and Wear Valleys NHS Foundation Trust

Current Status: **Ratified**

Compliance

All members of Tees, Esk and Wear Valleys NHS Foundation Trust staff will adhere to the parameters of trust policies. The consequences of non-compliance may include disciplinary action and/or legal action.

DOCUMENT CONTROL

Application	This policy pertains to all areas, departments and services of Tees, Esk and Wear Valleys NHS Foundation Trust
Associated policy reference and title	Not applicable
Date of Ratification	2 March 2011
Date of Review	March 2014
Replacing	1. Tobacco Control Policy T1 2. Staff No Smoking Policy CDDPST/POL/HR030/1 Guidance Notes for staff dealing with patients in respect of the No Smoking Policy CDDPST/GU/HR030/2
Lead	Modern Matrons Group AMH
Members of working party	Modern Matrons Group AMH

This policy has been agreed and accepted by: (Director)

Name	Designation	Signature	Date
Les Morgan	Chief Operating Officer		14 March 2011

This policy has been ratified by:

Trust Board or Trust Board Sub Committee (specify)	Date of Trust Board or Sub Committee
Executive Management Team	2 March 2011
This policy has gone through an equality impact assessment (EqiA)	Date of EqiA 28 February 2011

Amendment
26 June 2009 Extended review date to March 2010
3 March 2010 Extended review date to 1 March 2011
2 March 2011 Amendment to 6.5 where in the past patients were offered Nicotine Replacement Therapy/GP was informed, now support is offered from ward based staff, as appropriate.

CONTENTS

1. INTRODUCTION

1.1 Smoking is a major contributor to many serious illnesses including respiratory problems, vascular disease and various forms of cancer

1.2 The Public Health White Paper, 'Choosing Health', made a clear commitment to secure a smoke free NHS by the end of 2006.

1.3 Section 2 (2) of the Health and Safety at Work Act 1994 states:

'that employers will ensure the provision and maintenance of a working environment for employees that is, so far as is reasonably practical, safe, without risks to health and adequate as regards facilities and arrangements for their welfare at work'

1.4 Second hand smoke – breathing other people's tobacco smoke – has been shown to cause lung cancer and heart disease in non-smokers, as well as many other illnesses and minor conditions.

1.5 Tees, Esk and Wear Valleys NHS Foundation Trust has a responsibility for the maintenance, and where possible improvement, of the health of its patients and staff and acknowledges that breathing other people's smoke is both a public health hazard and welfare issue, proven to cause ill health. This policy recognises that second hand smoke adversely affects the health of all employees.

1.6 Tees, Esk and Wear Valleys NHS Foundation Trust has a responsibility, within the remit of health promotion within mental health services, to support people with mental health problems to stop smoking.

2. OBJECTIVES

This policy seeks to:

- Guarantee a healthy working environment and protect the current and future health of employees, patients and visitors
- Guarantee the right of everyone to breath in air free from tobacco smoke
- Comply with Health and Safety legislation and employment law
- Raise awareness of the dangers associated with exposure to tobacco smoke
- Take account of the needs of those who choose to smoke and to support those who wish to stop.

The aim of the policy is to:

- Protect the health of staff
- Protect the health of patients, visitors and contractors
- Set an example to other employees and workforces, particularly in health related locations by arranging for trust buildings, grounds and vehicles to be smoke free, and by requiring staff not to smoke whilst on duty.
- Inform staff and managers of their responsibilities in respect of the policy
- Support smokers to help them cope with increased restrictions or to stop smoking
- Support patients and visitors in complying with the policy and/or using their stay in hospital as an opportunity to stop smoking
- Promote the culture of a smoke free mental health service

3. SCOPE

3.1 This policy will apply to all staff, patients, visitors, contractors and other persons who enter the grounds and premises of the trust.

4. RESPONSIBILITIES

4.1 The responsibility for ensuring that this policy is implemented rests with all Executive Directors.

4.2 Each General Manager, Modern Matron, Senior Nurse or Service Manager has responsibility for ensuring that the policy is observed within their own area of responsibility and brought to the attention of existing and newly appointed staff.

4.3 All staff are responsible for the implementation of this policy.

5. KEY THEMES

5.1 Restrictions on Smoking

Smoking is not permitted in any part of the premises or grounds managed, leased or owned by the trust at any time, by any person regardless of their status or business within the organisation.

5.2 Service Users

All service users are required to abide by the smoke free policy, with the support of stop smoking specialists and access to NRT as appropriate, unless an exception is agreed. (see Appendix 1 re: Exceptions)

5.3 Visitors

All visitors, contractors and deliverers are required to abide by the smoke free policy. Staff members are expected to inform patients or visitors of this policy. However, they are not expected to enter into any confrontation that may put their personal safety at risk.

5.4 Staff

Staff are only permitted to smoke whilst off duty (in official break times only)

Staff are expected to be out of uniform whilst smoking.

Staff will not be permitted to smoke in either trust premises or grounds

Staff are not permitted to smoke at any time in public when representing the trust and when attending meetings on behalf of the trust, wherever these are held.

If any individual or group of individuals continue to infringe this policy, the manager should, if necessary, invoke disciplinary procedures as a means of securing adherence of the policy.

5.5 Vehicles

Smoking is not permitted in trust vehicles. Smoking is not permitted in leased or staff private vehicles whilst used on trust business, including for the purposes of transporting patients or colleagues.

5.6 Care In Private Homes

When care is offered to patients of Tees, Esk and Wear Valleys NHS Foundation Trust in their own home, it is essential that a request be made to provide a smoke free environment whilst the visit is taking place. This request should be made in the text of the appointment letter where possible. A verbal request can also be made at the time of the visit and the client should be respectfully asked not to smoke whilst the employee is working within that environment.

5.7 Support for Smokers

The trust recognises its duty towards employees who smoke. The Occupational Health Department will offer a support service for employees who wish to stop smoking:

- Information regarding smoking cessation methods
- Advice and support whilst on a smoking cessation programme
- Time to attend cessation clinics (up to a total of 4 hours)

Information on stopping smoking with support from local cessation services will also be provided for smokers, both patients and staff in the trust. The NHS Smoking help line number can be given to patients and staff which is **0800 169 0 169.** The help line can offer advice and support on stopping smoking along with a website at www.givingupsmoking.co.uk

5.8 **Recruitment**

All job advertisements will include reference to the trust's Smoke Free Policy

6. IMPLEMENTATION (see Appendix 1 re: Exceptions)

6.1 Any complaint relating to this policy from staff should follow the grievance procedure and on behalf of patients should be dealt with under the trust's complaints procedure.

6.2 The trust will encourage all members of staff to take advantage of smoking cessation training, to provide them with the knowledge and skills to raise the issue of smoking with services and refer service users appropriately to the smoking cessation service

6.3 The Occupational Health Department will provide advice and support for staff

6.4 To ensure that everyone entering trust sites understands that it is a smoke free environment, clear signs will be displayed.

6.5 Patients will be advised of the policy on admission and supported as appropriate.

6.6 Appropriate training and support has been provided to front-line clinical staff to provide brief interventions and other advice and support to patients

6.7 Job advertisements will include reference to the Smoke Free Policy and indicate that adherence to it will form part of the contract of employment

6.8 Employees who smoke and who do not wish to stop smoking should not smoke on premises. There will be an expectation that trust staff will set a good example by not smoking in view of service users or visitors and **never** smoke when wearing a name badge or other trust identification

6.9 The trust's Smoke Free Policy should be featured on all documentation, for example job and volunteer descriptions, induction packs, induction training and the trust's web site. Information for service users will include the smoke free policy.

7. MONITORING AND REVIEWING

7.1 Managers will be encouraged to support staff wishing to access the smoking cessation services by allowing them reasonable time to do so

7.2 Executive Directors and their teams will be responsible for monitoring the policy and ensuring that the services/departments they are responsible for adhere to the policy

7.3 Service users will be informed of the policy by their care co-ordinator and an explanation given to every service user before they begin using trust services

8. APPENDICES

Appendix 1	Exceptions
Appendix 2	Smoke Free Protocol for Domiciliary Visits

9. REFERENCES

Health Development Agency (2005) Guidance for Smoke Free Hospital Trusts.

HM Government (2004) Choosing Health: Making Healthy Choices easier

Health Development Agency (2004). The case for a completely smoke free NHS in England

10. RELATED DOCUMENTS

TEWV Clinical Risk Assessment and Management Policy
TEWV Health and Safety Policy
TEWV Disciplinary Policy and Procedure
TEWV Informal/Formal Complaints Policy
TEWV Challenging Behaviour Policy
TEWV Substance Misuse on Trust premises policy
TEWV Grievance Policy/Grievance Procedure

APPENDIX 1

EXCEPTIONS

Exceptions for patients may be made on a case by case basis. However, no blanket exceptions will be allowed for particular categories of patients.

It is realised that some patients may have circumstances that will require staff to make an assessment as to whether special arrangements need to be made so that the patient may be permitted to smoke on a trust site. Such circumstances might include detention under the Mental Health Act or the inability of a patient to give informed consent for help with smoking cessation.

Permission to grant an exception will rest with the Modern Matron/Senior Nurse and be formally recorded.

In all cases where an exception has been made, there should be demonstrable evidence that smoking cessation has been fully considered as part of the patient care pathway, in conjunction with the patient and/or their relatives.

Where an exception is made, every effort must be made to minimise staff exposure to smoke. This would mean that smoking would only be permitted outdoors in a designated smoking area, where staff and other patients would not be in close proximity to the smoker.

APPENDIX 2

SMOKE FREE PROTOCOL FOR DOMICILIARY VISITS

Smoking and passive smoking (i.e. breathing other people's tobacco smoke) is a major contributor to many serious illnesses including respiratory problems, vascular disease and various forms of cancer.

Tees, Esk and Wear Valleys NHS Foundation Trust acknowledges its statutory duty to provide public services and this rests under the provisions of the Health and Safety at Work Act 1994, which places a duty on all employers to ensure "so far as reasonably practicable, the health and safety and welfare at work of all their employees".

To help protect the health and safety of all our employees from the adverse effects of passive smoking the following protocol should be followed during a home visit:

- Ensure the staff member/service user requiring the visit is made aware of the trust's Smoke Free Policy prior to the visit and request that they refrain from smoking for the duration of the visit. This should be highlighted in the text of the appointment letter where possible.

- Where other household members/visitors smoke, employees should make them aware of the trust's commitment to protect the health and safety of staff and request they abstain from smoking for the duration of the visit.

- If staff are faced with non-compliance, the staff member/service user/other household member/visitor will be sent a letter requesting that they refrain from smoking for the duration of the visit and this should be brought to the attention of their line manager. If staff are faced with continued non-compliance, a further letter will be sent from the Line Manager. If the member of staff continues to be exposed to second hand smoke during visits, a letter will be forwarded to the staff member/service user to suggest that an alternative plan of care/action will need to be discussed, and alternative arrangements made which would maintain the safety of both staff and service users.

Shared Living Scheme/Supported Housing

Service users who wish to give up smoking should be offered help and advice from a stop smoking advisor. Those service users who do not wish to give up smoking should be encouraged to smoke outside the building in one of the designated smoking areas.

Exceptions

Emergency home visits – due to the emergency nature of these visits, it will not be possible to inform the service user, prior to the visit, of the trust's Smoke Free Policy. However, service users who smoke may be respectfully requested to refrain from smoking at the time of the visit. This would apply to: Crisis Team, Community Nurses working in a crisis situation, Approved Social Workers, Child Protection Team, Emergency Duty Team and Consultant Psychiatrists/S.12 Doctors.

HEALTH SCRUTINY FORUM

5 April 2012

Report of: **Health Scrutiny Forum**

Subject: **DRAFT FINAL REPORT – CANCER AWARENESS AND EARLY DIAGNOSIS**

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1. PURPOSE OF REPORT

1.1 To present the findings of the Health Scrutiny Forum following its investigation into Cancer Awareness and Early Diagnosis.

2. SETTING THE SCENE

2.1 At the meeting of the Health Scrutiny Forum on 11 August 2011, Members determined their work programme for the 2011/12 Municipal Year. The issue of 'Cancer Awareness and Early Diagnosis' was selected as the main scrutiny topic for consideration during the year.

2.2 Figures from the Department of Health in 2011 indicated that Hartlepool's death from cancer rate was 159.1[1] per 100,000 population under 75 years of age, although this was an improvement on the 2010 rate of 164.3[2] per 100,000 population, it was still comparable to the worst in England.

2.3 NHS Hartlepool is currently promoting the regional campaign "Be Clear on Cancer" which highlights cervical, ovarian, bowel, lung and breast cancer. The campaign also emphasises how earlier detection can save lives, with several factors being highlighted to cause longer delays for patients with cancer, these include:-

(i) Failing to recognise early cancer symptoms;

(ii) Fear / reluctance to seek medical opinion on symptoms; and

(iii) Awareness of screening programmes to detect cancer.

2.4 For bowel, breast and cervical cancer there are screening programmes that patients can participate in to ensure that those cancers can be detected as early as possible, so potentially improving outcomes for patients

[1] Association of Public Health Observatories, 2011
[2] Association of Public Health Observatories, 2010

2.5 Although there are many factors which can contribute to a patient developing cancer, the NHS is quite clear that:-

"Lung cancer is one of the few cancers where there is a clear cause in many cases – smoking. Although some people who have never smoked get lung cancer, smoking causes 9 out of 10 cases"[3]

3. OVERALL AIM OF THE SCRUTINY INVESTIGATION

3.1 The overall aim of the Scrutiny investigation was to evaluate the effectiveness of the delivery of early detection and awareness raising programmes for cancer, with specific reference to smoking cessation services.

4. TERMS OF REFERENCE FOR THE SCRUTINY INVESTIGATION

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

(a) To gain an understanding of the levels of cancer in Hartlepool;

(b) To explore the methods for early detection and screening of cancer;

(c) To assess the impact and delivery of smoking cessation services; and

(d) To examine the impact of cancer awareness raising activities in the Town and what more can be done to improve outcomes for patients.

5. MEMBERSHIP OF THE HEALTH SCRUTINY FORUM

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

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

Resident Representatives: Maureen Braithwaite, Norma Morrish and Ian Stewart

6. METHODS OF INVESTIGATION

6.1 Members of the Health Scrutiny Forum met formally from 11 August 2011 to 5 April 2012 to discuss and receive evidence relating to this investigation. A

[3] NHS, 2011

detailed record of the issues raised during these meetings is available from the Council's Democratic Services.

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

(a) Detailed Officer reports supplemented by verbal evidence;

(b) Evidence from the Authority's Portfolio Holder for Adults and Public Health Services;

(c) Verbal evidence received from the town's Member of Parliament;

(d) Detailed evidence and presentation received from representatives from Tees Public Health and NHS Tees;

(e) Comprehensive presentation from key cancer consultants and nurses from North Tees and Hartlepool NHS Foundation Trust; and

(f) Presentation by the Director from Fresh.

FINDINGS

7 LEVELS AND CAUSES OF CANCER IN HARTLEPOOL

7.1 Members were very keen to understand the levels and causes of cancer in Hartlepool as a baseline from which the Forum could then assess the impact of early diagnosis and awareness raising campaigns in the Town. Evidence gathered by Members in relation to the levels and causes of cancer in Hartlepool is detailed below:-

Evidence on Levels of Cancer

7.2 When the Forum met on 6 October 2011, Members received a comprehensive presentation from the Speciality Registrar in Public Health from the Tees Public Health Directorate. This presentation extracted some key elements of a much larger piece of work complied in conjunction with the Executive Director of Public Health into an overview of cancer in Hartlepool.

7.3 In focussing on the levels of cancer in Hartlepool, Members were concerned by the figures presented to them by the Speciality Registrar in Public Health and noted the following headline figures:-

(i) Cancer accounted for about 37% of the shorter life expectancy between Hartlepool and England (2006-08);

(ii) That between 1985-2008 the number of cancer cases in Hartlepool rose by 17%;

(iii) That by comparison to paragraph 7.3(ii) the number of cancers cases in the North East rose by 12% and in the rest of England by 15%;

7.4 Members noted that due to the small population sample per Ward area, there was no trend demonstrating less deprived areas had less cancer cases in fact the opposite was surmised as **Chart 1** overleaf confirms. Although the data related to old Ward areas, Members recognised that there was little change in the ward boundaries for the less deprived Wards, such as Elwick and Park, which showed higher numbers of cancer rates.

7.5 Members did, however, acknowledge that the higher cancer levels could have been due to the age profile of the ward and the level of uptake of screening, which was statistically often higher in less deprived areas. This may have been an explanation for the level of cancer mortality rates which were considerably better in Elwick despite the higher occurrence of cancer cases, as **Chart 2** overleaf indicates.

7.6 Members were particularly interested in the figures for the three most common cancers and at their meeting on 6 October 2012 the Speciality Registrar in Public Health provided the information collated in **Table 1** (below) in relation to the number of new cases of cancer from 1985 – 2008.

Table1: Percentage Change in Number of Cases of Cancer from 1985-2008 in Hartlepool

	Lung Cancer	Bowel Cancer	Breast Cancer
Men	- 43%	+ 78%	Not Applicable
Women	+ 5%	+ 56%	+ 62%

7.7 Although overall figures for the number of lung cancer cases in Hartlepool had fallen above the levels for the North East and England and accepting that lung cancer figures for men had dropped dramatically, Members of the Health Scrutiny Forum were somewhat concerned about the increase in lung cancer in women.

7.8 Despite the obvious improvements in the cases of lung cancer particularly for men, Members of the Forum were very concerned about the increase in both bowel and breast cancer cases. Members learnt that the level for bowel cancer was five times higher than the North East average and ten times the level in England. Whilst in relation to breast cancer although Hartlepool was just below the North East average of 70%, this was still significantly higher than the average increase across England of 15%.

Chart 1: Age Standardised Incidence Rate for all Cancers for Hartlepool by Electoral Wards 2003-2007

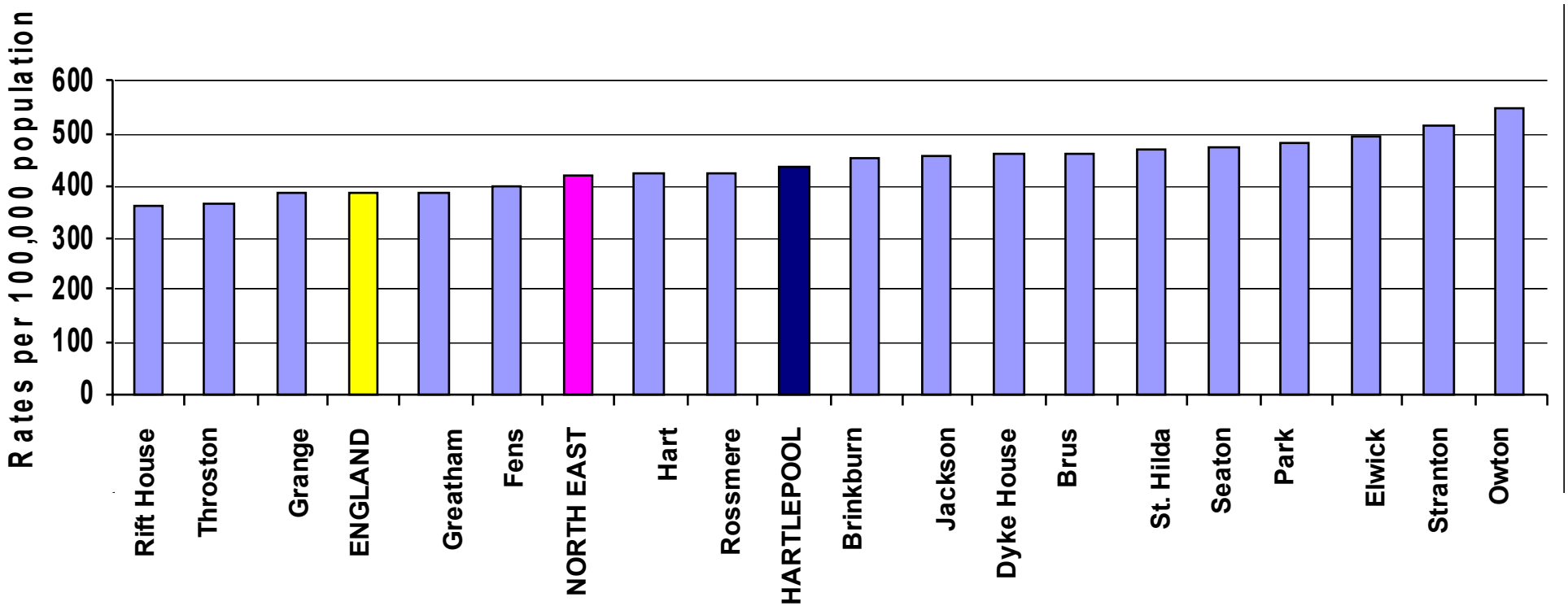
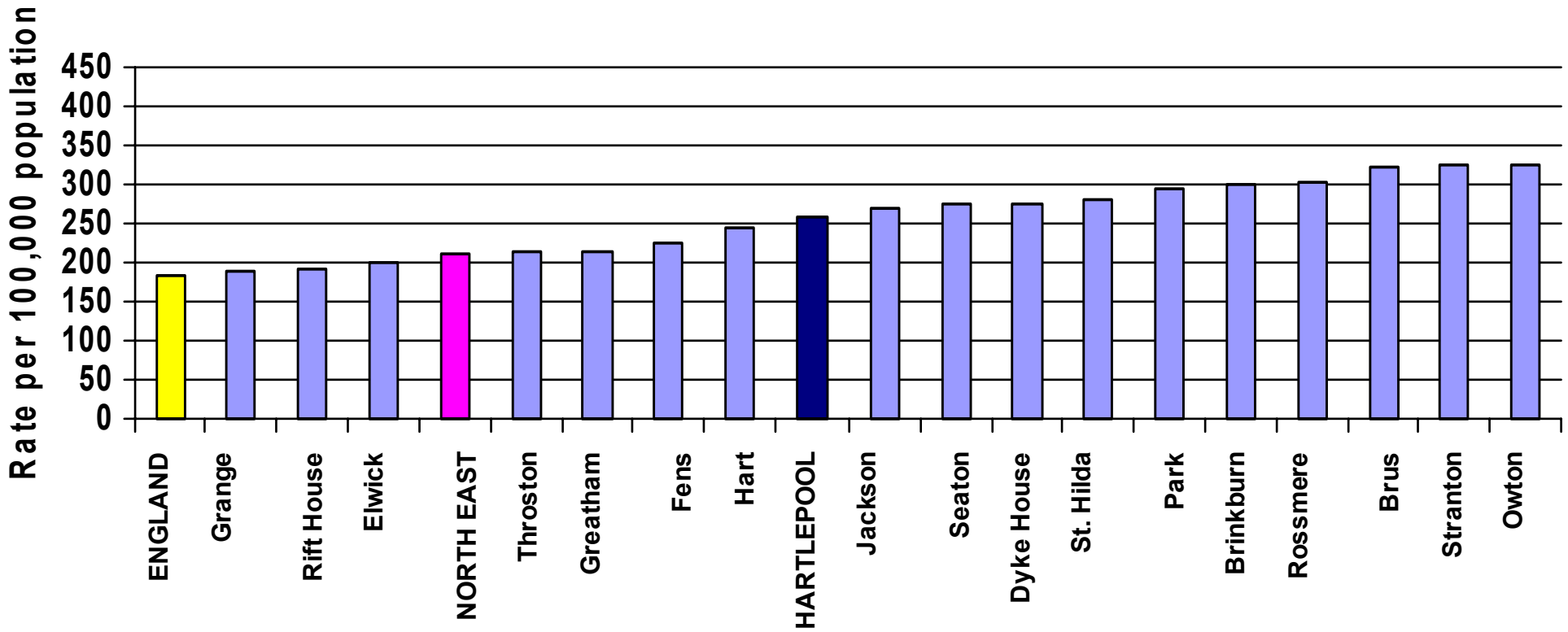


Chart 2: Age Standardised Mortality Rate for all Cancers for Hartlepool by Electoral Wards 2003-2007



Evidence on Causes of Cancer

7.9 In addition to understanding the levels of cancer in Hartlepool, Members wished to be appraised of the causes of cancer. The Speciality Registrar in Public Health at the Tees Public Health Directorate informed Members at their meeting of 6 October 2011, that many cancers had multiple risk factors with complex relationships between these factors. There was for example statistical evidence that breast cancer was often higher in more affluent areas, however, the Speciality Registrar in Public Health categorically stated to Members that evidentially nine out of ten cases of lung cancer could be unequivocally linked to smoking.

7.10 When the Consultant Respiratory Physician at North Tees and Hartlepool NHS Foundation Trust was present at the Health Scrutiny Forum meeting on 26 January 2012, it was reiterated about the dangers of smoking causing lung cancer along with lesser factors such as exposure to radon, asbestos and other industrial carcinogens, however, Members also noted that stopping smoking at any age could reduce the risk of developing lung cancer as **Table 2** (below) detailed:-

Table2: Risk of Male Smokers Developing Lung Cancer at 75 Based on age they Quit

Quitting age ⟶	**Lifetime (75)**	**60**	**50**	**40**	**30**
Risk of Developing lung cancer	15.9%	9.9%	6.0%	3.0%	1.7%

7.11 In relation to bowel and breast cancer it was noted by the Forum that although causes could be complex, there were certain factors that increased the risk of developing cancer. The Consultant Colorectal Surgeon at North Tees and Hartlepool NHS Foundation Trust provided the following as examples of potential cancer causing risk activities when present at the Forum meeting of 26 January 2012:-

(i) Poor Diet;

(ii) Smoking;

(iii) Inactivity / Obesity; and

(iv) High Alcohol Intake.

7.12 Members noted that specifically a high intake of red and processed meat and food containing high levels of saturated fat increased the risk of developing bowel cancer, whilst the long term use of Hormone Replacement Therapy (HRT) could also increase the risk of developing breast cancer.

7.13 Health Scrutiny Forum Members highlighted concerns if there was a link between pancreatic cancer and diabetes. During the meeting on 17 November 2011, the Forum received details of a literature research undertaken by the Speciality Registrar in Public Health at NHS Tees into whether there was a link between the two diseases. Despite evidence that pancreatic cancer can cause a "diabetic state" in a person, Members agreed that it was more likely that as there were shared risk factors such as obesity and smoking for both pancreatic cancer and diabetes, that the two diseases could co-exist without one causing the other. It was, however, noted that at the moment there was insufficient evidence that there was a link.

7.14 During the Forum meeting of 26 January 2012, Members questioned the Consultant Colorectal Surgeon at North Tees and Hartlepool NHS Foundation Trust, about whether there had been any studies into a link between high risk industrial workers suffering from bowel cancer as a result of the ingestion of dust, such as coal particulates. The Consultant Colorectal Surgeon informed Members that although no studies could be brought to mind, often the lifestyles of high risk industrial workers were the causality of their bowel cancer.

8 CANCER SCREENING DELIVERY AND UPTAKE

8.1 The Members of the Health Scrutiny Forum were keen to have an understanding of how cancer screening operated and the level of uptake of screening programmes in Hartlepool. The evidence gathered in relation to cancer screening is details as follows:-

Delivery of Cancer Screening

8.2 When the Forum met on 6 October 2011, the Consultant in Public Health at NHS Tees provided Members with an overview into how cancer screening services were delivered. This evidence was supplemented with detailed evidence when the Clinical Director of Public Health and the Public Health Specialist Nurse at NHS Tees were present at the Forum meeting on 17 November 2011.

8.3 The Public Health Specialist Nurse emphasised, at the Health Scrutiny meeting on 17 November 2011, that screening for cancer did more good than harm and was primarily concerned with detecting changes to the body that might lead to cancer. The process by which each eligible person went through was designed to sift people out who weren't showing signs of cancerous symptoms, so that those with changes in their body which might develop into cancer could be focussed on. However, in order to continue the monitoring of changes to the body, cancer screening programmes often operated on a three yearly cycle.

8.4 At their meeting of 17 November 2011, Members discussed the operation of breast screening services in Hartlepool. The Public Health Specialist Nurse advised Members that there was a mobile breast screening vehicle that

operated from One Life Hartlepool and then travelled to Peterlee. Women were called for breast screening through their GP practice, once they reached the age of fifty. Members the Health Scrutiny Forum raised concerns over the age at when breast screening began and that by contacting women to attend through their GP surgery, resulted in some women being as old as 53 before they received their first screening appointment. The Public Health Specialist Nurse advised Members that from 2012 the NHS Breast Screening Programme would be extended to cover women aged 47-73, which would mean every woman being invited to participate in the breast screening programme by their fiftieth birthday.

8.5 Members met on 6 October 2011, where the Consultant in Public Health from NHS Tees provided the Forum with details of how the bowel cancer screening programme operated. The Consultant in Public Health advised the Forum that bowel cancer screening was directed at those between the ages of 60-69 years old; recently this had been extended to those aged 75 and could be carried out in the comfort of your own home using a free testing kit sent through the post. Members queried why bowel cancer testing was not started before people turned 60 and acknowledged that statistically bowel cancer occurred more frequently for people in their 60s. Members were not surprised that 5-10% fewer men took up the offer of bowel cancer screening than women, although the Consultant in Public Health advised Members that there was emerging evidence of a preference for flexible sigmoidoscopy (using an endoscope) rather than the perceived 'yuck' factor of the testing kit. Members were advised that flexible sigmoidoscopy was being considered as a one-off earlier test for people aged 55, but was yet to be introduced nationally.

8.6 During the Health Scrutiny Forum met on 17 November 2011 Members received details on cervical cancer screening. The Consultant in Public Health highlighted the improvements which had been made in cervical screening. The introduction of Liquid Based Cytology (LBC) had seen a fall in inadequate test results to 2.5% in 2009, this meant that not as many women were recalled for testing and the turnaround in results was a lot quicker. The Forum were also advised by the Consultant in Public Health that the national introduction of the Human Papilloma Virus (HPV) vaccine in 2008 should in time see a reduction in cervical cancer cases, with the two strains of HPV targeted by the vaccine accounting for 70% of the cervical cancer cases.[4]

8.7 Members had questioned why there was no screening programme for pancreatic cancer, with blood tests available which could identify those at risk. The Clinical Director of Public Health at NHS Tees explained to Members at their meeting of 17 November 2011, that while pancreatic cancer was a devastating illness that was often fatal due to the lateness at which it was detected, it did only affect a small percentage of the population. At presented there was no agreed testing programme and to introduce one for such a small percentage of the population carried a risk as there was

[4] NHS, 2010

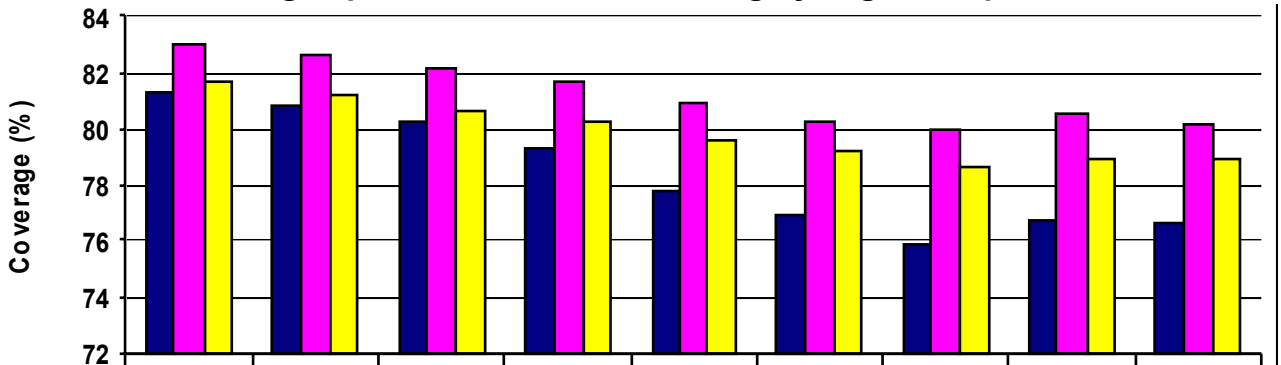
likely to be more 'false positive' results, which Members agreed could cause unnecessary anxiety for people returning positive results only to be later given the all clear. It was, however, noted by the Forum that where a person's medical or family history indicated a predilection to the disease, a greater monitoring of that person for pancreatic cancer would normally occur.

Uptake of Cancer Screening in Hartlepool

8.8 During the Health Scrutiny Forum meeting of 17 November 2011, Members received evidence from the Clinical Director of Public Health and the Public Health Specialist Nurse at NHS Tees in relation to the uptake of cancer screening in Hartlepool.

8.9 In relation to cervical screening, Members noted that there had been a gradual decline in the uptake as detailed in **Chart 3** (below). The Public Health Specialist Nurse emphasised to Members that the important factor was ensuring that once a woman was participating in the cervical screening programme that they continued to be involved. In relation to the screening levels indicated in **Chart 3**, Members queried the increase in cervical screening during 2008-09, which the Public Health Specialist Nurse explained could have been due to the death of the reality TV star Jade Goody from cervical cancer in March 2009.

Chart 3: Percentage Uptake of Cervical Screening by Eligible Population

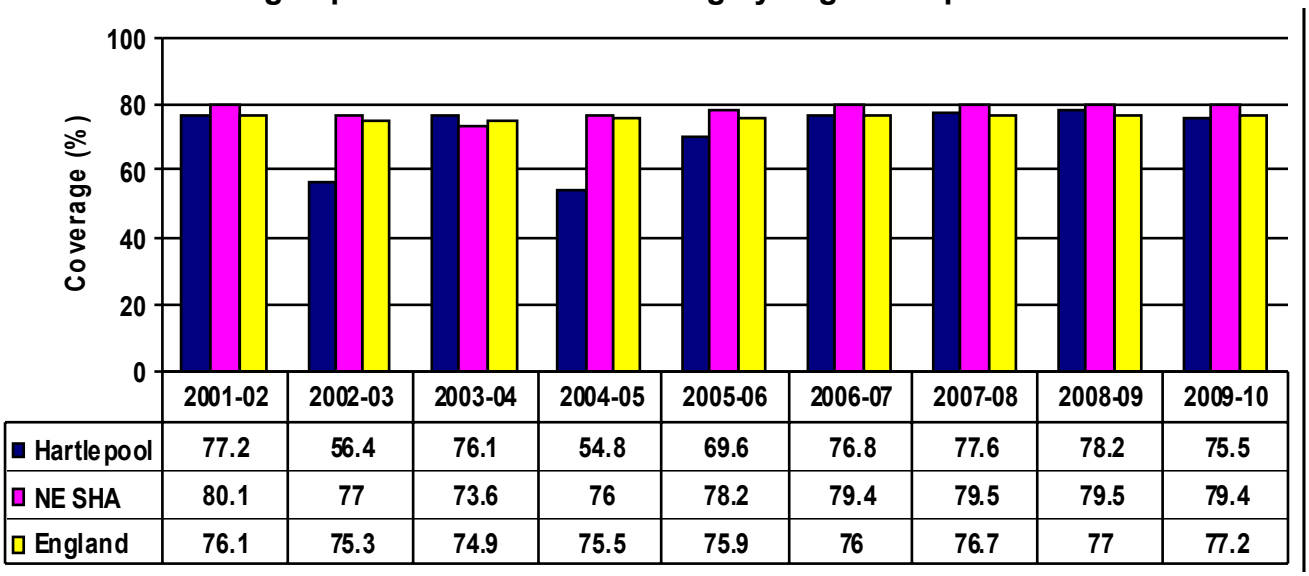


	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10
Hartlepool	81.3	80.8	80.2	79.3	77.8	76.9	75.9	76.8	76.6
NE SHA	83	82.6	82.1	81.7	80.9	80.2	80	80.5	80.1
England	81.6	81.2	80.6	80.3	79.5	79.2	78.6	78.9	78.9

8.10 Members noted in their meeting of 17 November 2011 that although breast screening had fluctuated and not followed the gradual decline in uptake indicated by cervical screening, there was still an overall downward trend as shown in **Chart 4** (overleaf). Members recognised that some women found breast screening uncomfortable, but when the Consultant Breast Surgeon from North Tees and Hartlepool NHS Foundation Trust was present at the Health Scrutiny Forum meeting on 26 January 2012, it was highlighted that for mammograms the slogan 'six minutes every three years might save your

life' was a message used by staff manning the cancer screening phone calls at the Foundation Trust.

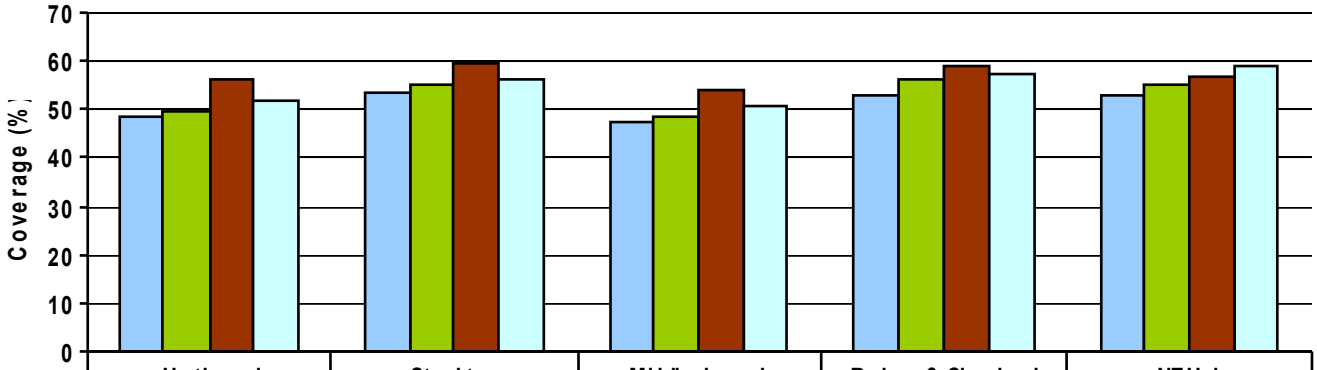
Chart 4: Percentage Uptake of Breast Screening by Eligible Population



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

8.11 The newest screening programme was for bowel cancer, which was introduced nationally in 2006. Members noted at their meeting of 17 November 2011 that the evidence (see **Chart 5** below) indicated after an encouraging uptake in bowel screening numbers, this had fallen during 2010; despite the overall North East average showing an uptake in figures.

Chart 5: Percentage Uptake of Bowel Cancer Screening by Eligible Population



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

8.12 What did concern Members of the Health Scrutiny Forum was the variation in cancer screening take-up across the Town's GP practices, which was highlighted to Members during a presentation by the Speciality Registrar in Public Health to the Forum meeting of 6 October 2012; as collated in **Table 3** overleaf. The Consultant Breast Surgeon, at the meeting on 26 January 2012, reinforced the

discrepancy in relation to cancer screening take-up across GP surgeries and reflected the concerns that the cancer team had in relation to these figures, although it was noted that NHS Hartlepool were aware of these anomalies.

Table 3: Percentage of Hartlepool Residents Attending Screening Sessions per Anonymised GP Surgery

Hartlepool GP Practice → / Screening Type ↓	A	B	C	D	E	F	G	H	I	J	K	Hartlepool PCT	England
Breast	70.8	53.3	71.5	65.2	74.5	65.5	71.5	64.8	67.3	52.0	75.2	**68.2**	**71.8**
Cervical	73.2	73.9	68.3	69.1	72.1	72.5	83.9	68.4	72.9	67.8	69.7	**71.6**	**75.4**
Bowel	52.4	40.1	49.3	43.1	57.6	52.9	55.0	52.3	46.7	48.4	52.2	**51.2**	**40.2**

Key:

Lowest take-up of screening

Highest take-up of screening

9 EARLY DETECTION OF CANCER

9.1 When the Health Scrutiny Forum met on 26 January 2012, Members received an extremely detailed presentation from the cancer team at North Tees and Hartlepool NHS Foundation Trust. The team provided Members with very detailed information about why early detection of cancer was important in relation to treatment that could be provided.

9.2 Members were advised by the Consultant Colorectal Surgeon at North Tees and Hartlepool NHS Foundation Trust that early presentation in relation to bowel cancer was very important in terms of survival rates. **Table 4** (overleaf), extracted from the NICE clinical guidelines, detailed five year relative survival rate based on the TNM stage; with TNM relating to the size of the **T**umor, the lymph **N**odes involved and the **M**etastasis (spread of cancer from one part of the body to another part)[5].

[5] Cancer Research UK(1), 2011

Table4: Approximate Frequency and Five Year Relative Survival (%) by TNM Stage

TNM Stage	Approximate Frequency at Diagnosis	Approximate Five-Year Survival
I	11%	83%
II	35%	64%
III	26%	38%
IV	28%	3%

9.3 Although **Table 4** highlighted the need for early presentation and therefore detection of bowel cancer, Members were concerned about the stage of presentation to the Multi-Disciplinary Team (MDT) as described by the Consultant Colorectal Surgeon in **Table 5** below; the Dukes Stage being another way of quantifying the bowel cancer stage:-

Table 5: Stage Presentation to MDT

Dukes Stage[6]	University Hospital of Hartlepool		University Hospital of North Tees		TOTAL	
	Number	Percentage	Number	Percentage	Number	Percentage
A	17	26.6%	38	21.5%	55	22.8%
B	12	18.8%	39	22.0%	51	21.2%
C1	13	20.3%	44	24.9%	57	23.7%
D	11	17.2%	34	19.2%	45	18.7%
No Stage	11	17.2%	22	12.4%	33	13.7%
TOTALS	64		177		241	

9.4 Having heard the evidence in relation to why early detection of bowel cancer was so important for the survival rate, Members of the Health Scrutiny Forum also considered evidence, at their meeting of 26 January 2012, from the Consultant Respiratory Physician at North Tees and Hartlepool NHS Foundation Trust. The Consultant Respiratory Physician described a similar pattern about the importance of early presentation in relation to lung cancer as being more positive for the outcome of any potential treatment.

[6] Cancer Research UK(2), 2011

9.5 **Picture 1** overleaf provided Members with a graphical understanding of which part of the lung each classification stage of lung cancer related to and in conjunction with **Table 6** (below), the Members of the Health Scrutiny Forum had a clear picture of how earlier presentation at Stages I and II would dramatically increase survival rates of five years or more.

Table 6: Lung Cancer Stage and Comparative 5 Year Survival Rate

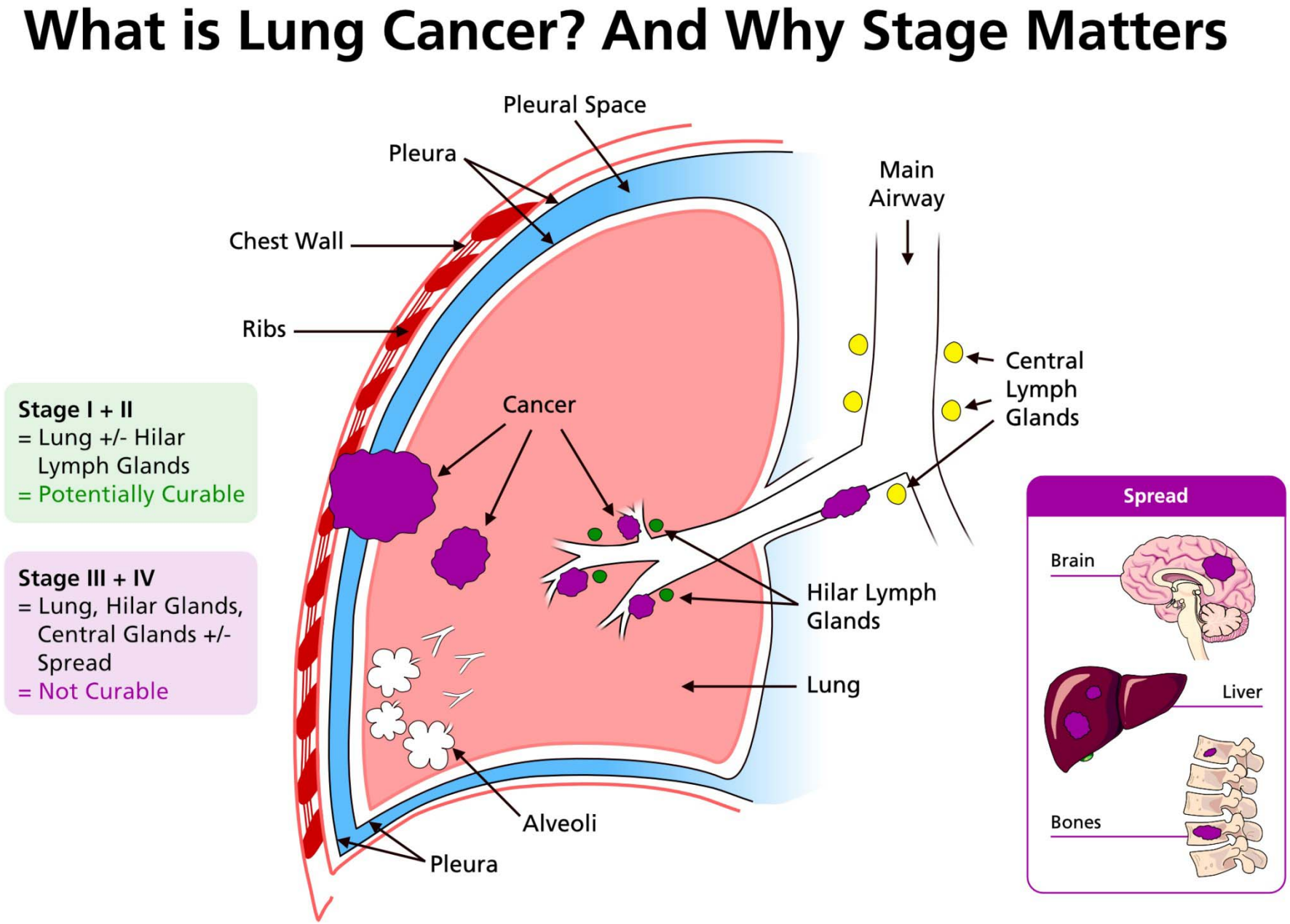
Stage	Non Small Cell Lung Cancer 5 Year Survival %	Small Cell Lung Cancer 5 Year Survival %
Ia	58-73 %	38 %
Ib	43-58 %	21 %
IIa	36-46 %	38 %
IIb	25-36%	18 %
IIIa	19-24 %	13 %
IIIb	7-9 %	9 %
IV	2-13 %	1 %

9.6 Members of the Forum were however, very concerned, when the Consultant Respiratory Physician presented evidence of the stages at which patients, covered by North Tees and Hartlepool NHS Foundation Trust, presented themselves and were diagnosed with having lung cancer; as detailed in **Table 7** (below). With over 70% of patients presenting at Stages III and IV, Members recognised that the outcome in terms of treatment was statistically poor and reflected lung cancer being the largest single contributor to deaths from cancer.

Table 7: Stage at Presentation – National Lung Cancer Audit 2011

Stage	Number (n=145) University Hospital of Hartlepool %	Number (n=170) University Hospital of North Tees %
Ia	4.1 %	10.6 %
Ib	11.7 %	7.1 %
IIa	6.9 %	4.7 %
IIb	6.2 %	5.3 %
IIIa	13.8 %	12.9 %
IIIb	11.0 %	17.1 %
IV	44.8 %	41.8 %

Picture 1:


What is Lung Cancer? And Why Stage Matters
Pleural Space
Pleura
Chest Wall
Ribs
Main Airway
Central Lymph Glands
Cancer
Hilar Lymph Glands
Lung
Alveoli
Pleura
Stage I + II
= Lung +/- Hilar Lymph Glands
= Potentially Curable
Stage III + IV
= Lung, Hilar Glands, Central Glands +/- Spread
= Not Curable
Spread
Brain
Liver
Bones

10 IMPACT AND DELIVERY OF SMOKING CESSATION SERVICES

10.1 Members of the Health Scrutiny Forum had recognised the importance of tackling smoking as a causality of many of the forms of cancer (see paragraph 7.11) as well as being the major contributory factor in 90% of cases of lung cancer. At their meeting of 5 April 2012 Members also considered additional evidence from ASH which sourced various studies into the effects of second hand smoke, with the Scientific Committee on Tobacco and Health (SCOTH) stating in a 2004 report that non smokers exposed to second hand smoke had a 24% increased risk of lung cancer. Members were, therefore, very interested in examining the impact of smoking cessation and other initiatives to combat the levels of smoking in Hartlepool, with evidence gathered during those meetings detailed as follows:-

Evidence from Stockton and Hartlepool Stop Smoking Service

10.2 When the Health Scrutiny Forum met on 23 February 2012, the Head of Health Improvement provided details that 24.7% of adults in Hartlepool smoked regularly, with this figure rising to 31.2% for manual / routine workers and over 44% in some Wards in the Town. At the end of the 2010/2011 municipal year Members were informed that 22.6% of women were recorded as smoking at the time of giving birth. Although this compared poorly with a regional average of 21.1% and a national average of 13.5%. This data was, however, tempered and it pleased Members that there had been a major improvement in smoking during pregnancy which was as high as 30% only five years ago.

10.3 In recognising the level of the smoking problem in Hartlepool, the Forum were informed of the major impact of the Stockton and Hartlepool Stop Smoking Service in the Town. The Director from Fresh informed Members, at their meeting of 23 February 2012, that Hartlepool had a stop smoking service they should be proud of and was nationally seen as an exemplar for how stop smoking services should operate.

10.4 The Stop Smoking Service Manager provided the Forum, on 23 February 2012, with a very detailed breakdown of Hartlepool's performance against the other Local Authorities in the North East; as summarised in **Table 8** (overleaf).

Table 8: Impact of Stop Smoking Services in 2010/11

Local Authority Area	% of 'Vital Signs'[7] Target Achieved	% of Clients Lost to Follow-up	% of Estimated Smoking Population Accessing Stop Smoking Services[8]	% of Pregnant Women Smoking at Delivery Accessing Stop Smoking Service & Setting a Quitting Date
Durham	95.1 %	35.4 %	9.6 %	21.1%
Darlington	101.0 %	34.7 %	9.3 %	28.5 %
Gateshead	101.4 %	38.5 %	13.8 %	28.6 %
Hartlepool	107.4 %	21.7 %	18.5 %	88.2 %
Middlesbrough	98.9 %	27.4 %	12.4 %	19.3 %
Newcastle	78.2 %	28.4 %	7.1 %	25.4 %
Stockton on Tees	113.2 %	21.9 %	11.9 %	35.6 %
North Tyneside	93.2 %	26.3 %	11.2 %	24.4 %
Northumberland	100.2 %	35.1 %	12.1 %	26.2 %
Redcar & Cleveland	92.9 %	26.2 %	13.3 %	22.5 %
South Tyneside	100.6 %	38.1 %	15.0 %	22.3 %
Sunderland	101.1 %	38.9 %	12.6 %	35.9 %

10.5 Members were delighted that in terms of clients lost to follow up and the estimated smoking population accessing stop smoking services, Hartlepool was outperforming the other North East Local Authorities. In particular Members were impressed with the 88.2% of pregnant women accessing and setting a quitting date for their smoking, however, the Stop Smoking Service Manager informed Members that recently the Head of Community Midwifery had been involved in a restructure and the post amalgamated, it was hoped that this did not impact on the currently impressive access figures.

Evidence from Fresh

10.6 The Director of Fresh was present at the Health Scrutiny meeting of 23 February 2012 and delivered an impassioned presentation to Members about the work of Fresh in combating the dangers of smoking. The Director for Fresh did highlight that smoking rates in the North East were declining at a faster rate that anywhere else in the country and this was mainly due to the partnership approach adopted across the region. Members were also advised that smoking should be the number one Public Health priority for the next ten years, as solving the issue would have major health benefits for the population as a whole.

10.7 Members of the Forum were provided with details of Fresh's campaign for plain, standardised tobacco packaging during the meeting of 23 February 2012. The Director for Fresh evidenced that two thirds of smokers begin before they are 18 years old, with the average age in the North East being 15. Fresh were very clear that there were many examples of cigarette packaging which was designed to attract young people to begin smoking and

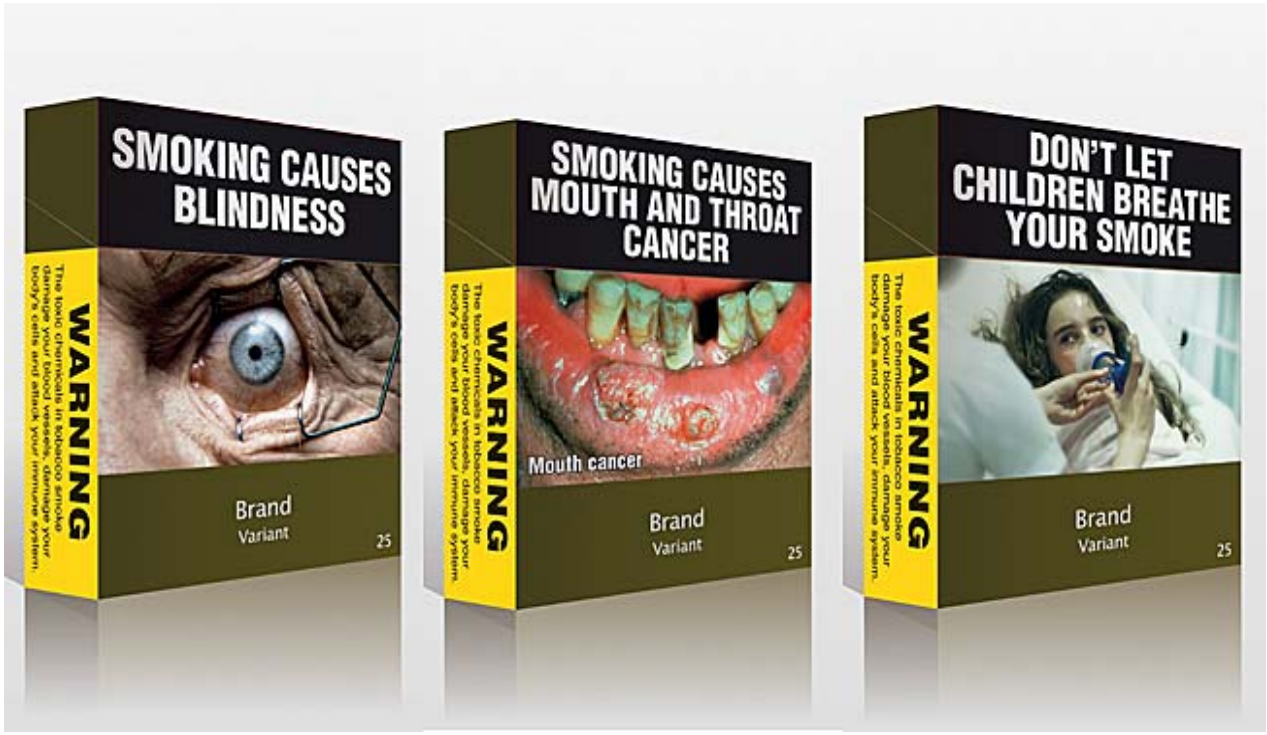
[7] Vital Signs are a set of National Performance Indicators
[8] Based on Integrated Household Survey prevalence (October 2009 – September 2010)

Members looked at a number of examples including the cigarette packaging shown in **Picture 2** (below) and in **Appendix A**.

Picture 2: An Example of Cigarette Packaging with a Particular Target Audience

10.8 The aim of the campaign by Fresh was to discourage young people from beginning to smoke, by having plain, standardised tobacco packaging. Members were informed that the Australian Government were introducing plain packaging from December 2012 and it was hoped that the UK Government would support the proposal. In considering the evidence from Fresh, the Health Scrutiny Forum was very supportive of this approach and felt that the images used on the cigarette packaging needed to be as strong as possible, in line with the examples shown in **Picture 3** (overleaf).

Picture 3: Examples of Plain, Standardised Packaging Proposed by Fresh



11 IMPACT OF CANCER AWARENESS RAISING ACTIVITIES

11.1 When Members met on 23 February 2012, they considered evidence from a study carried out by Dr Una Macleod into why some cancer patients were delayed in seeking medical advice. Dr Macleod argued that:-

"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."[9]

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."[9]

[9] Madeod, U. et al., 2009

11.2 However, Dr Macleod also highlighted that in addition to lack of awareness of cancer symptoms (as highlighted in paragraph 11.1), the various studies from 2002-2009 also made the following point that:-

"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."[10]

11.3 Having considered that the evidence from Dr Macleod pointed towards an issue around public awareness of cancer symptoms, the Forum wished to focus on the impact of cancer awareness raising activities in the Town. Members recognised that awareness of cancer symptoms was a key component in ensuring early presentation and better outcomes, as supported by the evidence from the cancer team at North Tees and Hartlepool NHS Foundation Trust (see Section 9). Evidence gathered by Members in relation to cancer awareness raising activities is detailed below:-

Impact of the Be Clear on Cancer Programme

11.4 The Cancer Awareness and Early Diagnosis Project Manager from NHS Tees provided Members with details of a survey commissioned by NHS Hartlepool entitled the Hartlepool Cancer Awareness Measure (CAM). The CAM was designed to collate people's awareness of the signs and symptoms of lung and bowel cancer. The Cancer Awareness and Early Diagnosis Project Manager informed the Forum that the first CAM undertaken in February 2011 in Hartlepool had produced the following results:-

(i) 33% of respondents were unable to name any signs or symptoms of bowel cancer;

(ii) 26% of respondents were unable to name any signs or symptoms of lung cancer; and

(iii) 28% of the respondents said that they currently smoked cigarettes.

11.5 As a response to the results from the CAM; Members of the Health Scrutiny Forum were informed that, NHS Hartlepool started a promotion of the regional cancer awareness programme 'Be Clear on Cancer' in May 2011. This involved producing a number of resources, such as posters (see **Appendix B**), information on beer mats, bus adverts and bingo dabbers; all with the aim of increasing people's awareness of the signs and symptoms of lung and bowel cancer.

11.6 The Health Scrutiny Forum were made aware by the Cancer Awareness and Early Diagnosis Project Manager that a second CAM was undertaken in June 2011 to evaluate the impact of the 'Be Clear on Cancer' campaign, with

[10] Madeod, U. et al., 2009

Members being delighted with the results where; 32% of respondents spontaneously identified blood in stools as a sign or symptom of bowel cancer; and 46% of respondents spontaneously identified a persistent cough as a sign or symptom of lung cancer.

11.7 Members were pleased to hear that the 'Be Clear on Cancer' campaign was now being run on a National basis to increase general awareness of cancer signs and symptoms, with the hope that people would present to a healthcare professional much earlier.

Implementation of the National Awareness and Early Diagnosis Project

11.8 The Cancer Awareness and Early Diagnosis Project Manager, at the Forum meeting of 23 February 2012, emphasised that 'Be Clear on Cancer' was only one initiative aimed at raising the public's awareness of cancer signs and symptoms. Members were also informed that the implementation of the National Awareness and Early Diagnosis (NAEDI) Project by NHS Tees was another important area of improving awareness of cancer signs and symptoms.

11.9 The Tees NAEDI Project built on the existing Healthy Heart Check Programme; with Members recognising that Cardiovascular Disease (CVD) and cancer shared common risk factors, such as those identified by the cancer team at North Tees and Hartlepool NHS Foundation Trust in paragraph 7.11. The Cancer Awareness and Early Diagnosis Project Manager highlighted that due to the established nature of the Healthy Heart Check Programme for all 40-74 olds fitting the inclusion criteria, there was a focussed group of people that could be targeted with cancer awareness information. In addition the Forum was pleased to learn that all GP Practices in Hartlepool were participating in the NAEDI Project, which would result in all Practice staff being trained in relation to awareness of cancer signs and symptoms. This commitment by Hartlepool GPs to the NAEDI Project also ensured that the 'Be Clear on Cancer' campaign was embedded in all GP Practices across Hartlepool.

The Teesside Cancer Awareness Roadshow

11.10 When the Health Scrutiny Forum met on 23 February 2012, the Macmillan Cancer Information and Volunteer Facilitator from NHS Tees presented to Members details of the Teesside Cancer Awareness Roadshow; which was a two year initiative funded by Macmillan Cancer Support. Members leant that the aim of the Teesside Cancer Awareness Roadshows were to:-

"Increase awareness of cancer symptoms, encourage uptake of NHS screening programmes and encourage people to seek help"

11.11 The Forum were pleased to learn that the Teesside Cancer Awareness Roadshow could be delivered in a bespoke manner, with a number of different carnival games designed to raise the awareness of cancer signs symptoms, encourage people to actively seek help and increase take-up of

screening programmes. The Macmillan Cancer Information and Volunteer Facilitator explained to Members that the balance of the importance and potential sensitivity of the subject was not lost through the utilisation of fun elements, with the aim of embedding the messages into people's minds, rather than giving them handouts to take away.

12 IMPROVING OUTCOMES FOR PATIENTS

12.1 Throughout the investigation into Cancer Awareness and Early Diagnosis, Members of the Health Scrutiny Forum placed great importance in discovering what more could be done to improve outcomes for patients, with the evidence gathered detailed as follows:-

Evidence from the Member of Parliament for Hartlepool

12.2 The Forum warmly welcomed the Member of Parliament for Hartlepool to their meeting on 6 October 2011. The MP reminded Members that for all there had been real health improvements in Hartlepool, the gap between Hartlepool and the rest of the Country was still large and more still needed to be done to bridge that gap. However, the MP was clear that this was not a criticism of colleagues in the health sector who were doing a marvellous job, but that people in Hartlepool needed to present themselves a lot sooner to healthcare professionals for early diagnosis and treatment; which was particularly vital in relation to cancer.

12.3 The MP made a number of recommendations to the Forum in relation to where it was felt a greater impact could be made in improving outcomes:-

(i) Encourage and Incentivise People to Come Forward and see their GP;
Although some people are aware of cancer symptoms, they are fearful of presenting themselves as they see it as a 'death sentence' and with the advances in treatment, this now was not necessarily the case.

(ii) Targeted Screening;
This could be very effective at increasing screening uptake by delivering it at venues such as the football club, hairdressers and local employers including the Council.

(iii) Good Practice in Other Areas;
Doncaster had achieved much success in getting men to attend screening sessions earlier. With the statistics pointing to men in their 60s presenting with cancer, screening was focussed on men in their 50s to diagnose cancers early, therefore, resulting in better outcomes in many cases.

12.4 In concluding evidence to the Forum, the MP was very clear that even in a time when finances were tight, it would be a mistake to move from

prevention and early diagnosis activities to treatment, as this would result in fire fighting the disease, this in the MP's view would be a false economy particularly when the evidence pointed towards better outcomes as a result of earlier presentation.

Evidence from the Portfolio Holder for Adults and Public Health Services

12.5 When the Forum met on 6 October 2011, Members were delighted to receive evidence from the Portfolio Holder for Adults and Public Health Services. The Portfolio Holder reflected on the increasing Public Health role that the Council would be taking on board through the Health and Social Care Bill. The Portfolio Holder felt that the increased influence in Public Health could only be beneficial in strengthening the Council's ability to improve outcomes through closer partnership working as advocated through the formation of the Health and Wellbeing Board.

12.6 In reflecting on what more could be done to improve outcomes, the Portfolio Holder reminded the Forum of the Town's industrial past and that although the messages on a healthier lifestyle, cancer, obesity and smoking needed to continue and be improved where possible, there needed to be a recognition that impact on health improvement statistics could still take some time to come through.

12.7 The Portfolio Holder did recommend to Members of the Health Scrutiny Forum that the challenge was how to raise awareness without coming across the audience as being patronising. The Portfolio Holder felt that the work done by the British Heart Foundation in targeting young children about the importance of a healthy lifestyle which then fed into the family was a good example of how health outcomes could be improved without directly mentioning cancer.

Evidence from North Tees and Hartlepool NHS Foundation Trust

12.8 When the cancer team from North Tees and Hartlepool NHS Foundation Trust was present at the Forum meeting of 26 January 2011, the team provided details of suggestions for how outcomes could be improved for cancer patients, with the common themes as follows:-

(i) Encourage greater participation in screening;

(ii) Raise awareness of cancer symptoms;

(iii) Reduction in obesity;

(iv) Sensible alcohol intake;

(v) Healthy lifestyle; and

(vi) Regular physical lifestyle.

12.9 In addition to the recommendations identified under paragraph 12.8, the Consultant Respiratory Physician commented, that in relation to lung cancer and its inextricable link to smoking for 90% of cases:-

(i) It was a key issue to ensure children did not start smoking; and

(ii) Where people were helped to stop smoking that this was done in a positive, supportive and non blame manner; promoting healthy environments and how the risk of lung cancer could be reduced when quitting at any age.

13 CONCLUSIONS

13.1 The Health Scrutiny Forum concluded:-

(a) That cancer is a major cause of ill health and death in Hartlepool ;

(b) That the vast majority of cancer cases are caused by lifestyle issues such as lack of physical activity and poor diet;

(c) That for lung cancer there is an inextricable link for 90% cases with the patient being a smoker;

(d) That quitting smoking at any age can reduce the risk of contracting lung cancer;

(e) That earlier diagnosis can significantly improve the outcomes of cancer treatment;

(f) That not being aware of cancer signs and symptoms is one of the barriers to early presentation to health care professionals;

(g) That bowel, breast and cervical screening is not about finding cancer, but to look for the changes in a patients body which may lead to cancer;

(h) That there has been a gradual decline in people attending screening programmes in Hartlepool, with Hartlepool falling behind the North East and England averages for screening take-up;

(i) That Hartlepool has a very good stop smoking service which is nationally recognised as an example of good practice;

(j) That although all GP Practices in Hartlepool have been involved in the 'Be Clear on Cancer' programme, there are still significant differences for screening take-up between GP practices;

14 RECOMMENDATIONS

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

(a) That in relation to the Teesside Cancer Awareness Roadshow:-

(i) Hartlepool Borough Council hosts a Roadshow ensuring messages are embed in the Council's health and wellbeing promotion to staff; and

(ii) Hartlepool Borough Council encourages appropriate Town based community venues and events to host a Teesside Cancer Awareness Roadshow.

(b) That Hartlepool's Health and Wellbeing Board ensures that Stop Smoking Services and smoking cessation is embedded in the JSNA;

(c) That in relation to the issue surrounding whether there is a link between high risk industrial workers and the contraction of cancers through the ingestion of particulates, such as coal dust:-

(i) The Public Health Directorate at NHS Tees carries out a literature research into the topic; and

(ii) That in relation to recommendation c(i) this information is shared with the Health Scrutiny Forum;

(d) That NHS Hartlepool and the emerging Clinical Commissioning Group:-

(i) Ensure that cancer screening levels are improved across GP Practices in Hartlepool; and

(ii) Devise and share a strategy with the Health Scrutiny Forum for targeting cancer screening and awareness activity in the workplace / venues where residents gather socially; building on the good practice of those workplaces who employ nurses.

(e) That the evidence about the impact of the role of the former Head of Community Midwifery in encouraging access to stop smoking services by pregnant women, be emphasised with North Tees and Hartlepool NHS Foundation Trust to seek assurances for its continued impact, following recent post restructuring;

(f) That Hartlepool Borough Council, through its new Public Health responsibility, ensures that young people in schools and youth groups receive appropriate hard hitting messages about the cancer risk of smoking, alcohol and poor diet.

ACKNOWLEDGEMENTS

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

Hartlepool Borough Council:

Councillor Ged Hall – Former Portfolio Holder for Adults and Public Health Services

Louise Wallace – Assistant Director for Health Improvement

Carole Johnson – Head of Health Improvement

Pat Marshall – Stop Smoking Service Manager

External Representatives:

Iain Wright – Member of Parliament for Hartlepool

Dr Victoria Ononeze – Speciality Registrar in Public Health, Tees Public Health Directorate

Madeleine Johnson – Consultant in Public Health, NHS Tees

Laura McGuinness –Cancer Awareness and Early Diagnosis Project Manager, NHS Tees

Dr Toks Sangowawa – Clinical Director of Public Health, NHS Tees

Rachel Fawcett – Public Health Specialist Nurse, NHS Tees

Mr Mat Tabaqchali – Consultant Colorectal Surgeon, North Tees and Hartlepool NHS Foundation Trust

Norma Robinson – Lead Colorectal Nurse Specialist, North Tees and Hartlepool NHS Foundation Trust

Dr Neil Leitch – Consultant Respiratory Physician, North Tees and Hartlepool NHS Foundation Trust

Tessa Fitzpatrick – Macmillan Lung Specialist Nurse, North Tees and Hartlepool NHS Foundation Trust

Mr Colm Hennessy – Consultant Breast Surgeon, North Tees and Hartlepool NHS Foundation Trust

Jan Harley – Lead Breast Nurse Specialist / Lead Cancer Nurse, North Tees and Hartlepool NHS Foundation Trust

Aisal Rutter – Director, Fresh

Pete Moody – Macmillan Cancer Information and Volunteer Facilitator, NHS Tees

COUNCILLOR STEPHEN AKERS-BELCHER
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April 2012

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BACKGROUND PAPERS

The following background papers were consulted or referred to 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 at the meeting of the Health Scrutiny Forum of 8 September 2011

(ii) The Association of Public Health Observatories (2011), *Health Profile 2011 Hartlepool*, Available from: http://www.apho.org.uk/default.aspx?QN=HP_METADATA&AreaID=50333 (Accessed 15 August 2011)

(iii) The Association of Public Health Observatories (2010), *Health Profile 2010 Hartlepool*, Available from: http://www.apho.org.uk/default.aspx?QN=HP_METADATA&AreaID=50333 (Accessed 15 August 2011)

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

(v) Presentation by Assistant Director for Health Improvement entitled 'Cancer in Hartlepool: An Overview' delivered to the Health Scrutiny Forum meeting of 6 October 2011

(vi) Report of the Executive Director of Public Health and Speciality Registrar in Public Health, Tees Public Health Directorate entitled 'Cancer in Hartlepool: An Overview' presented at the meeting of the Health Scrutiny Forum of 6 October 2011

(vii) Report of the Scrutiny Support Officer entitled 'Cancer Awareness and Early Diagnosis – Evidence from Member of Parliament for Hartlepool and the Portfolio Holder for Adult's and Public Health – Covering Report' presented at the meeting of the Health Scrutiny Forum of 6 October 2011

(viii) Report of the Scrutiny Support Officer entitled 'Scrutiny Investigation in to Cancer Awareness and Early Diagnosis – Setting the Scene Presentation – Covering Report' presented at the meeting of the Health Scrutiny Forum of 6 October 2011

(ix) Report of the Scrutiny Support Officer entitled 'Cancer Screening – Covering Report' presented at the meeting of the Health Scrutiny Forum of 17 November 2011

(x) Report of the Tees Valley Health Scrutiny Joint Committee entitled 'Cancer Screening Across the Tees Valley – Final Report' presented at the meeting of the Health Scrutiny Forum of 17 November 2011

(xi) Report of the Scrutiny Support Officer entitled 'Pancreatic Cancer and Diabetes' presented at the meeting of the Health Scrutiny Forum of 17 November 2011

(xii) Report of the Speciality Registrar in Public Health, NHS Tees entitled 'Pancreatic Cancer and Diabetes – Is there Evidence of a Link?' presented at the meeting of the Health Scrutiny Forum of 17 November 2011

(xiii) Presentation of the Public Health Specialist Nurse, NHS Tees entitled 'The Role of Screening in Cancer Awareness' delivered to the Health Scrutiny Forum meeting of 17 November 2011

(xiv) Report of the Scrutiny Support Officer entitled 'Evidence from North Tees and Hartlepool NHS Foundation Trust – Covering Report' presented at the meeting of the Health Scrutiny Forum of 26 January 2012

(xv) NHS (25 November 2011) Waiting times for suspected and diagnosed cancer patients: quarter ending September 2011, Available from: http://www.dh.gov.uk/health/2011/11/cancer-waiting-times/ (Accessed 10 January 2012)

(xvi) Presentation of the Consultant Colorectal Surgeon, North Tees and Hartlepool NHS Foundation Trust entitled 'Cancer Awareness and Early Diagnosis' delivered to the Health Scrutiny Forum of 26 January 2012

(xvii) Presentation of the Consultant Colorectal Surgeon, North Tees and Hartlepool NHS Foundation Trust entitled 'Bowel Cancer – A Secondary Healthcare Perspective' delivered to the Health Scrutiny Forum of 26 January 2012

(xviii) Presentation of the Consultant Respiratory Physician, North Tees and Hartlepool NHS Foundation Trust entitled 'Lung Cancer – A Secondary Healthcare Perspective' delivered to the Health Scrutiny Forum of 26 January 2012

(xix) Presentation of the Consultant Breast Surgeon, North Tees and Hartlepool NHS Foundation Trust entitled 'Breast Cancer – A Secondary Healthcare Perspective' delivered to the Health Scrutiny Forum of 26 January 2012

(xx) Report of the Scrutiny Support Officer entitled 'Evidence on Smoking Cessation – Covering Report' presented at the meeting of the Health Scrutiny Forum of 23 February 2012

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

(xxii) Report of the Scrutiny Support Officer entitled 'Evidence on Cancer Awareness – Covering Report' presented at the meeting of the Health Scrutiny Forum of 23 February 2012

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

(xxiv) 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)

(xxv) NHS (2010), *HPV vaccine – Why it is Needed*, Available from: http://www.nhs.uk/Conditions/HPV-vaccination/Pages/Why-it-should-be-done.aspx (Accessed 17 February 2012)

(xxvi) Cancer Research UK (1) (2011), *TNM and number stages of bowel cancer*, Available from: http://cancerhelp.cancerresearchuk.org/type/bowel-cancer/treatment/tnm-and-number-stages-of-bowel-cancer (Accessed 21 February 2012)

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(xxviii) Presentation of the Macmillan Cancer Information and Volunteer Facilitator, NHS Tees entitled 'Teesside Cancer Awareness Roadshow' delivered to the Health Scrutiny Forum of 23 February 2012

(xxix) Presentation of the Cancer Awareness and Early Diagnosis Project Manager, NHS Tees entitled 'Cancer Awareness and Early Diagnosis Initiatives' delivered to the Health Scrutiny Forum of 23 February 2012

(xxx) Presentation of the Director, Fresh entitled 'Plain, Standardised Tobacco Packaging' delivered to the Health Scrutiny Forum of 23 February 2012

(xxxi) Presentation of the Stop Smoking Service Manager entitled 'Stockton & Hartlepool Stop Smoking Service' delivered to the Health Scrutiny Forum of 23 February 2012

(xxxii) Presentation of the Head of Health Improvement entitled 'Smoking & Tobacco Control' delivered to the Health Scrutiny Forum of 23 February 2012

(xxxiii) 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)

(xxxiv) Report of the Scrutiny Support Officer entitled 'Information on Second Hand Smoke' presented at the meeting of the Health Scrutiny Forum of 5 April 2012.

(xxxv) Ash (2011), *ASH Fact Sheets: Second Hand Smoke*, Available from: http://www.ash.org.uk/files/documents/ASH_113.pdf (Accessed 6 March 2012)

(xxxvi) Minutes of the Health Scrutiny Forum of 11 August 2011, 8 September 2011, 6 October 2011, 17 November 2011, 26 January 2012, 23 February 2012 and 5 April 2012.

Appendix A

PLAIN PACKS PROTECT

CIGARETTE PACK DESIGNS

The **Plain Packs Protect** campaign wants all cigarettes in plain standardised packs. The evidence is clear that plain packs are:

- **less attractive, especially to young people;**
- **strengthen the impact of health warnings; and**
- **make the packs less misleading.**

Tobacco companies describe current packs as ***'mobile advertising for the brand'*** - help stop this by signing up to **www.plainpacksprotect.co.uk**

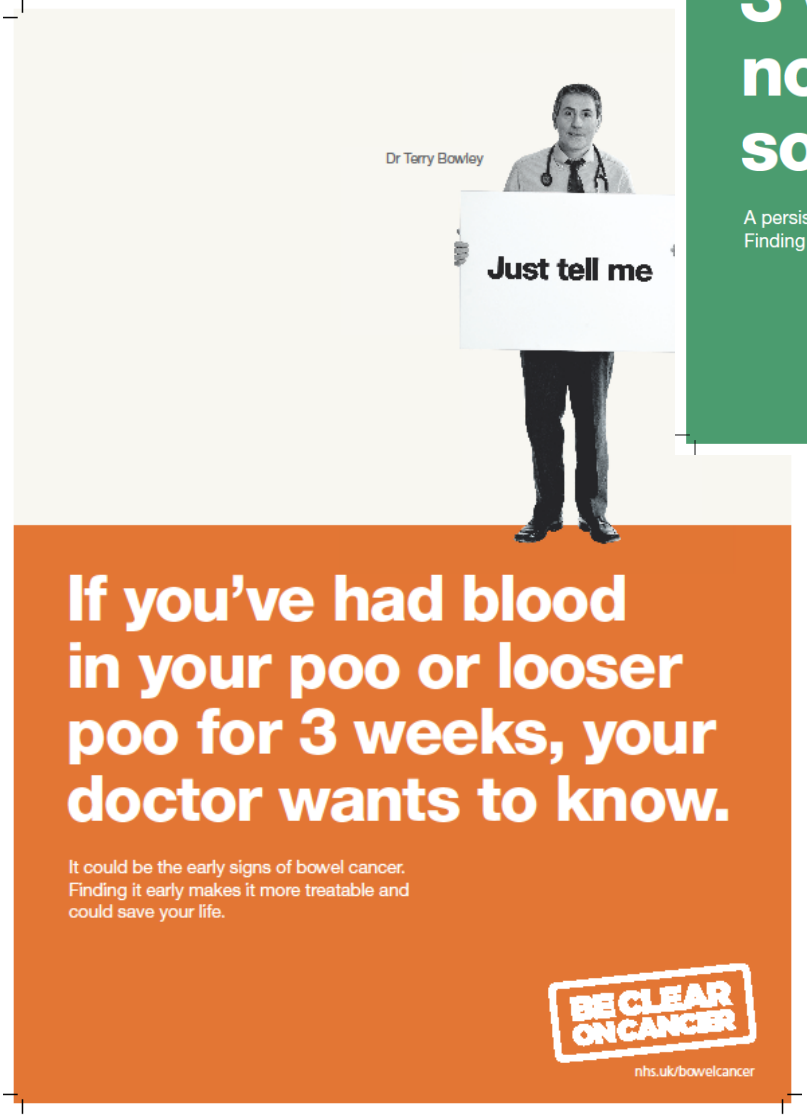
Popular brands with children

Designed to attract young women

New designs are coming on the market all the time

Appendix B

Be Clear on Cancer Posters



HEALTH SCRUTINY FORUM

05 April 2012

Report of: Scrutiny Support Officer

Subject: THE EXECUTIVE'S FORWARD PLAN

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1. PURPOSE OF REPORT

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

2. BACKGROUND INFORMATION

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

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

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

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

DECISION REFERENCE: CE46/11 – Review of Community Involvement & Engagement (Including LSP Review): Update on decisions taken 'in principle'

Nature of the decision

Key Decision - Test (ii) applies

Background

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

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

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

The Health and Social Care Bill, which sets out the statutory requirement to introduce a Health and Wellbeing Board, had its third reading in the House of Commons on 7th September 2011. The Bill has now been passed to the House of Lords for consideration. The first reading took place on 8th September and the second reading took place on 11th and 12th October. The Committee stage, where the Bill was subject to detailed line by line examination, ran until 21st December 2011. The Bill is currently in the Report Stage in the House of Lords where there will be further line by line examination. This Stage started on the 8th February and is expected to run until 13th March after which it will have its third reading in the House of Lords. Once the House of Commons and the House of Lords agree the final Bill it can then receive Royal Assent and become an Act of Parliament i.e. the proposals of the Bill will become law. The Statutory Guidance on Health and Wellbeing Boards will not be published until after the Bill becomes law and this is not expected until late in Spring 2012.

The 'in principle' decisions related to the structure of community involvement and engagement and the development of a Strategic Partners Group and its membership. It is these decisions that are the subject of this Forward Plan entry. They will be confirmed or reviewed dependent upon the guidance issued for the statutory Health and Wellbeing Board.
Who will make the decision?

The decision will be made by Cabinet however some elements will require Council agreement for changes to the Constitution.

Ward(s) affected

The proposals will affect all wards within the Borough.

Timing of the decision

At the Cabinet meeting on 18th July 2011 it was agreed that a further report would be brought to Cabinet once the statutory Health & Wellbeing Board guidance had been issued. If the 'in principle' decisions that Cabinet have taken are unaffected then they

will be agreed for implementation. If those 'in principle' decisions are affected then Cabinet will be asked to consider alternative proposals which reflect the new position. It is expected that the guidance will be published in late Spring 2012 and a report will be taken to Cabinet following the publication date which is currently anticipated to be May 2012. The detailed timescales for this are currently unclear and may be subject to change.

Who will be consulted and how?

Cabinet will be asked to consider the implications of guidance on the development of the statutory Health and Wellbeing Board on the 'in principle' decisions relating to the structure of community involvement and engagement and the development of a Strategic Partners Group and its membership.

Information to be considered by the decision makers

Cabinet will be presented with detail from the guidance on the development of the statutory Health and Wellbeing Board and how this will impact, if at all, on the 'in principle' decisions that they made on 18th July 2011.

How to make representation

Representation should be made to:

Andrew Atkin, Assistant Chief Executive, Civic Centre, Hartlepool TS24 8AY.
Telephone: (01429) 523003.
Email: Andrew.atkin@hartlepool.gov.uk

Catherine Frank, Local Strategic Partnership Manager, Civic Centre, Hartlepool TS24 8AY.
Telephone: (01429) 284322.
Email: catherine.frank@hartlepool.gov.uk

2.5 A summary of all key decisions is attached as **APPENDIX A** to this report.

2.6 Copies of the Executive's Forward Plan will be available at the meeting and are also available on request from the Scrutiny Team (01429 5236437) prior to the meeting.

3. RECOMMENDATIONS

3.1 It is recommended that the Health Scrutiny Forum:-

(a) considers the Executive's Forward Plan; and

(b) decides whether there are any items where value can be added to the decision by the Health Scrutiny Forum in advance of the decision being made.

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

BACKGROUND PAPERS

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

(a) The Forward Plan – April – July 2012

TIMETABLE OF KEY DECISIONS

Decisions are shown on the timetable at the earliest date at which they may be expected to be made.

1. DECISIONS EXPECTED TO BE MADE IN APRIL 2012

CE 50/11 (page 11)	Options in Relation to ICT Support Arrangements	Cabinet
CAS 106/11 (page 14)	Priority Schools Building Programme	Cabinet
CAS 120/12 (page 23)	Consultation on Denominational Home to School Transport	Cabinet
CAS 123/12 (page 18)	Schools' Capital Works programme 2012/13 (Phase 2)	Portfolio Holder
RN 13/09 (page 23)	Disposal of Surplus Assets	Cabinet/Portfolio Holder
RN 29/10 (page 25)	Hartlepool Domestic Violence Strategy	Cabinet
RN 68/11 (page 27)	Community Cohesion Framework	Portfolio Holder
RN 69/11 (page 29)	Flexible Support Fund	Cabinet
RN 70/11 (page 30)	Innovation Fund	Cabinet
RN 74/11 (page 31)	Former Leathers Chemical Site	Cabinet
RN 77/11 (page 33)	Wynyard Master Plan	Cabinet
RN 89/11 (page 35)	Former Brierton School Site	Cabinet
RN 90/11 (page 37)	Mill House Site Development and Victoria Park	Cabinet/Council
RN 98/11 (page 41)	Acquisition of Assets	Cabinet/Portfolio Holder
RN 102/11 (page 47)	Partnering Arrangement with Housing Hartlepool for the Provision of Services	Cabinet
RN 5/12 (page 51)	Seaton Carew Development Sites – Results of Joint Working Arrangement with Preferred Developer	Cabinet
RN 6/12 (page 53)	5-Year Highway Maintenance Programme 2012-2017	Portfolio Holder
RN 8/12 (page 54)	Neighbourhood Plans AST Determined by the Localism Act	Cabinet
RN 9/12 (page 55)	Troubled Families	Cabinet
RN 10/12 (page 58)	Acquisition of the Longscar Building, Seaton Carew	Cabinet

2. DECISIONS EXPECTED TO BE MADE IN MAY 2012

CE 46/11 (page 8)	Review of Community Involvement & Engagement (Including LSP Review): Update on decisions taken 'in principle'	Cabinet
RN 96/11 (page 39)	Hartlepool Voluntary & Community Sector Strategy	Cabinet
RN 99/11 (page 43)	Community Infrastructure Levy	Cabinet

3. DECISIONS EXPECTED TO BE MADE IN JUNE 2012

CE 44/11 (page 7)	Workforce Arrangements	Cabinet
RN 100/11 (page 45)	Raby Road Corridor Developer Agreement	Cabinet
RN 3/12 (page 49)	Hartlepool CCTV Strategy 2012 - 2015	Cabinet
RN 11/12 (page 60)	Public Lighting Strategy	Portfolio Holder

4. DECISIONS EXPECTED TO BE MADE IN JULY 2012

No Items

TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE

A meeting of the Tees Valley Health Scrutiny Joint Committee was held on 30 January 2012.

PRESENT: Representing Darlington Borough Council:
Councillors Newall and Mrs H Scott

Representing Hartlepool Borough Council:
Councillor G Lilley

Representing Middlesbrough Council:
Councillors Dryden and Mrs H Pearson

Representing Redcar & Cleveland Council:
Councillors Carling and Mrs Wall

Representing Stockton-on-Tees Borough Council:
Councillors Javed, N Wilburn and Mrs M Womphrey.

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

****PRESENT BY INVITATION:** D Brown, Service Director, Tees, Esk and Wear Valleys NHS Foundation Trust
M Cotton, Assistant Director of Communication and Engagement, North East Ambulance Service NHS Foundation Trust
S Featherstone, Chief Executive, North East Ambulance Service NHS Foundation Trust.

**** APOLOGIES FOR ABSENCE** were submitted on behalf of Councillor J Taylor (Darlington Borough Council), Councillors S Akers-Belcher and Griffin (Hartlepool Borough Council) and Councillor Cole (Middlesbrough Borough Council).

DECLARATIONS OF INTEREST

Name of Member	Type of Interest	Item / Nature of Interest
Councillor Javed	Personal/Non Prejudicial	Agenda Item 4 in so far as it related to Tees, Esk and Wear Valleys NHS Foundation Trust –an employee.
Councillor Mrs Wall	Personal/Non-Prejudicial	Agenda Item 4 in so far as it related to North East Ambulance Service NHS Foundation Trust - related to a number of employees.

**** MINUTES**

The minutes of the meeting of the Tees Valley Health Scrutiny Joint Committee held on 19 December 2011 were submitted and approved as a correct record.

NHS OPERATING FRAMEWORK – IMPLICATIONS FOR THE LOCAL NHS

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representatives from the North East Ambulance Service NHS Foundation Trust (NEAS) and

Tees, Esk & Wear Valleys NHS Foundation Trust (TEWV) to address the Joint Committee about the recently published NHS Operating Framework and its implications for the respective organisations.

Members were advised that each year the Department of Health (DoH) published an Operating Framework for the NHS the purpose of which was to outline the DoHs priorities for the coming year and detailing the areas that leaders of the NHS would be particularly held to account for their organisations' performance.

It was acknowledged that the NHS faced one of the most challenging financial environments with a requirement to save in the region of £20 billion by 2015 which equated to around 20% of its annual budget. The NHS also faced significant social challenges such as the burden created by an ageing population that would typically require more care, better (but more expensive) medicine and medical technology, as well as ever increasing expectations of its service users.

The Chair welcomed David Brown, Service Director, (TEWV) who focussed on the main issues relating to the key challenges of the NHS Operating Framework.

Firstly, reference was made to one of the key areas for the Trust to sustain a strong performance on Finance and Quality whilst at the same time continuing to make efficiency savings. The expectation of needing to achieve improvements whilst also making financial savings was seen as a major challenge. It was stated that although it was encouraging that the Trust had been awarded the Mental Health Services Provider of the year 2011 there was no room for complacency in maintaining current standards and performance.

Another key challenge related to the need to make changes to meet QUIPP and continue to make efficiency savings. Savings had been achieved by means of providing alternative community services which had resulted in the closure of certain hospital wards by reducing the length of stay for patients. Such measures had generated £3 million savings.

Reference was made to the Any Qualified Provider proposals in particular the intention for one of the priorities to be improving access to Psychological Therapies. Given the significant number of people currently involved and the potential for this to be substantially increased it was considered important for the correct procedures to be in place taking into account the financial risks.

The Joint Committee's attention was drawn to the Government Health Reforms with particular regard to current work as a member of a Shadow Health and Wellbeing Board and associated Partnership Group.

In relation to the care of older people, another key area, it was stated that much could be done in respect of patients with dementia. In commenting on the measures being pursued which included increased liaison with the acute sector reference was made to work undertaken in Birmingham which had achieved savings of £6 million. The Joint Committee was advised of the intention to examine and emulate such work and advise the Clinical Commissioning Group accordingly.

An indication was given of a couple of areas where it was considered that further improvements could be made. Such areas included issues relating to patients' dignity and improved service in Pathway. It was recognised that this required a whole system approach.

Other areas which required further work involved persons with challenging behaviour, liaison service with acute sector, palliative care for older people and enabling carers to access short breaks.

Members commented on the Government Health Reforms and in particular the importance of ensuring appropriate representation in respect of elected Members and patient's perspective on Health and Wellbeing Boards.

Although the requirements around being patient focussed were agreed it was acknowledged that determining the extent of and when to provide appropriate information to patients remained a

challenge. To improve communications and ensure a patient's understanding of their care plan was of crucial importance.

In response to Members' questions further information was provided on the investment into and work around community care settings. As previously indicated the Trust had achieved efficiencies by pursuing alternative measures resulting in the closure of hospital wards and 25% financial savings being re-invested into the service. It was also pointed out that the Crisis service was once again being re-examined. Although there was more staff out of hours it was acknowledged that there was still a need to continue to make improvements with regard to this service.

Members commented on the role and involvement of GPs in the Trust's work and an apparent gap in service of appropriately trained staff in dealing with adults diagnosed with autism. In response, reference was made to a service carried out by the County Durham and Darlington NHS Foundation Trust and of the commissioning intentions in Teesside regarding the training of adult teams for appropriate different skills required in dealing with adults with autism.

Whilst Members acknowledged the savings achieved with regard to such measures as the closure of hospital wards they sought assurances that as part of the community strategies there were appropriate measures in place to support carers.

Members sought clarification regarding the proposed increased liaison with the acute trusts. In response, the Joint Committee was advised that it was intended to put a business case together in order to demonstrate the benefits and set out proposals for commissioning groups. Members requested that further information regarding this matter be circulated to the Joint Committee.

The Joint Committee referred to the guidance on the proposed Government Health Reforms which was considered lacked clarity and was open to interpretations. Reference was made to an overall lack of communication and to variations in the structures such as the Health and Wellbeing Boards. Members expressed concerns as to how the commissioning intentions of two Clinical Commissioning Groups would appropriately take into account the several Joint Strategic Needs Assessments.

It was agreed that areas such as the development of community services continued to be monitored and the potential for emerging issues to be included in the Joint Committee's work programme be considered.

The Chair welcomed representatives from the (NEAS).

The Joint Committee was advised of the increasing focus of the DoH on more outcome based performance measures. Over the next 12 months there was a need to build appropriate systems to ensure the effectiveness of 11 specific measures.

As an organisation the award of the £45 million contract to run the 111 service in the North East was seen as a massive milestone for NEAS. The 111 service for non-urgent injuries or illnesses ran alongside the emergency 999 service. County Durham and Darlington area was one of only four areas across the UK to initially pilot the NHS 111 service. The NHS 111 service was designed to simplify the process for people who were currently often confused about telephone numbers and the type of healthcare services available to suit their needs. Members suggested that it would be helpful if further information could be circulated to the Joint Committee on the 111 service and how it differed from the current system.

As with other organisations the savings to be achieved next year, £2 million in the case of NEAS was seen as a major challenge.

The NHS Operating Framework required the operational standards of 75% of Category A calls resulting in an emergency response arriving within eight minutes and 95% of Category A calls resulting in an ambulance arriving at the scene within 19 minutes to continue to be met or exceeded.

As part of the performance measures the continuation of the operational standard of 95% of patients being seen within four hours at Accident and Emergency services was welcomed.

The requirements to maintain a good standard of preparedness to respond to a range of threats and disruptive events included the Olympic Games in respect of 2012 for which additional funding had been identified.

One area of uncertainty related to the Government Health Reforms and changes to the commissioning agenda. Across the North East there would be one Commissioning Support Unit supporting 13 Clinical Commissioning Groups with effect from 1 April 2013. The Joint Committee was advised that currently no-one was leading on commissioning in relation to the Ambulance Service although it was at the hub of urgent care. Members suggested that clarification be sought from the Strategic Health Authority in this regard.

Specific reference was made to the further opportunities provided by the CQUIN arrangements in the NHS Operating Framework. Members were advised of the opportunity to make further developments in relation to safeguarding. The 2012/2013 NHS Operating Framework provided that the amount that providers could earn would be increased to 2.5% on top of actual outturn value and also the possibility of recurring funding if the commissioner was satisfied that it would be necessary to maintain the improvement.

The Joint Committee was advised of a new pilot scheme to commence shortly to measure patient's experience at Accident and Emergency services and Patient Transport Service and for such information to be collected in real time. In response to Member's questions it was confirmed that independent people would be undertaking the survey to assist with the openness and robustness of the survey.

In response to a Member's question regarding the recent distribution of leaflets of the NHS 111 service in an area which wasn't covered by such a service the NEAS representatives confirmed that such a matter would be investigated.

In view of the continuing increasing demands on the service an indication was given of the implementation of new structures which would involve some complex changes including work practices and shift patterns. Such changes were a major challenge and would result in an increase of staff and ambulances across the North East.

AGREED as follows:-

1. That the local NHS representatives be thanked for the information provided.

2. That arrangements be made for a briefing meeting for the Joint Committee to be held at 10.00 a.m. on 27 February 2012.

3. That the meeting of the Joint Committee scheduled for 27 February 2012 commence at 10.30 a.m. and not 10.00 a.m. as previously indicated.

PROSTHETIC SERVICES – TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE – SCRUTINY WORK PROGRAMME

The Scrutiny Support Officer submitted a report regarding a suggested topic for inclusion in the Joint Committee's work programme. The basis of the topic was reported as follows:-

'The design, development and fitting of prosthetics for amputees in Stockton is commissioned by James Cook University Hospital to Otto Vock Prosthetics. There does not appear to be a UK centre of excellence where Otto Vock can seek advice or where patients can seek alternative advice and support.

An informal complaint has been received that the service is exceedingly slow, old fashioned, lacking in professionalism and of poor standard. This mirrors a complaint made several years ago, suggesting that the service has not improved.

A review of this service would include:

- length of time individuals wait for a prosthetic;
- quality and fit of prosthetics;
- advice given to those being fitted for a prosthetic;
- best practice in other areas/countries.'

Members gave an indication of a number of informal complaints which had been made suggesting that the prosthetic service locally could be improved given the level of service provided elsewhere.

The Joint Committee agreed on the importance of such a service to improve the quality of life of service users.

Members expressed support in undertaking the scrutiny investigation and that initial information be sought regarding the commissioning arrangements, size of patient base, how the service was planned and provided and opinions on how the service was performing.

AGREED that Prosthetic Services be included in the Joint Committee's Scrutiny Work Programme.

ANY QUALIFIED PROVIDER UPDATE

The Scrutiny Support Officer submitted a report which provided the latest NHS Tees update on the topic of Any Qualified Provider.

Informed by national engagement activity, the Department of Health had identified a list of potential services for priority implementation and had asked PCTs to identify three community or mental health services in which to implement patient choice of Any Qualified Provider in 2012/2013.

Alongside internal activity to consider which areas would be most appropriate to be taken forward first by NHS Tees during September 2011 views had been sought from patients, carers, the public, staff, partners and stakeholders on extending patient choice through offering the option of Any Qualified Provider.

Following a survey the report listed the most popular first choices for increasing choice of provider. Most respondents had identified easier access to appointments and more convenient locations as the perceived benefits of extending patient choice of provider followed by shorter waiting times and better quality service.

The Joint Committee was advised that following consideration of responses to the engagement activity and NHS Tees' current position in terms of contractual timescales and service review intentions the first three areas chosen by NHS Tees for implementation of Any Qualify Provider were confirmed as:-

- Adult Hearing Services for which NHS Tees was responsible for developing a national standard specification;
- Primary Care Psychological Therapies (adults);
- Wheelchair Services (adults and/or children).

AGREED that the information provided be noted.