HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL BOROUGH COUNCIL

10 January 2013

at 9.00 a.m.

in the Council Chamber, Civic Centre, Hartlepool.

MEMBERS: HEALTH SCRUTINY FORUM:

Councillors S Akers-Belcher, Brash, Fisher, Hall, Hargreaves, G Lilley and Wells

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 13 December 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**

   6.1 Proposals for Inclusion in Council Plan 2013/14 – *Child and Adult Services Departmental Management Team*

   6.2 Briefing Report and Immunisation Strategy – *Director of Public Health*

7. **ITEMS FOR DISCUSSION**

Scrutiny Investigation into the JSNA topic of Sexual Health

7.1 Service provision, what people say and effective intervention:-

(a) Covering Report – *Scrutiny Support Officer*

(b) 'What people say' – *Representatives from the Voluntary and Community Sector and Youth Groups*

(c) Sex and Relationships Education in Schools and its impact / effectiveness – *Representatives from Local Schools*

(d) Teenage Pregnancy Performance Report – *Director of Public Health*

(e) Presentation – what needs might be unmet, additional needs assessment; and recommended commissioning priorities – *Director of Public Health*

(f) Formulate a view in relation to the needs of Hartlepool residents, the current level and quality of service provision to meet those needs and formulation of recommendations – *Members of the Forum*

7.2 Service Transformation / Transition to a New Hospital:-

(a) Covering Report – *Scrutiny Support Officer*

(b) Presentation – *Representatives from North Tees and Hartlepool NHS Foundation Trust*

7.3 Hip Replacements:-

(a) Covering Report – Scrutiny Support Officer

(b) Presentation - *Representatives from North Tees and Hartlepool NHS Foundation Trust*

7.4 Briefing Report on Patient Flows – *Representatives from Hartlepool and Stockton-on-Tees Clinical Commissioning Group*

8. **ISSUES IDENTIFIED FROM FORWARD PLAN**

9. **MINUTES FROM THE RECENT MEETING OF THE SHADOW HEALTH AND WELLBEING BOARD**

No items.

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

10.1 Minutes of the meeting held on 3 December 2012

11. **REGIONAL HEALTH SCRUTINY UPDATE**

No items

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

For Information:

Date of Next Meeting – 7 February 2013, 9am in Council Chamber, Civic Centre, Hartlepool

HEALTH SCRUTINY FORUM

Date: 10 January 2013

Report of: Child and Adult Services Departmental Management Team

Subject: PROPOSALS FOR INCLUSION IN COUNCIL PLAN 2013/14

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1. PURPOSE OF REPORT

1.1 To provide the opportunity for the Health Scrutiny Forum to consider the proposals for inclusion in the 2013/14 Council Plan that fall under the remit of the Committee.

2. BACKGROUND

2.1 For 2013/14 a review of the Outcome Framework has been undertaken to ensure that it still accurately reflects the key outcomes that the Council and Partners have identified as being important for the future of the Borough. A revised outcome framework, to be implemented from April 2013, was reported to Scrutiny Coordinating Committee on 19 October 2012 and Cabinet on 29 October 2012.

2.2 As in previous years detailed proposals are being considered by each of the Scrutiny Forums in January. A further report will be prepared for Scrutiny Coordinating Committee on 18 January 2013 detailing the comments/observations of each of the Scrutiny Forums to enable a joint response to be prepared for Cabinet.

2.3 As discussed at the Scrutiny Coordinating Committee on 19 October 2012, from 2013/14 the three Departmental Plans will be brought together to form the Council Plan which will set out collectively how the key priorities/outcomes that the Council have identified will be delivered. This is a different approach to previous years and therefore there will be no separate Corporate Plan. This will eliminate the unnecessary duplication and reporting of actions that was an unintended consequence of drawing the old Corporate Plan actions and indicators from the three Departmental Plans, without losing the focus that having separate Departmental Plans brings to the overall process.

2.4 The Council Plan is still a working document and as such there are areas where information could change. Where this does occur the information will be included in the final draft of the Plan that is to be considered by Scrutiny Coordinating Committee on 8 March 2013, by Cabinet on 18 March 2013 and by Council on 11 April 2013.

3. PROPOSALS

3.1 The Director of Public Health will deliver a short presentation at the meeting detailing the key challenges that the Council faces over the next year, and beyond, and setting out proposals, from the Child and Adult Services Departmental Plan, for how these will be addressed.

3.2 The main focus of the presentation will be on the outcomes that have been included in the Outcome Framework and how these will be delivered in 2013/14. The Assistant Director will take each outcome in turn, explaining how each outcome will address the challenges faced by the Council. After each outcome Members will be given the opportunity to comment on the proposals before the presentation moves onto the next outcome.

3.3 The Outcomes that fall under the remit of the Health Scrutiny Forum, and will therefore be included in the presentation are: -

- Outcome 9: Improve health by reducing inequalities and improving access to services;
- Outcome 10. Give every child the best start in life;
- Outcome 14. There is reduced harm caused by drugs and alcohol misuse;
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3.4 **Appendix A** provides detail on the proposed actions identified to deliver the outcomes that fall under the remit of the Health Scrutiny Forum. Officers from across the Council have also been identifying the Performance Indicators (PIs) that will be monitored throughout the year to measure progress and these are also included in the appendix.

3.5 As in 2012/13, it is not possible at this stage to include year end outturn and future targets as these are not yet available. It is normal practice to use a number of criteria when setting targets, such as current performance, budget information and other external factors such as Government policy changes. Therefore it is normal for targets to be set around year end when more information is known. Where available, this information will be included in the proposals reported to Scrutiny Coordinating Committee in March 2013.

4. NEXT STEPS

4.1 The remainder of the Council Plan proposals have already been, or will be, discussed at the relevant Scrutiny Forums between 4 January and 17 January 2013. Comments and observations from those Scrutiny Forums will be added to those received at today's meeting and included in the overall

presentation to Scrutiny Coordinating Committee on 18 January 2013. Due to the short length of time between the Scrutiny Forums and the Scrutiny Coordinating Committee meeting on the 18th January it will not be possible to provide a detailed response to the comments and observations made at the Scrutiny Forums at the SCC meeting.

4.2 The final draft of the Council Plan, which will include a detailed response to the comments and observations from the Scrutiny Forums in January, will then be considered by Scrutiny Coordinating Committee on 8 March 2013 and Cabinet on 18 March 2013 before being taken for formal agreement by Council at its meeting on 11 April 2013.

4.3 Progress towards achieving the actions and targets included in the Council Plan will be monitored throughout 2013/14 by officers across the Council and progress reported quarterly to Elected Members.

5. RECOMMENDATIONS

5.1 It is recommended that the Health Scrutiny Forum: -

- considers the proposed outcome templates (Appendix A) for inclusion in the 2013/14 Council Plan;

- formulates any comments and observations to be included in the overall presentation to the meeting of the Scrutiny Coordinating Committee on 18 January 2013.

Contact Officer: - Louise Wallace
Director of Public Health
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Child and Adult Services Departmental Plan 2013/14 – Action Plan

SECTION 1 OUTCOME DETAILS			
Outcome:	9. Improve health by reducing inequalities and improving access to services	**Theme:**	Health and Wellbeing

Lead Dept:	Child and Adult Services	**Other Contributors:**	Regeneration and Neighbourhoods

SECTION 2 ACTIONS		
Action	**Due Date**	**Assignee**
Develop a corporate approach to measuring excessive winter deaths	Sep 2013	Louise Wallace
Be an active lead partner in the delivery of the physical activities workstream for Public Health	March 2014	Pat Usher
Ensure implementation of the NHS health check programme	March 2014	Louise Wallace
Implement the early detection and awareness of cancer programme across Hartlepool	March 2014	Louise Wallace
Ensure that the department has procedures in place to meet the requirements of the Equality Act 2010 by co-ordinating activities across the department to contribute to the items included in the Equality & Diversity Action Plan	March 2014	Leigh Keeble
Ensure all eligible people (particularly in high risk groups) take up the opportunity to be vaccinated especially in relation to flu	March 2014	Louise Wallace
Ensure all eligible groups for respective screening programmes are aware and able to access screening	March 2014	Louise Wallace
Ensure implementation of the Health and Wellbeing Strategy	March 2014	Louise Wallace
Review Joint Strategic Needs Assessment (JSNA) through the Health and Wellbeing board	March 2014	Louise Wallace
Influence the commissioning of effective based Stop Smoking and work collaboratively through the Smoke Free alliance to reduce illicit tobacco across the town	March 2014	Louise Wallace
Ensure the development of a comprehensive plan to protect the health of the population	March 2014	Louise Wallace
Ensure the delivery of comprehensive sexual health services	March 2014	Louise Wallace

SECTION 3 PERFORMANCE INDICATORS & TARGETS				
Code	**Indicator**	**Assignee**	**Targeted or Monitor**	**Collection Period (e.g. Fin/Acd)**
NI 39	Alcohol related hospital admissions	Louise Wallace	Targeted	Financial Year
NI 123	Stopping smoking	Carole Johnson	Targeted	Financial Year
NI 123 (NRA)	Stopping smoking (Neighbourhood Renewal Area narrowing the gap indicator)	Carole Johnson	Targeted	Financial Year
P081	GP Referrals - The number of participants completing a 10 week programme of referred activity	Pat Usher	Targeted	Financial Year
P035	GP Referrals – of those participants completing a 10-week programme for the percentage going onto mainstream activity	Pat Usher	Targeted	Financial Year
P080	Vascular Risk Register (Vital Signs)	Louise Wallace	Monitor	Financial Year
NI 120a	All-age all cause mortality rate - Females	Louise Wallace	Monitor	Calendar Year
NI 120b	All-age all cause mortality rate - Males	Louise Wallace	Monitor	Calendar Year
NI 121	Mortality rate from all circulatory diseases at ages under 75	Louise Wallace	Monitor	Calendar Year
NI 122	Mortality for all cancers aged under 75	Louise Wallace	Monitor	Calendar Year

SECTION 4 RISKS		
Code	**Risk**	**Assignee**
CAD R014	Failure to make significant inroads in Health Impact	Carole Johnson; Louise Wallace

SECTION 1 OUTCOME DETAILS			
Outcome:	10. Give every child the best start in life	**Theme:**	Health and Wellbeing

Lead Dept:	Child and Adult Services	**Other Contributors:**	Regeneration and Neighbourhoods

SECTION 2 ACTIONS		
Action	**Due Date**	**Assignee**
Review and update local breastfeeding annual action plan	March 2014	Carole Johnson
Implement Child Measurement Programme	March 2014	Deborah Gibbin
Ensure a range of Physical Activity opportunities are available for children & young people (up to age 25)	March 2014	Pat Usher
Review, update and implement Smoking in Pregnancy Action Plan	March 2014	Carole Johnson
Work with partner agencies, young people, schools and families to tackle substance misuse (including alcohol)	March 2014	John Robinson
Review the Substance Misuse Service for young people and future commissioning options	June 2013	Ian Merritt
Implement the British Heart Foundation Younger Wiser Programme	March 2014	Deborah Gibbin
Review the process of Public Health Transition and ensure the transition is complete	March 2014	Louise Wallace
Increase the uptake of child vaccinations	March 2014	Deborah Gibbin
Implement the Child Poverty Action Plan	March 2014	Danielle Swainston
Develop a Children & Young People obesity pathway	March 2014	Deborah Gibbin
Implement the Early Intervention Strategy	March 2015	Danielle Swainston
Embed common assessment as a means to identify and respond to need	October 2013	Danielle Swainston
Implement the Early Years Pathway delivering targeted support to children pre birth to five	September 2013	John Robinson

SECTION 3 PERFORMANCE INDICATORS & TARGETS				
Code	**Indicator**	**Assignee**	**Targeted or Monitor**	**Collection Period (e.g. Fin/Acd)**
LAA HW P001	Percentage of women smoking at time of delivery	Carole Johnson	Targeted	Financial Year
NI 53a	Prevalence of breastfeeding at 6- 8 wks from birth - Percentage of infants being breastfed at 6- 8 weeks	Deborah Gibbin/Carole Johnson	Monitor	Financial Year
CSD P049a	Measles, Mumps and Rubella (MMR) immunisation rate – children aged 2 (1st dose)	Deborah Gibbin	Monitor	Financial Year
CSD P049b	Measles, Mumps and Rubella (MMR) immunisation rate – children aged 5 (2nd dose)	Deborah Gibbin	Monitor	Financial Year
New	Uptake of Diphtheria, Tetanus, Polio, Pertussis, Hib immunisations (by age 2 years)	Deborah Gibbin	Monitor	Financial Year
NI 55(iv)	The percentage of children in Reception who are obese	Deborah Gibbin	Monitor	Financial Year
NI 56(ix)	The percentage of children in Year 6 who are obese	Deborah Gibbin	Monitor	Financial Year
NI 112	The change in the rate of under 18 conceptions per 1,000 girls aged 15- 17, as compared with the 1998 rate	Deborah Gibbin	Monitor	Financial Year
New	Children achieving a good level of development at age 5	Danielle Swainston	Monitor	Academic Year
NI 117	Percentage of 16 to 18 year olds who are Not in Education, Employment or Training (NEET)	James Sindair/Mark Smith	Targeted	Financial Year
NI 75	Percentage of pupils achieving 5 or more A*- C grades at GCSE or equivalent including English and Maths	Tom Argument	Targeted	Academic Year
New	Number of children defined as a Child in Need, rate per 10,000 population under 18	Sally Robinson	Monitor	Financial Year

SECTION 4 RISKS		
Code	**Risk**	**Assignee**
CAD R025	Failure to meet statutory duties and functions in relation to childcare sufficiency	Danielle Swainston
CAD R026	Failure to deliver Early Intervention Strategy	Sally Robinson

CAD R029	Failure to effectively manage risks exhibited by young people and families (Actively Managed)	Sally Robinson

SECTION 1 OUTCOME DETAILS			
Outcome:	14. There is reduced harm caused by drugs and alcohol misuse	**Theme:**	Community Safety

Lead Dept:	Child and Adult Services	**Other Contributors:**	Regeneration and Neighbourhoods

SECTION 2 ACTIONS		
Action	**Due Date**	**Assignee**
Ensure effective integrated treatment of Drug and Alcohol services	March 2014	Chris Hart
Ensure effective criminal justice initiatives following appointment of the Police Crime Commissioner (PCC)	March 2014	Chris Hart
Strengthen safeguarding and address Hidden Harm issues within substance misuse services	March 2014	Karen Clark

SECTION 3 PERFORMANCE INDICATORS & TARGETS				
Code	**Indicator**	**Assignee**	**Targeted or Monitor**	**Collection Period (e.g. Financial/academic)**
	Number of substance misusers going into effective treatment – opiate	Chris Hart	Targeted	Financial Year
	Proportion of substance misusers that successfully complete treatment – Opiate	Chris Hart	Targeted	Financial Year
	Proportion of substance misusers who successfully complete treatment and re-present back into treatment within 6 months of leaving treatment	Chris Hart	Targeted	Financial Year
	Reduce alcohol related hospital admissions	Chris Hart	Targeted	Financial Year

SECTION 4 RISKS		
Code	**Risk**	**Assignee**
CAD R006	Alcohol investment does not enable the provision of sufficient services to meet the increased level of need. (Actively Managed)	Michelle Chester; Chris Hart
CAD R018	Government reduces grant allocations i.e. Pooled Treatment and DIP (Drug Intervention Programme)	Michelle Chester; Chris Hart

Hartlepool Health Improvement Service

Immunisations 2012

Briefing Update

1. Introduction

The purpose of this briefing is to update Members of the Health Scrutiny Forum about the progress being made towards the uptake of immunisations. For the purpose of this paper the routine childhood immunisation programme and at risk programme ~ seasonal influenza will be presented.

A child born in Hartlepool can expect to receive at least seven injections in their first year of life. By the time they get to 18 years of age they would have received at least 16 separate injections (13 for boys) that protect each child against 10 vaccine preventable diseases (11 for girls).

2. Childhood Vaccines

The World Health Organisation (WHO) recommends that at least 95% of children receive three primary doses of diphtheria, tetanus, polio and pertussis in the first year of life and more that 95% receive one dose of measles, mumps and rubella vaccine by two years of age.

Currently all childhood immunisations, with the exception of the school leaver booster and Human Papillomavirus (HPV) are delivered through GP practice and supported by the health visiting teams. The schedule for the programme starts when a child is 2 months old, please see appendix 1 for a description of the current routine immunisation schedule.

2.1 Vaccine coverage targets

Table 1 ~ primary immunisation course by 12 months 2010/11

Vaccine	Hartlepool	North East	England	Target
D/TaP/IPV/Hib	92.4%	95.5%	94.2%	95%
MenC	92%	95.4%	93.4%	95%
PCV	91.5%	95.5%	93.6%	95%

Table 1.1 ~ primary immunisations course by 12 months 2005/6 – 2010/11

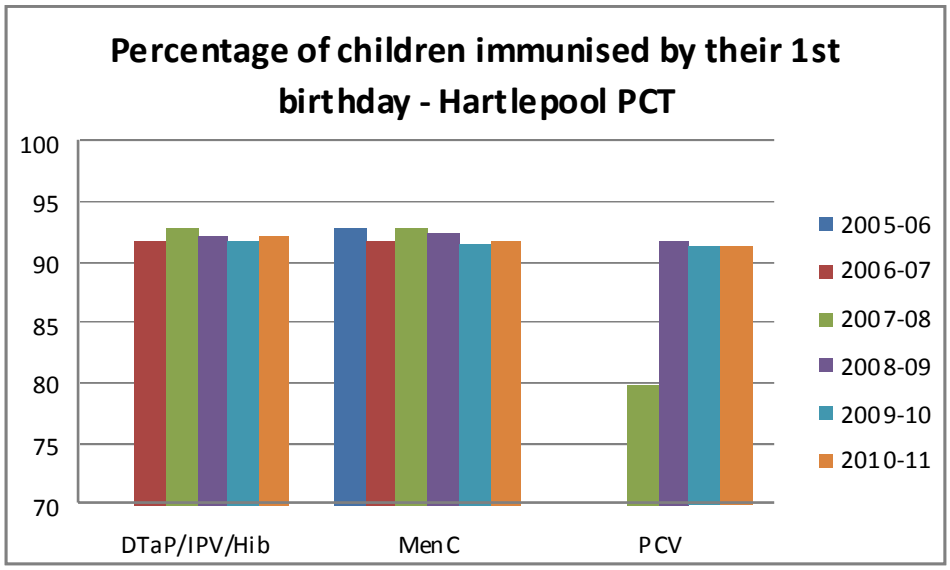


Table 2 ~ child immunisation course by 24 months 2010/11

Vaccine	Hartlepool	North East	England	Target
MMR (1)	85.4%	91.4%	89.1%	95%
Hib/MenC booster	87.5%	94.6%	91.6%	95%
PCV booster	85.1%	94.6%	89.9%	95%

Table 2.1 ~ % of Hartlepool children immunised against MMR compared to the North East and England averages

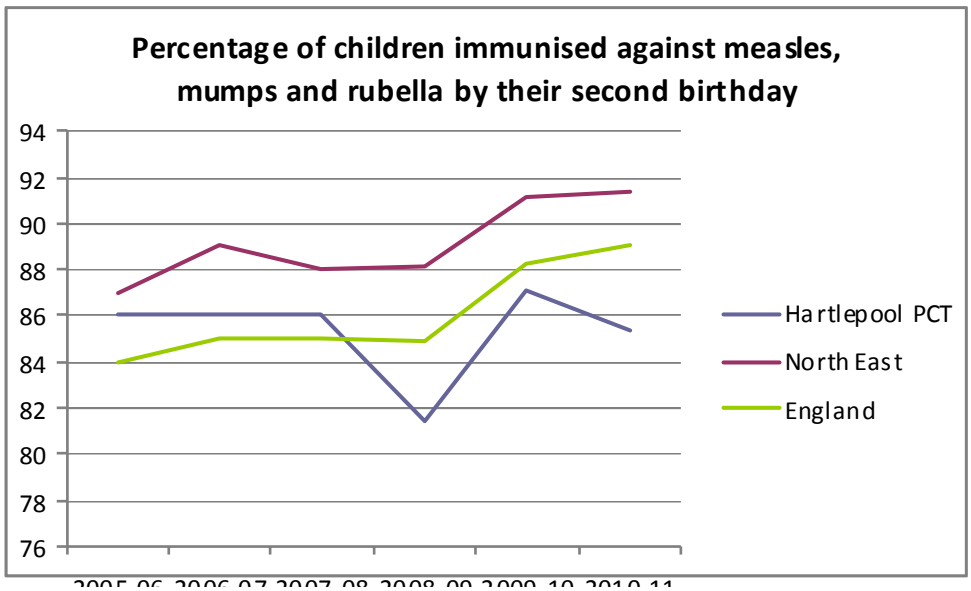
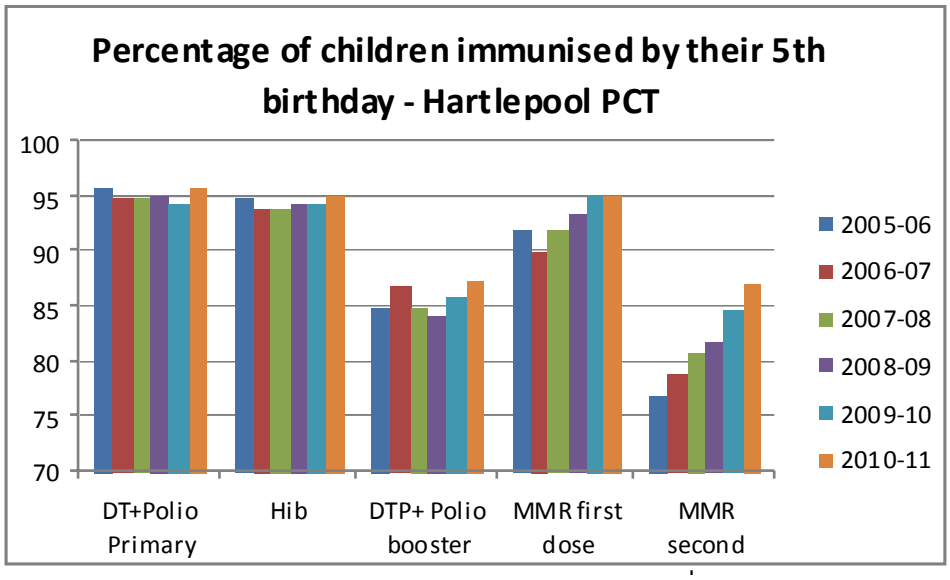


Table 3 ~ completed Primary immunisations and boosters by 5 years 2010/11

Vaccine	Hartlepool	North East	England	Target
MMR (2)	87.2%	88.7%	84.2%	95%
D/TaP/IPA	87.4%	90.5%	85.9%	95%

Table 3.1 ~ % of children immunised by their 5th birthday 2006/06 to 2010/2011



2.2 Human Papillomavirus

The aim of the Human Papillomavirus (HPV) vaccine is to reduce the incidence of cervical cancer in women. Young women have 3 doses of the HPV vaccines before they reach an age when the likelihood of HPV infection increases and they are put at risk of cervical cancer. In Hartlepool the HPV programme is delivered in Year 8 and is delivered through a school based service.

In England 84.2% of females aged 12 – 13 years who were eligible to receive HPV vaccine in the academic year completed the three dose course. In the North East 87.5% of girls in this cohort completed the three dose course. In Hartlepool 90.2% of girls eligible completed the three dose course which is significantly higher than the North East and England average.

3. At Risk Programme ~ Seasonal Flu

Influenza (flu) can potentially be a life threatening condition resulting in serious illness particularly for those in the at risk groups. The Department of Health currently recommends to reach, or exceed, the target of 75% for all individuals aged over 65 years and older as recommended by the World Health Organisation (WHO). Current national policy advises that seasonal flu vaccine should be offered to:

- All aged 65 and older
- Individuals aged 6 months or over in a clinical risk group

- Those living in long stay residential care facilities
- Those in receipt of a carer's allowance or those who are the main carer of an elderly or disabled person
- All pregnant women
- Frontline health and social care workers

At risk groups who should receive influenza vaccine include individuals with:

- Diabetes
- Chronic respiratory disease
- Chronic heart disease
- Chronic kidney disease
- Chronic liver disease
- Chronic neurological disease
- Individuals who are immunosuppressed

Table 4: Seasonal flu vaccine uptake: 2009/10 to 2011/12

Organisation	65 and over			Under 65 (at risk only)		
	2009/10	2010/11	2011/12**	2009/10	2010/11	2011/12**
Hartlepool*	72.3	71.8	73.0	57.1	52.9	52.0
North East	73.9	74.5	75.8	52.6	52.0	53.7
England	72.4	72.8	-	51.6	50.4	-

*denotes PCT with less than a 100% response rate (Hartlepool 93%)
** denotes provisional data

3.2 Pregnant Women

Seasonal flu vaccine is recommended for all pregnant women, irrespective of their stage of pregnancy. Flu immunisation of women:

- Reduces rates of influenza among pregnant women
- May reduce the likelihood of prematurity and smaller infant size and weight at birth associated with influenza during pregnancy
- Provides passive immunity against flu to infants in the first few months of life

Table 5: Season flu vaccine uptake in pregnant women: 2011/12

Organisation	Pregnant and NOT IN a clinical risk group**	Pregnant and IN a clinical at risk group**	All pregnant women (combined)**
Hartlepool*	25.2	43.1	26.4
North East	31.4	54.8	33.3
England	-	-	-

*dentes PCT with less than a 100% GP response rate (Hartlepool 93%)
** denotes provisional data

Appendix 1: Current routine child immunisation schedule

When to immunise	What is given	Protection
Two months old	Diphtheria, tetanus, pertussis, polio and haemophilus influenzae type b (DTaP/IPV/Hib) ***1st Dose***	Protects against: diphtheria, tetanus, pertussis (whooping cough), polio and haemophilus influenza (type b)
	Pneumococcal (PVC) ***1st Dose***	Protects against pneumonia, middle ear infection, some forms of septicaemia, pneumococcal meningitis
Three months old	Diphtheria, tetanus, pertussis, polio and haemophilus influenzae type b (DTaP/IPV/Hib) ***2nd Dose***	Protects against: diphtheria, tetanus, pertussis (whooping cough), polio and haemophilus influenza (type b)
	Meningitis C (MenC) ***1st Dose***	Protects against: meningococcal type C, a type of bacteria that can cause meningitis and septicaemia
Four months old	Diphtheria, tetanus, pertussis, polio and haemophilus influenzae type b (DTaP/IPV/Hib) ***3rd Dose***	Protects against: diphtheria, tetanus, pertussis (whooping cough), polio and haemophilus influenza (type b)
	Pneumococcal (PVC) ***2nd Dose***	Protects against pneumonia, middle ear infection, some forms of septicaemia, pneumococcal meningitis
	Meningitis C (MenC) ***2nd Dose***	Protects against: meningococcal type C, a type of bacteria that can cause meningitis and septicaemia
Within a month of the first birthday	Haemophilus influenzae type b, Meningitis C (Hib/MenC) ***Booster Dose***	Protects against: haemophilus influenza (type b) and meningitis C
	Measles, mumps and rubella (MMR) ***1st Dose***	Protects against measles, mumps and rubella
	Pneumococcal (PVC) ***3rd Dose***	Protects against pneumonia, middle ear infection, some forms of septicaemia, pneumococcal meningitis
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio (DTaP/IPV) *Pre school booster dose*	Protects against: diphtheria, tetanus, pertussis (whooping cough) and polio
	Measles, mumps and rubella (MMR) ***2nd Dose***	Protects against measles, mumps and rubella
Girls aged 12 – 13 years	Human Papillomavirus Vaccine (HPV) ***3 injections given at 0, 1.2 months and 6 month intervals***	Protects against the HPV virus which has been shown to cause cervical cancer
Thirteen to 18 years old	Tetanus, diphtheria and polio (Td/IPV) ***Teenager Booster Dose***	Boost protection against tetanus, diphtheria and polio

IMMUNISATION STRATEGY 2011-2012, NHS TEES (draft copy)

Peter Kelly's forward

After clean water immunisation is the most effective public health intervention in the world, saving lives and promoting good health Immunisation plays a critical part in preventing ill health and helping people lead healthier lives etc

1.0 Introduction

Immunisation is generally regarded as one of the most effective and cost- effective public health interventions in modern health care. It is also one of the few direct health interventions that can be quantified and measured. The importance of immunisation has been re-determined recently with the H1N1 pandemic which highlighted the need for worldwide preventative measures to be deployed promptly and safely on a considerable scale. The impact of this programme raises two issues, namely the importance of a sustainable and robust immunisation strategy to enable completion of the programme without detriment to other routine vaccination strategies and the collaboration of partner organisations to enable efficient implementation. Although the NHS is currently facing challenging times and the greatest transition that it has ever experienced, it is essential that we do not loose focus on the delivery of our public health agenda. The public health outcomes framework for England 2013-2016 (DH, 2012) gives reference to population vaccination coverage as a critical indicator to be taken to protect the public's health. Public health England will have a core role in the delivery of these improvements supported by NHS's and local authorities locally. 2012/2013 will be a crucial year in which further developments of the public health outcomes framework will emerge for this purpose although our key actions in this document will remain consistent, this strategy will remain a live and evolving document.

2.0 Background

2.1 Global Background

Around the world immunisation policy and strategy is largely based on the World Health Organisations (WHO) global policies. WHO is responsible for directing and co-ordinating public health policy across the globe and with regard to immunisation, for setting coverage rates and disease elimination targets such as for polio and measles

Global Alliance for Vaccines and Immunisation (GAVI), and the Expanded Programme on Immunisation (EPI), are two such programmes committed to ensuring all children throughout the world are vaccinated against vaccine preventable diseases (VPD). The success of these programmes can be measured in developing countries by the significant drop in mortality rates form VPD from one in four children (30 years ago) to a current level of one in 10 children (to reflect adults).

2.2 National Background

The DH and the JCVI receive advice from a variety of experts on subjects such as epidemiology, mathematical modelling and future predictions of infectious diseases, safety issues, quality control and public opinion. All these factors help to define, inform and develop immunisation policy in the UK . The effectiveness of the policy can be

measured in two ways. Firstly by the numbers of individuals vaccinated and secondly by the reduction in transmission of infectious disease or herd immunity. In September 2009 the National Institute for Health and Clinical Excellence (NICE) published public health guidance 21 'Reducing the difference in the uptake of immunisations', which focused on increasing immunisation uptake among children and young people aged under 19 years in groups and settings where immunisation coverage is low.

The guidance gives 6 clear recommendations to implement under the following headings:
1. Immunisation programmes
2. Information systems
3. Training
4. Contribution of nurseries, schools, FE colleges
5. Targeting groups at risk of not being fully immunised
6. Hepatitis B immunisation for infants

3.0 Local Position
2.3.1 Background
The challenges to achieve national uptake targets around children's immunisations, influenza and pneumococcal for older people, are well recognised in Teesside. Immunisations are also required throughout life to protect from travel and occupational related infections and it is essential that the population of Teesside have access to these, to protect themselves and their families. It is therefore a key responsibility of Tees Primary Care Trust to ensure vaccination programmes are commissioned and delivered in a well-organised and structured manner, in order to maximise the availability and uptake of vaccinations to achieve national targets, developing herd immunity to prevent outbreaks of infection.

The population of Teesside is approximately 550,000. There are four individual PCT`s who historically worked independently. Currently, there is one Tees wide Public Health Directorate served by two community provider services, one north of the river and one south.

The current position is that some of the childhood immunisation uptake rates across Teesside are falling below DH and local vital signs targets, the latter requiring an uptake rate of approximately 95% coverage in childhood immunisations to achieve herd immunity. This increases the risk of child morbidity from a variety of infectious diseases which are preventable through vaccination. Even in areas of good uptake there may be pockets of individuals who are unimmunised or partly immunised and therefore at risk from infectious disease as evidenced by the recent measles outbreak in Hartlepool 2009, shortly followed by the need to respond to the H1N1 Pandemic Vaccination Programme. Local uptake data can be seen in Appendix1. This impacted on our ability to be proactive towards increasing the vaccination uptake. Although various local and national initiatives have been implemented to improve uptake, this remains sporadic and uncoordinated. Additionally, methods of data collection vary across the patch and some discrepancies in data accuracy have been identified.

In May 2010 we were visited by the National Support Team (NST) to provide robust support to help meet national targets and improve our commissioning and delivery systems. The diagnostic visits from the NST to Tees PCT and local partners highlighted the challenges and opportunities of our current delivery system. The recommendations of the NST visit are highlighted briefly in the following 5 categories.

Five Key areas

1. Vision – the need for a systematic approach to immunisation and the development of a multi-disciplinary immunisation strategy and an immunisation action plan.
2. Data – Standardisation of data collection
3. Training – Review workforce requirements to ensure that there is a sustainable and skilled workforce
4. Industrialisation – Identify, evaluate and industrialise good practice across Teesside
5. Communication – Build on existing communication networks

2.3.2 Routine childhood immunisations
Currently all childhood immunisations, with the exception of the school leaver booster and HPV are delivered through GP practice (table 1) and supported by health visiting teams.
Responsibility for childhood immunisation however should not rest solely with the GP or practice nurse. The National Institute for Clinical Excellence (NICE) has produced guidance on "Reducing Differences in the Uptake Rates of Immunisation", which suggests:

- Improving access to immunisation services
- Adopting a multifaceted coordinated programme as part of local child health strategy
- Ensuring vaccination status is monitored as part of a wider assessment of child health
- Engaging and involving the wider population including, children's services, education, and other health professionals.

We recognise that a more flexible approach to vaccination is needed in order to provide a more equitable service across Teesside
Table 1

Age	Diseases Protected Against	Vaccine given	Location given
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib) Pneumococcal infection	DTaP/IPV/Hib and Pneumococcal conjugate vaccine (PCV)	GP Practice
Three months old	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib) Meningitis C (meningococcal group C)	DTaP/IPV/Hib and Men C	GP Practice
Four months old	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib) Meningitis C (meningococcal group C) Pneumococcal infection	DTaP/IPV/Hib and Men C and PCV	GP Practice
12- 13 months	Haemophilus influenza type b (Hib) and meningitis C Measles, mumps and rubella (German measles) Pneumococcal infection	Hib/MenC MMR and PCV	GP Practice
Three years and four months or soon after	Diphtheria, tetanus, pertussis and polio Measles, mumps and rubella	DTaP/IPV or dTaP/IPV and MMR	GP Practice
Girls aged 12 to 13 years	Cervical cancer caused by human papillomavirus types 16 and 18	HPV	School

13 to 18 years old	Tetanus, diphtheria and polio	Td/IPV	School
High risk groups all ages/ over 65 year olds	Influenza, Pneumonia	Influenza Pnuemococcal PPV	GP Practice/ Home visit
All ages	Hepatitis A and B, Rabies, Typhoid, Japanese encephalitis, Yellow fever etc	Travel vaccines	GP Practice/ private clinic

2.3.3 Adult immunisation schedule:
Influenza vaccination
The purpose of the seasonal flu immunisation programme is to offer protection to those who are most at risk of serious illness or death should they develop flu. National uptake targets are in place for influenza vaccine uptake in the over 65year olds and the at risk groups.

Uptake rates are as follows:

- 75% uptake for people aged 65 years and over as recommended by the WHO
- 75% uptake for people under age 65 with clinical conditions which put them more at risk from the effects of flu, and pregnant women, as recommended by the EU

A trajectory target for increases in uptake in clinical risk groups and pregnant women has been outlined as 60% in 2011/12, and 70% in 2012/13, so that an uptake of 75% can be reached or exceeded in 2013/14. As can be seen from the clinical risk uptake data below is somewhat of a challenge.

Transmission of flu health care settings can be significantly reduced by immunisation of health care workers. Uptake of flu vaccine in health care workers in Teesside can be seen below.

Routine vaccination of poultry workers is no longer included in the programme.

Table 2. Seasonal Flu Vaccine Survey (GP) - February 2011 (1 Sep 10 to 28 Feb 11) % uptake rates

PCT	Over 65's	At risk	Pregnant women
Hartlepool	71.80%	52.90%	42.90%
Stockton	72.40%	48.10%	45.60%
Middlesbrough	75.10%	49.80%	35.10%
Redcar & Cleveland	78.10%	54.10%	45.40%

Pnuemococcal vaccination
Polysaccharide pneumococcal vaccine (PPV) is currently offered to all people over the age of 65 years. There is no currently no target for this vaccine and as highlighted in the next section the efficacy of this vaccine is questionable. However, pneumococcal disease is a major cause of morbidity and mortality in the elderly and individual vaccination should still be encouraged.

2.3.4 Changes to the immunisation schedules
Horizon scanning is important in order to prepare for changes in the current immunisation schedules (childhood and adult). Currently the Joint Committee for immunisation and Vaccination (JCVI) are examining evidence and have recommended:

- Changing the delivery of meningitis C vaccine to babies from 2 doses to 1 dose (with 12 month booster) and including an adolescent men C vaccination. Booster doses of other vaccines in adolescence are also being considered.
- Including other age groups 0-6 months and 5years to 18 years into the influenza programme. The impact of these changes on both Primary care and school nursing services could be immense and forward planning is necessary to ensure service delivery. Additionally a planned programme of public information and awareness raising is required as part of our strategy.

Epidemiological evidence has also shown that polysaccharide pneumococcal vaccine (PPV) does not significantly reduce invasive pneumococcal disease in the elderly and although this programme is still in place further considerations of this programme may possibly be made in the future.

Introduction of a herpes zosta vaccine for over 75 year olds is also being considered

2.3.5. Non routine immunisations
Hepatitis B for neonates
Without vaccination up to 90% of babies born to hepatitis B infected mothers will become chronic hepatitis B carriers, which in turn increases their risk of both cirrhosis of the liver and hepatocellular carcinoma in later life. About 25% of those infected in childhood will die from these causes. If these babies are vaccinated, in over 90% of cases, perinatal transmission can be avoided. Successful disease prevention can only be provided if the vaccinations are given according to the schedule.

In the two localities of Teesside (South Tees and North Tees) there are different service models currently employed to follow up babies once discharged from maternity services. Within this strategy we aim to ensure that there is a robust pathway in place to ensure vaccination and follow up of all babies born in Teesside.

Tuberculosis
Over the last 50 years, the demographic pattern of tuberculosis has changed from a disease which affected a wide range of the population to one which now predominately affects certain sub groups of the population with 2/3rds of the cases being born abroad. Due to the declining rates in the indigenous population, in 2005 the schools programme for BCG population was discontinued and replaced with a targeted vaccination programme for at risk groups. Locally the rate of TB diagnosis varies across Teesside.
Rates of TB diagnosis between 2007-2010 (source HPA):
Middlesbrough 17.8 per 100,000
Stockton 4.7 per 100,000
Hartlepool 6.6 per 100,000
Redcar and Cleveland 3.6 per 100,000
The national average is 15.3 per 100,000.

2.3.5 Child health information Systems
The implementation of child health information and reporting systems across Tees is currently very different in the South of Tees and North of Tees PCT areas.

In the two South of Tees PCT areas a single Child Health Information System (CHIS) records a comprehensive range of data relating to all children for whom the two South of Tees PCTs have responsibility. This single CHIS is managed by the Middlesbrough,

Redcar and Cleveland Community Services Child Health Records Department (MRCCS CHRD). Amongst other things the South of Tees CHIS provides lists of children in need of immunisation to all GP practices across the two South of Tees PCT areas. South of Tees GP practices return details of the childhood immunisations they have completed to the MRCCS CHRD so that the South of Tees CHIS can be kept up-to-date. In addition the MRCCS CHRD currently compiles the quarterly COVER reports for the two South of Tees PCT areas.

In the two North of Tees PCT areas, two different CHISs are in operation, one for each North of Tees PCT area. The range of data held within these CHISs is currently not as comprehensive as that held by the South of Tees CHIS. Neither of the North of Tees CHISs currently sends lists of children needing immunisation to the GP practices. The compilation and reporting of quarterly COVER data is carried out by the Tees PCTs Primary Care Informatics team (Tees PCI) which forms part of the Tees Directorate of Strategic Intelligence. Put simply, there are actually three different kinds of system in operation within the North of Tees PCT areas.
What has become apparent during the course of an evaluation exercise is that none of the child health information and reporting systems currently in operation across Tees is without fault or fully serves the needs of those that it endeavours to serve.

4.0 The Vision, aims and objectives

Our vision is that people of Teesside live longer, "healthier lives". Through this strategy we aim to fully protect people of Teesside against vaccine preventable diseases. We will strive to provide flexible vaccine programmes that will reflect the evolving needs of the population of Teesside.

It will also ensure that services deliver equitable immunisation programmes by being flexible to meet the needs of local communities. Utilisation of evidence from uptake data, horizon scanning to identify trends in population demographics and identifying new vaccine developments is important in informing developments to enable workforce and service delivery planning.

4.1 The aims of this strategy are:

- Reduce the risk of vaccine preventable disease by maximizing the uptake of vaccinations
- To achieve herd immunity in the Teesside population
- To ensure that immunisation services are equitable and accessible to all
- To provide high quality, standardised immunisation services through effective commissioning

4.2 The objectives of this strategy are:

Based on the 2009 NICE guidelines and aim to work in partnership with all key stakeholders across Tees to using a bottom up approach to develop an inclusive strategy which reflects that immunisation is every bodies business.

- **Immunisation programmes**. To provide a multifaceted, coordinated approach to immunisation programmes, improving access to services and providing tailored information and support.

- **Information systems**. Ensure NHS Tees child information systems are up to date reconciled and consistent.
- **Training**. Ensure that all staff who give and/or advice on immunisations are adequately trained in line with national minimum standards and competent to deliver this service.
- **Contribution of nurseries, schools, FE colleges.** Work in partnership with other organizations to promote and deliver immunisation programmes**.**
- **Targeting groups at risk of not being fully immunised**. Ensure immunisation services are accessible to all to address health inequalities and high risk groups are targeted appropriately.
- **Hepatitis B and BCG immunisation for neonates.** Develop a targeted and coordinated programme for neonates across acute and community settings.
- **Seasonal Influenza and Pneumococcal.** Increase uptake rates to reflect the DH trajectory over the next 3 years.
- **Other immunisation programmes:** Ensure HPV and BCG programmes are running effectively
- **Communication.** Develop an internal and external communication plan, paying particular attention to community engagement and a social marketing initiatives
- **Horizon scanning** to identify risks and trends in population demographics, and identify new vaccine developments to enable workforce and service delivery planning.

5.0 Progress and challenges

5.1 What progress have we made?

- ❖ We have an established immunisation strategy group
- ❖ We have established a governance structure for immunisation committees and sub groups
- ❖ We have previously developed some effective partnership working with local authorities during a recent measles outbreak and pandemic flu response.
- ❖ We have begun to develop links with the local Be Healthy groups, enabling us to share data and explore ways to improve immunisation uptake.
- ❖ We have established a hepatitis B stakeholder group and action plan for Teesside

5.2 What are the challenges?

- Maintaining focus throughout the current transitional phase and changes in the organisational and contractual delivery of health care services.
- Securing funding to support new initiatives
- Confusion regarding responsibility and accountability in delivering vaccine programmes
- PCT vital signs targets are higher than those of the services providers e.g. GPs
- Targets vary across the four PCT 's.
- Immunisation services do not offer patient choice or flexibility Clinic times and capacity not able to meet the demand for vaccination services not accessible due to demands of working hours.
- Securing funding for new initiatives

6.0 Performance management

In order to ensure the effectiveness of the strategy, continual monitoring of the uptake rates and performance of service providers is required.
This strategy will focus on commissioning high quality services to enable us to maximise uptake by achieving our objectives, focusing on raising awareness of the importance of immunisation across the community and ensuring that Teesside has a trained and skilled workforce to deliver immunisation programmes with the knowledge to inform families.

NHS Tees is committed to ensuring the population it serves is protected from vaccine preventable diseases and the following section of this strategy describes the outcomes and actions required to meet the objectives of this strategy, to ensure that vaccine preventable diseases are prevented by maximising uptake. These actions will be incorporated in commissioned contracts

- Continual monitoring of immunisation uptake at practice level and population level will ensure that areas of poor uptake are identified at an early stage and enable staff responsible for delivery to be alerted and actions to be put in place to improve uptake in a more pro-active response.
- Continual monitoring of performance against contracts as described within the Strategy will indicate progress and provide an early warning of a drop in uptake of immunisations.
- We can be assured that this strategy has been successful when we are reaching national targets equitably across Teesside. This will ensure that we do not have vulnerable groups of unvaccinated people in Teesside. The Immunisation Strategy Group will be responsible for monitoring the strategy and immunisation uptake and developing action plans to ensure that uptake continuously improves and is maintained across Teesside.

7.0 Governance

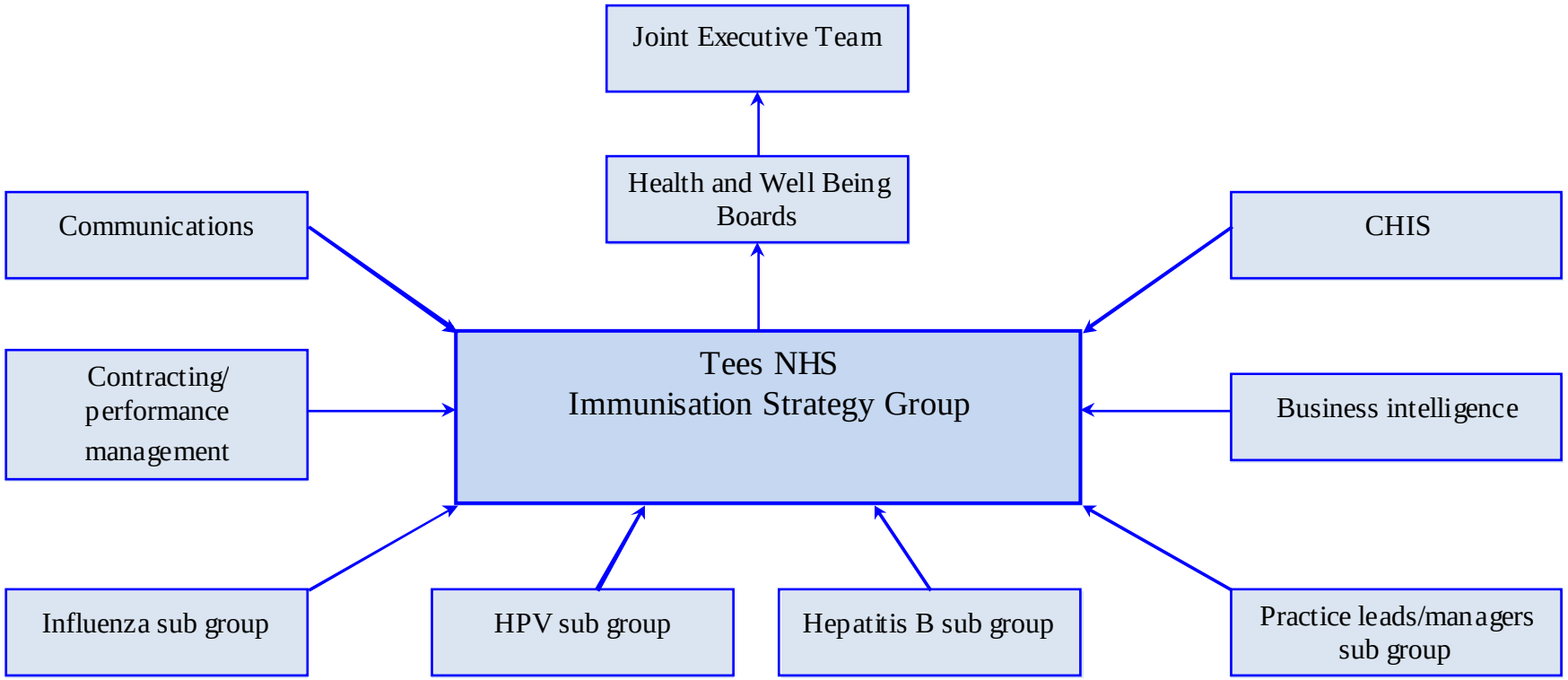
A number of groups will be responsible for the implementation and performance monitoring of the strategy. The public health contracts manager in collaboration with relevant contracting authorities provides overall co-ordination and support of the commissioning process.

The Immunisation Strategy will be implemented through the Immunisation Strategy Group.

Significant events involving vaccination will be reported according to PCT policy to ensure that lessons are learned from aspects of good and poor practice.

The NHS Tees Immunisation Strategy Group is responsible for:
_ Monitoring the strategy.
_ Developing and implementing the action plan.
_ Monitoring immunisation uptake.
_ Providing quarterly updates to health & wellbeing boards

Tees NHS Immunisation Strategy Governance Structure



8.0 Cost of implementing the strategy
It is anticipated that the majority of objectives in this strategy can be delivered through contracted services that are already in place with appropriate funding and therefore is cost neutral.

Changes in the National Immunisation Programme and additional campaigns attract new monies from the DH, which will be used to commission the delivery of the additional services and provide training where necessary.

Over the life of the strategy resources may need to be re-distributed depending on service development and cost implications against any current DES or LES will occur as uptake across all immunisations needs to increase to meet national targets.
Additional resources may be required for:

- Working more closely with schools and colleges
- Providing training where appropriate
- Reconciling child health information systems and GP practice records to ensure consistency.
- Ensuring accurate transfer of immunisation information between providers and between services
- and systems.
- Undertaking audit and quality assurance of immunisation records.
- Providing Outreach programmes for children from traveler, or new immigrant families.
- Providing home visits to parents who do not bring their children to attend immunisation appointments.
- Developing media campaigns
- Developing social marketing initiatives
- Developing immunisation awareness campaigns.

NHS Tees Action plans

9.0 Action plans :Are rated:
Priority 1 – to be completed in 12 months
Priority 2 – to be commenced within 12 months
Priority 3 - ongoing

Objective 1: Immunisation programmes

	Objective	Action	Priority	Progress	Who should take action
1.1	Develop a robust strategy group to monitor and deliver on the proposed action plans	Widen membership of strategy group to include Commissioners, managers and coordinators (PCTs), children's services, Sure Start children's centres and services for vulnerable groups, Health professionals responsible for children and young people's immunisation services e.g. paediatricians, health visiting and school nursing teams, GPs	P1	Group Established Dec11	Toks NC JL RF
1.2	Ensure there is an identified healthcare professional in the PCT and every GP practice who is responsible – and provides leadership – for the local childhood immunisation programme	Contact Practice leads to establish a Practice leads sub group. Attend practice manager/nurse forums Work with the Practices to ensure leaders are identified and trained to take responsibility for immunisations and are aware of national and local guidelines. Work with Practice leads and practice managers and Health Visitors to address immunisation issues in Practice Work with Practices on the Vaccine Efficiency Savings Programme Audit (VESPA) Work with school nurses/health visitors to establish a seamless service in the community	P 1 P1 P1 P1	Employed extra PH nurse to work with Practices. Practices contacted regarding VNN and VESPA.	Public Health/ Primary Care Public health, Practice leads, Practice managers, medicines management

	Objective	Action	Priority	Progress	Who should take action
1.4	Improve access to immunisation services.	Work with practices on encouraging flexibility of immunisations appointments for parents/carers i.e extending clinic times, ensuring children and young people are seen promptly and by making sure clinics are child- and family-friendly.	P1	As above	Public health, Practice leads, Practice managers,
		Work with primary care contracting on current requirements within GP contracts and how to use targets for payments.		Regional DES in place	Public health/ Community services,/ NEPCSA/Contracting/CCG
		Work with local authority to establish and develop new services to capture "difficult to reach" patients "Pilot" community engagement model to improve immunisation uptake.	P1	Difficulties in data sharing has placed this programme temporarily on hold. Currently exploring possibility of making changes to Red Book to enable data sharing.	PH/Service providers/contracting local authority
1.5	Ensure Equitable immunisation programmes are delivered through flexible services to meet the needs of local communities.	Establish the requirements of both DES and LES contracts and formalise the process of renewal	P 1	Working with Contracting department and PCSA	PH/Contacting
		Contracts and Service level agreements will be reviewed to reflect changes in local and national targets. Performance will be managed and uptake data fed back to providers at quarterly meeting	P 1		Contracting/PH

	Services will be planned taking into consideration the reasons for poor vaccine uptake,	Ensure Immunisation targets to are consistent across all four PCT's	P 2		PH/ PH
1.7	Ensure there are enough immunisation appointments available so that all young people and children can receive immunisations in a timely manner	Investigate with CHIS if this is a problem in Teesside	P2		PHF/PH/CHIS
1.8	Ensure young people and parents know how to access immunisation services and information.	Review content of GP contracts and service specifications include: _ Providing patients with tailored information, advice and support on the vaccinations and immunisation including the benefits and risks. _ Ensuring patients have the opportunity to discuss any concerns they might have about immunisations.	P2		PH/CCG/Practices/Comms

Objective 2: Information systems

	Objective	Action	Priority	Progress	Who should take action
2.1	Ensure PCTs and GP practices have a structured, systematic method for recording, maintaining and transferring accurate information on the vaccination status of all children and young people.	Set up sub group (CHIS working group)to look at the problems associated with information recording and dissemination	P1	Group formed April 2011	PH/CHIS/ PCI
		Meet with Practice Managers to discuss any concerns with CHIS	P1	Agreement from North Tees Practice Managers	
		Establish one centralised repository of data across North Tees.	P1	Specification developed for North Tees Foundation Agreement from LMC Dec11	PH/CHIS/ PCI PH/CHIS/ PCI
		Meet with Stockton and Hartlepool CCGs to secure agreement to proposal to merge CHIS across Teesside.	P1	Awaiting final signatures to contract	PH/CHIS/ PCI
	Monitor vaccination status as part of a wider assessment of children	Ensure data collection systems are in place to allow accurate reporting to GP and CHD.	P1		PH/CHIS/ PCI

	and young people's health	:			
2.2	Record any factors which may make it less likely that a child or young person will be up-to-date with vaccinations in their patient records and the personal child health record.	Investigate current practices and work with service providers to establish data sets.	P2		PH/Practices
2.3	Ensure up-to-date information on vaccination coverage is available and disseminated to all those responsible for the immunisation of children and young people.	Work with service providers to establish communication links through CHIS working group Gather information for practices and Public health on prospective numbers of children requiring information per quarter	P2		PCI PCI/CHIS

Objective 3: Training

	Objective	Action	Priority	RAG rating/progress	Who should take action
3.1	Ensure all staff involved in immunisation services are appropriately trained and updated regularly	Ensure service specification includes mandatory training requirement.	P2	Training commissioned for RN's HCW's, Midwives, Surestart workers	PH
		Plan for provision of professional training from April 2012	P2		PH
		Develop tier 2 and 3 training to deliver to all agencies in contact with families and young people	P2		PH
3.2	Ensure training complies with national minimum standards	Investigate sources of appropriate training and obtain tenders	P1	Completed	PH

Objective 4: Contribution of nurseries, school, colleges of further education

	Objective	Action	Priority	Progress	Who should take action
4.1	Work with nurseries and schools to support immunization programmes.	Monitor practice of schools monitoring of vaccination status on school admission Engage with school nurses regarding immunisation uptake rates Formalise processes for feedback on coverage to CCGS/Scrutiny Panel/Children's Services	P1 P1 P1 P1	Awareness training for Surestart workers	PH School nurses
4.2	Work with community nurses to ensure systematic and consistent messages are delivered to parents	_ Establish links with local children centre leads. _ Ensure early years establishments have up to date information on immunisations. _ offer training to staff to advise young people and their parents about the vaccinations recommended at secondary school age and provide information in an appropriate format. Children's Services will be commissioned to	P1 P1 P1 P1		PH school nurses

		ensure immunisations are promoted at every possible opportunity including school education programmes Ensure that promotion of childhood immunisation is included in childhood specification	P1		

Objective 5 :Targeting groups at risk of not being fully immunised

	Objective	Action	Priority	Progress	Who should take action
5.1	Improve access to immunisation services for those with transport, language or communication difficulties, and those with physical or learning disabilities.	Audit in Practice what information is provided in different formats, for example, for those whose first language is not English Collate local data and analyse validity in order to assess as to whether specific population sub groups have low or high immunisation uptake rates. Utilise findings to commissioning services to increase access to areas or individuals with low immunisation uptake. Commissioned services will establish the reasons why children have failed to attend two or more appointments by contacting the parents or guardians and feed this information back to the Child Health department and will take action as far as possible to ensure that children who have failed to attend to appointments are immunised.	P2 P1 P1 P1	Working with practices to establish any problems	

		Work with local authority to establish and develop new services to capture "difficult to reach" patients "Pilot" community engagement model to improve immunization uptake.		Difficulties in data sharing has placed this programme temporarily on hold. Currently exploring possibility of making changes to Red Book to enable data sharing.	
5.2	Ensure Prison health services should check the immunisation history of all offenders	Establish links with prison nurses to determine current service and uptake for immunisation in this group Work with Offender Health on audit of local resources within prisons for immunisation	P2		
5.5	Ensure the immunisation status of looked after children is checked during their initial health assessment, annual review health assessment other statutory reviews.	Establish links with LAC nurses to determine current service and uptake for immunisation in this group	P1		

Objective 6:Hepatitis B immunisation for infants

	Objective	Action	Priority	Progress	Who should take action
6.1	Implement DH recommendations on hepatitis follow up for babies born to hepatitis B positive mothers (see sub group action plan)	Identifiy person responsible for coordinating the local Hepatitis B vaccination programme for babies. Establish a working group of stakeholders to implement the regional NESHA hepatitis B framework for the screening and vaccination of infants. Group to feed back to Immunisation strategy group 3 monthly. Develop an local action plan to implement necessary processes to achieve a robust and continuous service across Teesside Develop community follow up for neonatal hepatitis B Monitor programme and quality assurance in terms of patient safety and service delivery	P1 P1 P1 P1	In place Established Dec 11 Developed Dec 2011 Action plan in place LES developed for GP follow up to be discussed at the LMC	PH, maternity services, Acute services, community services, CCG's
6.2					

Objective 7: Seasonal influenza and pneumococcal uptake rates

	Objective	Action	Priority	Progress	Who should take action
7.1	Increase the awareness of the importance of increasing flu vaccine uptake amongst service providers	Provide feed back to Practices on uptake rates. Continue to identify practices with low uptake and work with practices to highlight areas of improvement Contact practice with good uptake to assess good practice Continue to ensure all service providers are trained and up to date with the relevant information on influenza Work with midwives to increase awareness of the importance of flu vaccine for pregnant women	P1 P1 P1 P1 P1	Steering group established Practices with lowest uptake in the at risk groups established and Commenced working with Work with individual practices Training for midwives- discussions in progress Establishing extent of GP's providing vaccination to care homes Establishing the extent of vaccination among health a social care workers	PCI & PH
7.2	Increase the awareness of the importance of increasing flu vaccine uptake amongst the public and at risk groups	Identify groups with low vaccine uptake and work with Communications department to produce information for the public highlighting the importance of flu vaccine for these groups	P1		Comms/PH
7.3	Increase uptake of flu	Increase awareness of the benefits of flu vaccine			

	vaccine amongst health care w orkers	both for the HCW and their patients	P1		Comms/PH
7.4	Ensure opportunistic pneumococcal vaccination is undertaken by service providers	Explore w ith practices w hat methods could be employed to improve pneumococcal uptake	P2		PH/commiss ioned providers

Objective 8: Other immunisation programmes: Ensure HPV and BCG programmes are running effectively

	Objective	**Action**	**Priority**	**RAG rating/progress**	**Who should take action**
8.1	HPV-Ensure service provider contracts are up to date and fit for purpose	Re establish HPV sub group to initiate communication on 2011/12 contract	Priority 1	Commenced Jan 2012	PH
8.2	HPV-Ensure systems are in place for up load of current data to open Exeter	To be included in the 2011/12 contract	Priority 1	In progess	
8.3	HPV- Ensure systems are in place for up load of retrospective data to open Exeter	Investigate other PCT areas methods of up loading data	Priority 1	Commenced up loading data	
8.4	HPV-Ensure seamless transition from use of cervarix to Gardasil in September 2012	Re establish HPV sub group meetings to determine current training needs.	Priority 2		
8.5	BCG- establish current contract arrangements	Develop links w ith acute respiratory teams	Priority 2		

Objective 9: Develop an internal and external communication plan, paying particular attention to community engagement and a social marketing initiatives

	Objective	Action	Priority	RAG rating/progress	Lead
9.1	Improve communication around current immunisation programmes with health professionals within primary care, acute trusts and community settings.	The Immunisation Co-ordinator and public health team will work with the communications department and partners to promote immunisations through various community groups at a local level.	P2		
9.2	Improve communication around current immunisation programmes with the public.	Engage with relevant community and voluntary services and the general public to enhance knowledge and understanding of immunisation.	P2		
9.3	Engage communities in the development or change to current immunization programmes through social marketing initiatives	Engage with relevant community and voluntary services and the general public to enhance knowledge and understanding of immunisation. Work to publicise immunisation issues through media events and campaigns.	P2		

Objective 10: Horizon scanning to identify risks and trends in population demographics, and identify new vaccine developments to enable workforce and service delivery planning.

	Objective	Action	Priority	RAG rating/progress	Who should take action
10.1	Ensure Service providers are aware of possible future changes to immunisation schedules and capacity issues	Keep abreast of JCVI meetings and current research into possible need for booster vaccinations in specific age groups Develop links with the Health Protection Agency to update on local and national infectious disease issues.	P3 P3	Ongoing	PH
10.2	Ensure public are given appropriate information and awareness on new emerging vaccines and vaccine programmes	Engage with relevant community and voluntary services and the general public to enhance knowledge and understanding of immunisation. Work to publicise immunisation issues through media events and campaigns.	P3		
10.3					

References

Department of Health 2006 Immunisation against infectious disease D Salisbury, M Ramsay, K Noakes
Department of Health 2005 Vaccination services: Reducing inequalities in uptake
Department of Health 2004 Choosing Health: Making healthy choices easier
Department of Health 2005 Vaccination services reducing inequalities in uptake
Department of Health 2008 Operational Plans2008/09 - 2010/11, (Implementing the 2008/09 Operating Framework) National Planning Guidance and "vital signs"
Joint Committee for Immunisation and vaccination (JCVI) http://www.dh.gov.uk/ab/JCVI/index.htm

Appendix 1. Local Cover data 2010/11

12 month cohort

		DTaP / IPV / HiB	Men C	PCV
Eligible	*n*	12,243	12,243	12,243
Immunised	*n*	11,527	11,449	11,469
	%	94.2%	93.5%	93.7%

24 month cohort

		DTaP / IPV / HiB	MMR	Men C	HiB / Men C	PCV
Eligible	*n*	11,998	11,998	11,998	11,998	11,998
Immunised	*n*	11,545	10,705	11,521	11,025	11,154
	%	96.2%	89.2%	96.0%	91.9%	93.0%

5 year cohort

		DT / Pol	Pertussis	HiB	MMR	Men C	PCV
		Primary	*Primary*	*Infant*	*1st dose*	*Infant*	*Infant*
Eligible	*n*	11,719	11,719	11,719	11,719	11,719	
Immunised	*n*	11,326	11,334	11,300	11,145	11,304	
	%	96.6%	96.7%	96.4%	95.1%	96.5%	

		DTaP / IPV	HiB / Men C	MMR	PCV
		Booster	*Booster*	*2nd dose*	*Booster*
Eligible	*n*	11,719	4,952	11,719	4,952
Immunised	*n*	10,632	3,636	10,485	3,954
	%	90.7%	73.4%	89.5%	79.8%
			*		*

** Due to scheduling parameters, data for Hib/Men C and PCV for the 5 year cohorts was only collected for the last 2 quarters*

HEALTH SCRUTINY FORUM

10 January 2013

Report of: Scrutiny Support Officer

Subject: SCRUTINY INVESTIGATION INTO THE JSNA TOPIC OF 'SEXUAL HEALTH' – EVIDENCE FROM LOCAL SCHOOLS, COMMUNITY AND VOLUNTARY GROUPS AND YOUTH GROUPS - COVERING REPORT

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1. PURPOSE OF REPORT

1.1 To inform Members that representatives from the Public Health Team, Local Schools, Voluntary and Community Sector Groups and Youth Groups have been invited to attend this meeting to provide information in relation to the investigation into the JSNA topic of Sexual Health.

2. BACKGROUND INFORMATION

2.1 Members will recall that at the meeting of this Forum on 23 August 2012, Members agreed the Scope and Terms of Reference for their investigation into the JSNA topic of Sexual Health.

2.2 Subsequently, the following representatives have been invited to attend this meeting:-

(a) Voluntary and Community Sector Groups and Youth Groups to provide evidence on the services available and access to the services;

(b) Representatives from local schools to provide evidence on sex and relationships education in schools and its impact / effectiveness.

2.3 During this evidence gathering session with the representatives detailed in paragraph 2.2 the following JSNA questions in relation to the topic of Sexual Health will be covered:-

(a) What services are currently provided?

(b) What do people say?

(c) Evidence for effective intervention?

2.4 The complete JSNA entry for Sexual Health is attached as **Appendix A** to this report for Members information.

2.5 The Health Scrutiny Forum at their meeting of 29 November 2012 received information from the Young Inspectors which detailed their findings and recommendations following their inspection of the sexual health service at the One Life Centre. Members requested feedback on the implementation of the recommendations. The feedback is attached as **Appendix B** to this report.

2.6 During this evidence gathering session, Members should be mindful of the Marmot principle 'Strengthen the role and impact of ill health prevention'.

3. RECOMMENDATION

3.1 That Members of the Forum consider the evidence from the representatives in attendance at today's meeting, seeking clarification on any relevant issues where required.

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BACKGROUND PAPERS

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

(i) Report of the Scrutiny Support Officer entitled 'Scrutiny Investigation into Sexual Health – Scoping Report' presented to the Health Scrutiny Forum on 23 August 2012

(ii) Report of the Scrutiny Support Officer entitled 'Scrutiny Investigation into the JSNA Topic of Sexual Health – Evidence from the Portfolio Holder for Adult and Public Health Services and the Young Inspectors' presented to the Health Scrutiny Forum on 29 November 2012

(iii) Report of the Young Inspectors – One Life Centre (Sexual Health) presented to the Health Scrutiny Forum on 29 November 2012

(iv) Presentation by the Young Inspectors entitled 'One Life Centre (Sexual Health) presented to the Health Scrutiny Forum on 29 November 2012

(v) Minutes of the Health Scrutiny Forum held on 29 November 2012

Hartlepool JSNA - Behaviour and Lifestyle - Sexual health

Sexual health is an important element of physical and mental health. Good sexual health requires relationships to be safe and equitable, with ready access to high quality information and services that reduce the risk of unintended pregnancy, illness or disease. Sexual health is influenced by a range of factors including sexual behaviour, attitudes and societal factors, quality of Sex and Relationship Education (SRE), as well as biological risk and genetic predisposition.

Sexual health in the UK has deteriorated significantly over the last decade, with increases in many sexually transmitted infections (STIs) including human immunodeficiency virus (HIV). It is important that STIs and HIV are prevented or treated early, to avoid long-term complications and risk of transmission to others.

Deprivation, social exclusion and sexual health are inextricably linked. The National Strategy for Sexual Health and HIV acknowledges the relationship between sexual ill-health, poverty, social exclusion, and the disproportionate burden of HIV infection on gay and bisexual men and some BME groups (Department of Health, 2008)

A national Sexual Health Strategy is under development and will set out the vision for sexual health services.

This topic is most closely linked to:

- Children
- Transition Years
- Sexual Violence Victims
- Alcohol misuse
- Education
- Poverty
- Migrants

1. What are the key issues?

- Teenage pregnancy rates in Hartlepool are higher than England. There is a high rate of conceptions for girls aged under 16 years.
- Some sexually transmitted infection (STI) rates are high and/or increasing, particularly gonorrhoea and syphilis.

- The diagnosed HIV prevalence in Hartlepool is the fifth lowest in the North East. Significant numbers of HIV cases remain undiagnosed.
- There is inconsistency in the provision of dedicated young people's sexual services, particularly those linked to educational establishments and in electoral wards with the highest teenage pregnancy rates. Services that support teenage fathers are sub-optimal.
- Uptake of long-acting reversible contraception (LARC) is low.
- There are inequalities in the promotion of sexual health, caused by discrimination, stigmatisation and barriers to information. Current provision may not be aligned with need.
- Routes along the pregnancy termination pathway are not consistent. For example, post-termination contraception is not always delivered appropriately.

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2. What commissioning priorities are recommended?

2012/01
Reduce under 18 conceptions by maintaining efforts to reduce teenage pregnancy in the context of work to reduce child poverty and health inequalities and focusing targeted interventions in specific areas where there are high levels of teenage pregnancy.

2012/02
Reduce sexually transmitted infections by increasing testing in high risk groups and maximising service contacts. Increase chlamydia testing coverage and diagnosis by focusing on the National Chlamydia Screening Programme key messages and use of the commissioning toolkit.

2012/03
Increase uptake of HIV testing and reduce late HIV diagnosis by exploring the merits, acceptability and cost-effectiveness of setting up specific community-based HIV testing sites targeted at the Black African population and men who have sex with men.

2012/04
Ensure young people have access to sexual health services by making certain that services are delivered in accordance with service standards and are appropriate and accessible to all, including provision and access for young people. Improve the quality and opportunities for sex and relationship and risk-taking behaviour education in schools and other settings.

2012/05
Increase long-acting reversible contraception (LARC) provision and ensure the workforce is trained to offer and provide LARC.

2012/06
Make sure that service provision is in line with need by combatting discrimination and stigmatisation and reducing barriers to access sexual health information.

2012/07 Ensure termination of pregnancy services are available to all and that post-termination support and contraception advice are delivered.

Additional information and data to support this topic can be found in the Appendices.

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3. Who is at risk and why?

There is a clear relationship between sexual ill health, poverty and social exclusion (DH, 2008). Groups most at risk of poor sexual health who may experience barriers to accessing services include: women; young people; asylum seekers and refugees; black and minority ethnic groups; single homeless people; gay and bisexual men; sex workers; looked after young people; injecting drug users; people with learning difficulties; people in prisons and youth offending institutions; and young people not in education, training or employment.

Age

General population aged 35 years and over

In the general population, when long-term relationships end, there is some evidence to suggest individuals lack awareness of sexual health issues and there is a low rate of condom use (Family Planning Association).

Young people

Teenage conceptions in the UK are amongst the highest in western Europe (DFES, 2006).

The 16-24 years old age group is the most at risk of being diagnosed with a sexually transmitted infection and accounts for:

- 65% of all chlamydia
- 50% of genital warts
- 50% of gonorrhoea.

In 2007, 11% of all new HIV diagnoses were in young people. Young men who have sex with men remain the group of young people most at risk of acquiring HIV in the UK.

Over one-third of teenage mothers have no qualifications and only 33% are in education, employment or training, compared to 90% of all 16-19 year olds. Teenage parents and their children are more likely to experience poorer outcomes in comparison to older mothers and their children, including:

- higher rates of infant mortality;
- increased risk of low birth weight which affects the child's long-term health;
- poor emotional health and wellbeing experienced by teenage mothers;
- increased risk of living in poverty.

Gender

Young men who have sex with men are the group most at risk of acquiring HIV in the UK.

Human papilloma virus (HPV) is one of the most common sexually transmitted infections. It is the main cause of cervical cancer.

Socioeconomic Status
Measures such as income, employment, benefits and the index of multiple deprivation are closely correlated with teenage pregnancy rates.

The risk of becoming a teenage mother is ten times higher among girls in social class five (unskilled occupations) families compared with social class one (professional occupations) families (ONS, 1998).

Ethnicity
In England, the diagnosed prevalence of HIV was 3.7% among black Africans, nearly 10 times higher than among black Caribbean populations (0.4%) and over 40 times the rate found in the white population (0.09%) (HPA, 2008).

Risks associated with poor sexual health
The consequences of poor sexual health include:

- pelvic inflammatory disease, which can cause ectopic pregnancies and infertility;
- cervical and other genital cancers;
- hepatitis, chronic liver disease and liver cancer;
- premature delivery of the newborn and still births;
- unintended pregnancies and abortions;
- psychological consequences of sexual coercion and abuse;
- poor educational, social and economic outcomes for teenage mothers and their children;
- reduced life expectancy.

Sexual behaviour is a major determinant of sexual and reproductive health. Certain behaviours are associated with increased transmission of STI and HIV, including age at first sexual intercourse and number of lifetime partners, concurrent partnership, payment for sex, and alcohol and substance misuse.

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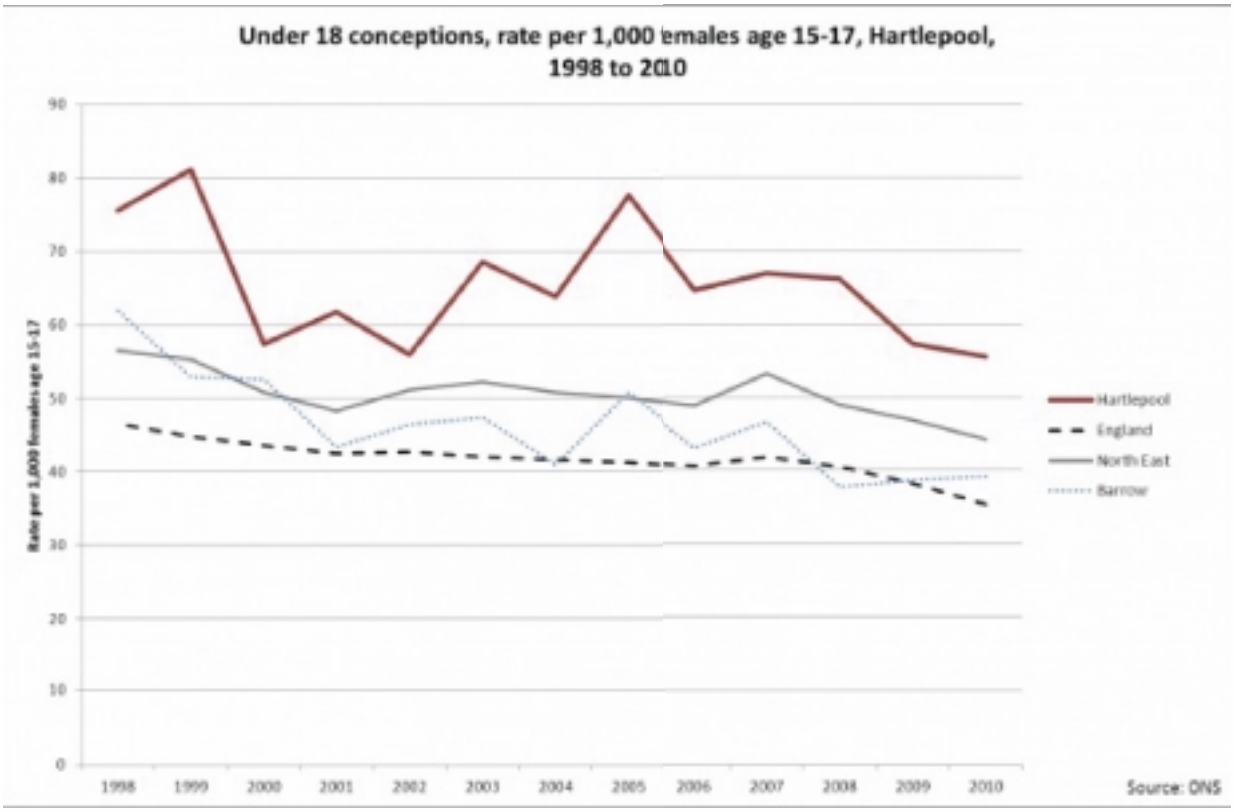
4. What is the level of need in the population?

Under 18 conceptions
The rate of conceptions aged under 18 years in 2010 was 55.5 per 1,000 females (aged 15-17). This was higher than the rate of 35.4 per 1,000 in England. This is down from 57.3 in 2009 and 66.1 in 2008.

Average conception rates have fluctuated between 1998 and 2010. The overall trend shows a slowly declining rate over this time period. Increases or decreases observed in quarterly and annual published data need to be considered in the context of the trend data and not in isolation.

It is useful to compare Hartlepool with an area outside of Teesside that has similar characteristics (the next least deprived area that is in the same ONS cluster) but different commissioning and service provision arrangements (see Appendices for more details). Since 2003, rates have been higher than those observed in Barrow-in-Furness. Rates in Barrow are falling faster than Hartlepool, thus widening the gap. As a comparable area to Hartlepool, it could be useful to understand what interventions are in place in Barrow.



Under 18 conceptions, number and rate per 1,000 females age 15-17, Hartlepool													
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Number	134	146	108	120	110	134	126	149	126	129	126	106	100
Rate	75.6	81.2	57.4	61.8	56.0	68.6	63.9	77.6	64.6	66.9	66.1	57.3	55.5
Source: ONS													

In Hartlepool there is a strong correlation between teenage pregnancy and the level of deprivation. An analysis of under-18 conception rates at a ward level demonstrates that the more deprived the area, the higher the number of under-18 conceptions (see Appendices).

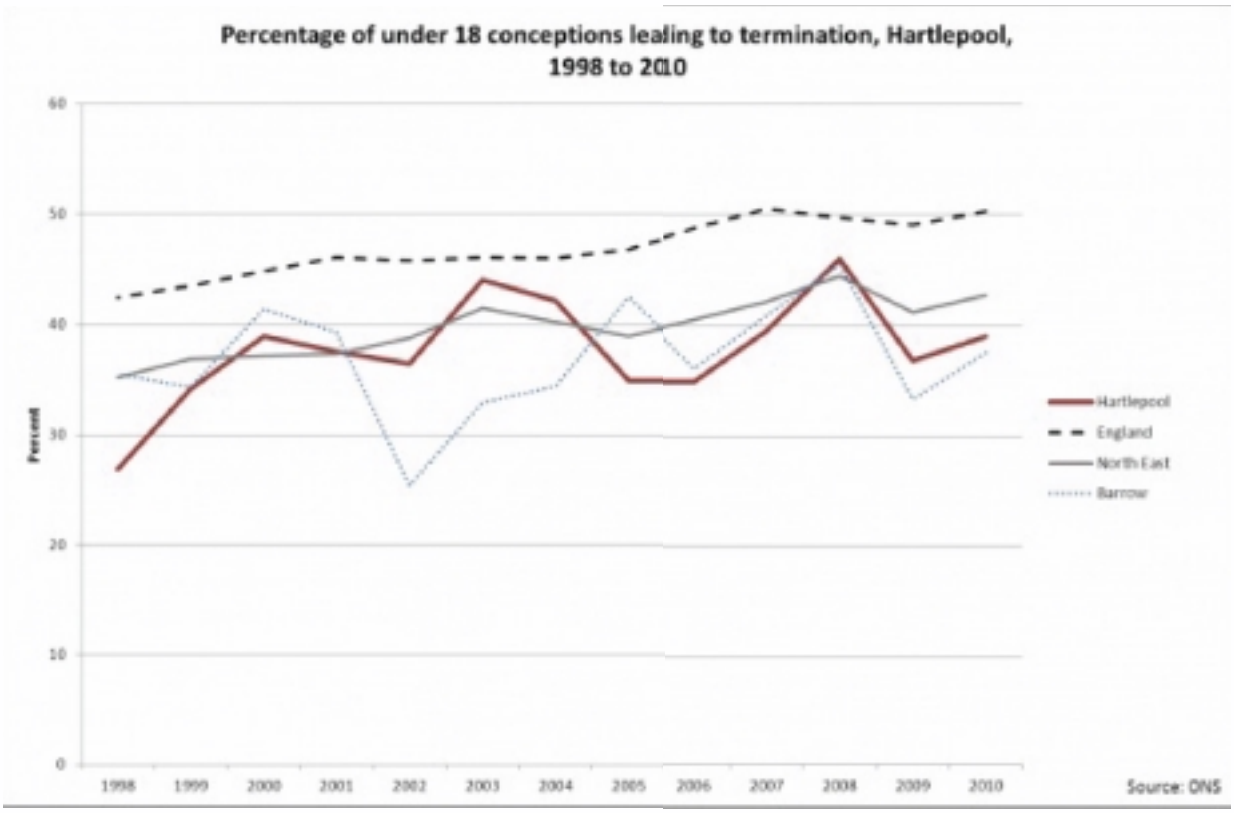
Under 16 conceptions

The Hartlepool under 16 conception rate for 2008-10 was 11.2 per 1,000 (60 conceptions; on average 20 per year). The North East rate was 10.1 and England was 7.4 per 1,000. In comparison the Hartlepool under 16 conception rate for 2005-07 was 13.3 per 1,000 (76 conceptions). The proportion of under 16 conceptions that led to a termination in 2008-10

was 60% (England 61.6%) compared to 61% in 2005-07.

Under 18 terminations

Hartlepool has a lower rate of terminations than England for all years between 1998 and 2010. This pattern may be due to the services available and models of service provision; the alternative options presented; and/or cultural factors (for example, the acceptability of termination and whether it was a planned pregnancy).



Local hospital data is now being used to monitor births and terminations for females aged under 18. Combining births and terminations provides an estimate of conceptions. This more timely monitoring will be important for monitoring numbers, but does not take account of variation in the number of females ages 15-17. It tends to over-estimate official ONS data.

Under 18 live births and terminations, Hartlepool, 2005 to 2010

Year	Births	Terminations	Total	ONS conceptions
2005	106	68	**174**	149
2006	101	63	**164**	126
2007	77	57	**134**	129
2008	77	53	**130**	126

2009	74	45	**119**	106
2010	61	35	**96**	100
Total	496	321	817	736
				Source: NHS Tees

Sexually Transmitted Infections (STIs)

Monitoring of all main acute STIs is carried out by the Health Protection Agency (HPA). The following STIs have epidemiological significance, serious clinical impact and policy importance:

- Total acute STIs
- Chlamydia
- Syphilis
- HIV/AIDS
- Gonorrhoea

Overall acute STI diagnoses
In 2010, overall acute STI rates in Hartlepool were the highest in Tees but lower than the North East and England. The high rate seems to be mainly driven by relatively high chlamydia rates in 15-24 year olds, herpes and (to an extent) warts rates.

- the syphilis rate is the lowest of all Tees localities and lower than the North East and England;
- the herpes rates is the highest in Tees and higher than North East rates but below England rates;
- the warts rate is lower than in Stockton and the North East but higher than the rest of Tees and England.

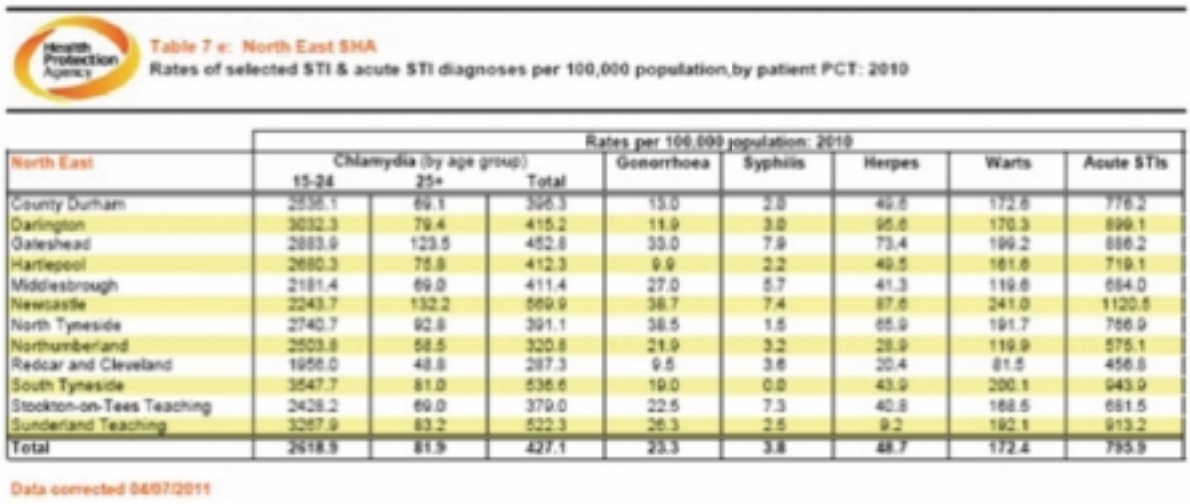


Table 7 e: North East SHA
Rates of selected STI & acute STI diagnoses per 100,000 population, by patient PCT: 2010

North East	Rates per 100,000 population: 2010							
	Chlamydia (by age group)			Gonorrhoea	Syphilis	Herpes	Warts	Acute STIs
	15-24	25+	Total					
County Durham	2536.1	69.1	396.3	13.0	2.0	40.6	172.6	776.2
Darlington	3032.3	79.4	415.2	11.9	3.0	95.6	170.3	899.1
Gateshead	2883.9	123.5	452.8	33.0	7.9	73.4	199.2	886.2
Hartlepool	2680.3	75.8	412.3	9.9	2.2	49.5	161.6	719.1
Middlesbrough	2181.4	69.0	411.4	27.0	5.7	41.3	119.6	684.0
Newcastle	2243.7	132.2	569.9	38.7	7.4	87.6	241.0	1120.5
North Tyneside	2740.7	92.8	391.1	38.5	1.5	65.9	191.7	788.9
Northumberland	2503.8	58.5	320.8	21.9	3.2	28.9	119.9	575.1
Redcar and Cleveland	1956.0	48.8	287.3	9.5	3.6	20.4	81.5	456.8
South Tyneside	3547.7	81.0	536.6	19.0	0.0	43.9	200.1	943.9
Stockton-on-Tees Teaching	2428.2	69.0	379.0	22.5	7.3	40.8	168.5	681.5
Sunderland Teaching	3267.9	83.2	522.3	26.3	2.5	9.2	192.1	913.2
Total	2618.9	81.9	427.1	23.3	3.8	48.7	172.4	795.9

Data corrected 04/07/2011

Chlamydia

Data from National Chlamydia Screening Programme (NCSP, 2012) shows:

- All Tees localities achieved the coverage target of 25% in 20011/12. Coverage is lower in all Tees local authority areas than the rest of the North East; and is lower in males, which is consistent with the regional and national picture. Males tended to access testing in education and outreach facilities; women in education and 'other community core' facilities.
- The proportion of positive tests (community and GUM) was among the highest in the region for each Tees locality except Redcar & Cleveland. However, the percentage of positive tests is decreasing over time, indicating testing may not target the highest risk groups.
- In 2010/11, diagnosis rates were less than 2,000 per 100,000 15-24 year olds for all Tees localities (NCSP aim is 2,400 per 100,000). In 2011/12, the diagnosis rate was above 2,000 in Stockton and above 2,600 in Hartlepool, but still below 2,000 in Middlesbrough and Redcar & Cleveland. Almost all other localities in the North East met or exceeded 2,400 per 100,000. The data suggests higher diagnosis rates in other localities may be driven by higher GUM diagnosis rates rather than community diagnoses.

Number of chlamydia tests and positive diagnoses, Tees PCTs, 2011/12

PCT	Number of tests	Number of positive tests	Positive rate (%)
Hartlepool	4,115	320	7.78
Middlesbrough	6,058	451	7.44
Redcar &	4,526	309	6.83

Cleveland			
Stockton	7,015	529	7.54
North East	-	-	7.09
England	-	-	7.33
			Source: National Chlamydia Screening Programme

Syphilis

- The number of new syphilis diagnoses in Tees GUM clinics increased from 6 in 2003 to 39 in 2007 (NHS Tees, Sexual health needs assessment). This reflects the national increase. Since 2007, the number of syphilis cases has fluctuated but peaking in 2009 at 51.
- Number of cases in the first 3 quarters of 2011 is lower than the same period in 2009 and 2010. There were significantly more cases in males in the third quarter of 2011, mostly aged 20-24 years.
- The number of cases in Teesside continues to decrease. (Health Protection Agency North East: Regional Epidemiology Unit, 2011).
- The proportion of North East infectious cases has been rising since the beginning of 2010, as has the proportion of men who have sex with men cases. (Health Protection Agency North East: Regional Epidemiology Unit, 2011)

Diagnosed HIV prevalence

Hartlepool has a BME population of 3.2% (approximately 2,900 people) (ONS, 2011). Teesside has seen a continued rise in HIV diagnosis over the past few years. In 2010/11, the England HIV prevalence dropped by 4.4% but the North East rose by 7%.

The diagnosed HIV prevalence has increased in the North East and is greater for males than females. The diagnosed HIV prevalence in Hartlepool is the fifth lowest in the North East. This is possibly due to the ethnic mix, compared to some other North East localities. Late diagnosis is known to be an issue, so the true prevalence is likely to be higher. In some localities, HIV may be a 'hidden' problem – the HPA is investigating whether high-risk groups for HIV are currently accessing services.

Diagnosed HIV prevalence (per 1,000 15-59yr olds), North East local authorities

Region	Local Authority	LA code	Residents accessing HIV related care* (aged 15-59)	Estimated resident population in 1,000s** (aged 15-59)	Diagnosed HIV prevalence per 1,000 (aged 15-59)
North East	County Durham	EJ	144	303.0	0.48
	Darlington	EH	49	58.2	0.84
	Gateshead	CH	148	114.0	1.30
	Hartlepool	EB	27	53.7	0.50
	Middlesbrough	EC	118	87.7	1.35
	Newcastle upon Tyne	CJ	313	193.8	1.62
	North Tyneside	CK	97	118.0	0.82
	Northumberland	EM	57	175.5	0.32
	Redcar and Cleveland	EE	19	78.2	0.24
	South Tyneside	CL	35	92.3	0.38
	Stockton-on-Tees	EF	98	115.8	0.85
	Sunderland	CM	101	173.6	0.58

(Source: HPA)

Gonorrhoea

The number of gonorrhoea cases diagnosed by hospital GUM departments in Teesside has been rising since 2007. Although the number of cases in 2010 is lower than 2009 it does not include the full year's data. It is important to note that these are only diagnoses by hospital GUM departments and the addition of community-based data would provide a complete picture.

Numbers of reported new diagnoses of gonorrhoea (uncomplicated and complicated), Tees GUM departments, 2007-2010

Clinic site	2007	2008	2009	2010(1)
University Hospital of Hartlepool	30	27	28	18
James Cook University Hospital	64	79	74	62
University Hospital of North Tees	20	19	33	27
Total	**114**	**125**	**135**	**107**

(1) incomplete data

Source: GUMCAD and Korner (KC60) reports

Human papilloma virus (HPV)

Vaccination against HPV has been routinely carried out for girls in year 8 (aged 12 to 13) since 2008/09. For full protection, 3 doses of the vaccine are required. In Hartlepool, 90.2% of girls received all three doses in 2010/11 compared with 84.2% in England (Department of Health, 2012).

Additional data can be found within the Sexual Health Balance Scorecard.

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5. What services are currently provided?

Sexual Health Teesside is an integrated contraception, sexual health and GUM service operating a hub and spoke model of service delivery across Teesside.

The vision for integrated sexual health services on Teesside is that:
"Everyone across Teesside will have timely access to comprehensive sexual health services that will promote the sexual health and wellbeing of all individuals. They will be high quality, with fully integrated care pathways, that will be holistic & client focused. Services will be delivered by a range of Doctors, Nurses, Pharmacists and Voluntary Agencies in a variety of different settings." (NHS Tees, 2010)

The following services are offered on either a 'walk-in' basis or by a pre-bookable appointment:

- Integrated contraception and sexual health/genitourinary services (CASH and GUM) including STI screening and treatment;
- Chlamydia screening;
- Psychosexual service, sexual dysfunction advice, counselling and treatment;
- Sexual assault victims and onward referral to the Sexual Assault Referral Service (SARC) for support and forensic testing if requested;
- Male sterilisation (vasectomy);
- Hepatitis B immunisation for those at risk of infection.

Sexual Health Teesside is contracted to provide training and development to partner agencies. They have a pathway for delivering HIV post-exposure treatment and onward referral to acute services. Sexual Health Teesside is contracted to provide services in prisons. Sexual Health Teesside sub-contracts with: laboratory services; Teesside Positive Action (providing STI testing); pharmacies to provide emergency hormonal contraception (EHC) and chlamydia testing; and GPs to provide implants, IUDs and chlamydia testing.

There are no drop-in clinics currently being delivered in Hartlepool and the dedicated young person's clinic which used to be held on a Tuesday evening is now open to all ages.

Sexual Health Teesside delivers a number of weekly school and college-based clinics in two of the three colleges and 4 of the 5 secondary schools in Hartlepool. Further work is needed to develop services for the remaining school and college.

Termination of Pregnancy Service operates from the University Hospital of Hartlepool. Appointments can be made via a GP or nurse referral. Women are presenting at earlier gestations. Further care pathway work is required to refine access further and ensure a robust

post-termination contraception plan is in place.

BPASprovide termination services to women who are 18 weeks gestation or over.

Hart Gablesprovides support, information and assistance to lesbians, gay men, bisexual people and transgendered people of all ages.

Teesside Positive Action (TPA)provide rapid HIV testing and a fast track service for clients receiving a reactive result, including 24-hour support line and follow-up emotional and practical support.

The Centre for Clinical Infectionat James Cook University Hospital offer HIV treatment and support.

C Card Schemeis a free service available at over 45 sites, to young people aged 13 to 25 in Hartlepool. It is co-ordinated by the Sexual Health Outreach Team and comprises condom provision, pregnancy testing and chlamydia screening.

Sexual Health Teesside Service (SHTS) contraception data

Emergency hormonal contraception (EHC) provision

Pharmacies provide the greatest proportion of EHC in all localities. Hubs and spokes are also popular sources of provision. However in Hartlepool, provision through spokes is minimal and hubs provide 26% of EHC. This may be due to the service provision model in Hartlepool – a small number of spokes due to the relatively small size of the town, or other factors such as cultural issues or awareness leading to preference of pharmacies.

Condom provision

Hubs are the greatest provider of condoms in all localities, followed by outreach.
Pharmacies are great providers of EHC but not of condoms and this could be a focus for activity (maximising contacts). Colleges are very low providers of condoms.

Psychosexual Counselling

The proportion of follow-up attendances to first attendances is very low for Hartlepool compared to Middlesbrough and Redcar and Cleveland. This may be due to the smaller numbers of first attendance in Hartlepool, referral practices, appropriate referral levels, or access to services. The historical location of the service in Middlesbrough may also have an effect.

Long Acting Reversible Contraception (LARC)

Sexual Health Teesside and GP LARC prescribing data show:

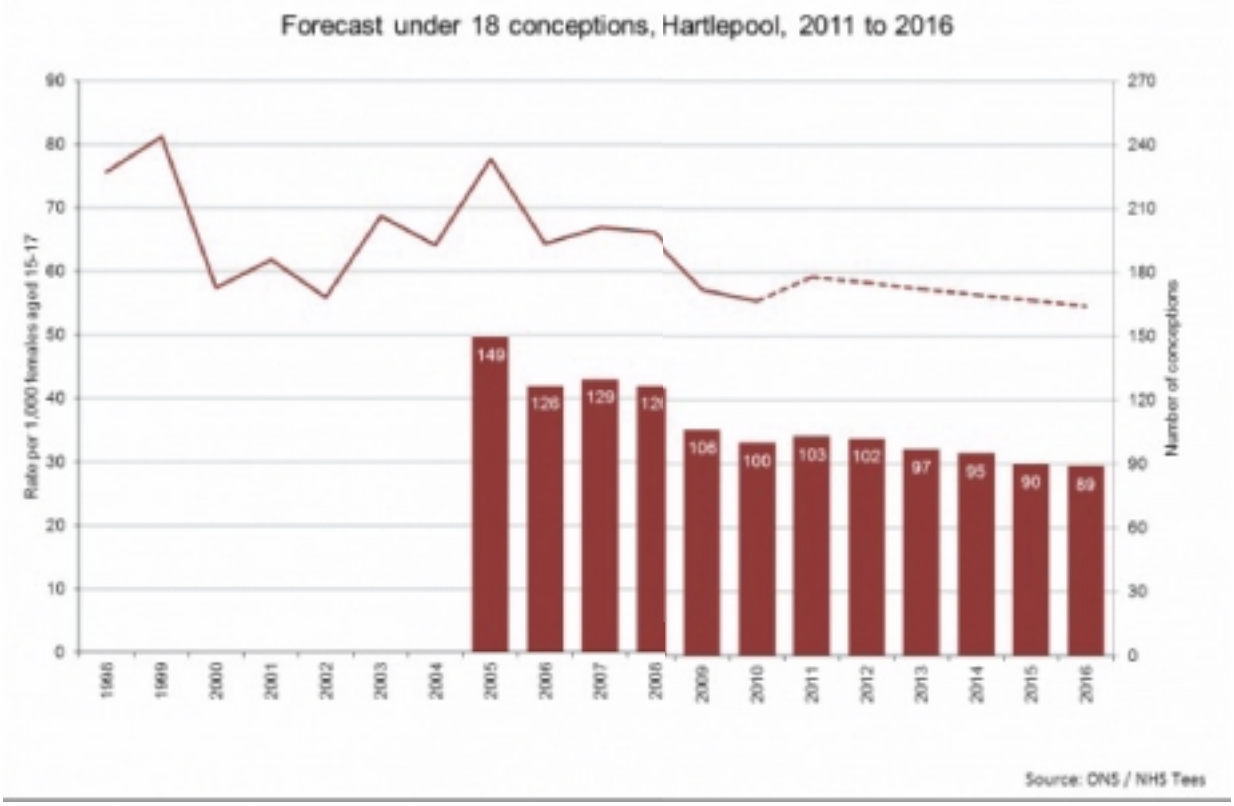
• The greatest proportion of contraceptive methods delivered by GPs in 2011/2012 is the combined pill.
• Second highest was the Progesterone only pill with a reduction in provision from 2010/2011.
• The third highest was the injection which slightly increased from 2010/2011.
• Overall LARC provision by GPs remains low.

6. What is the projected level of need?

Under 18 conceptions

Under 18 conception rates for 1998-2010 were used to project rates for 2011-2016 (see Appendices for more details). Hartlepool rates are projected to decrease to about 55 per 1,000 in 2016. The number of under 18 conceptions is also predicted to decrease. Population size tends to fluctuate in a cyclical pattern, so actual numbers may fluctuate beyond 2016 and it will be important to build in flexibility to account for this in service planning.

Importantly, projections are based on the assumption that current service provision and initiatives to reduce under 18 conceptions, continue. In practice, interventions are likely to change to reflect best evidence of effectiveness. There will be variation around the long-term trend, so the projection may not be exact. Projections may be conservative and should be interpreted with some caution. Nevertheless, as the best available information, the projections should still inform commissioning and service planning. Target setting is a separate process to forecasting and stretch targets may differ from projections.



7. What needs might be unmet?

Although TPA provide rapid testing for HIV they do not appear to have the capacity to provide this service in Hartlepool, therefore access to rapid HIV testing is required.

Access to sexual health services for people with learning disabilities.

Sexual health services for young people. Following “You’re Welcome” feedback

recommendations and the continuous rise in teenage pregnancies, this dedicated service is a requirement to meet the needs of young people in Hartlepool.

School-based sexual health services are not available in all schools and colleges.

Some schools are not delivering recommended sex and relationship programmes which are age appropriate and evidence-based.

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8. What evidence is there for effective intervention?

National Institute for Health and Clinical Excellence

Prevention of sexually transmitted infections and under 18 conceptions(PH3)

Increasing the uptake of HIV testing among black Africans in England(PH33)

Long-acting Reversible Contraception(CG 30)

Sexually Transmitted Infections in Black African Caribbean Communities in the UK(HPA, 2008).

Better prevention, better services, better sexual health - The national strategy for sexual health and HIV Department of Health (2001).

Progress and priorities – working together for high quality sexual health: Review of the National Strategy for Sexual Health and HIV(Independent Advisory Group for Sexual Health, 2008).

Service Standards for Sexual and Reproductive Healthcare(Faculty of Sexual & Reproductive Healthcare, 2012)

UK National Guidelines for HIV testing 2008British HIV Association (BHIVA, 2008)

Teenage Pregnancy: Accelerating the Strategy to 2010(DfES, 2006)

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9. What do people say?

The Hartlepool Young Inspectors carried out seven mystery shops at the One Life Centre in Hartlepool during November 2011. The overall conclusions were positive in terms of booking an appointment, the environment of the clinic and the skills and attitudes of the staff both reception and clinical. Some negative points were that people's names were called when the nurse was ready and this was felt to be a breach of confidentiality - a number system would ensure that confidentially could be maintained.

Recommendations from the Young Inspectors included:

- Mentioning confidentiality at the beginning of each consultation so that young people are reassured.

- Clinic times to be reviewed due to buses not operating in the evening and young people find it difficult to come back into the town centre.
- A drop-in clinic specifically for young people.
- There could be more to do when waiting for your appointment - TV could be on and magazines could be available.

The APAUSE year 11 questionnaire for the academic year 2010/11 showed that, after completing STI questionnaire, 78% of questions were answered correctly by boys and 83% by girls. There were 65% of girls and 75% of boys that viewed their sex and relationship education as OK.

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10. What additional needs assessment is required?

Assess the sexual health needs of Black and Minority Ethnic (BME) groups.

Assess the sexual health needs of people with learning disabilities and their access to services.

Health needs assessment at a sub-PCT level may be useful, though some data is currently unavailable at this level. This could include assessing the demographic profiles of those receiving different methods of contraception.

Using the Mosaic segmentation tool would help to determine optimum methods for comunication about services and to target health-promoting messages.

Further analysis of STI data to include community and GUM data combined would inform future health needs assessment.

Key contact

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Hartlepool PCT, Middlesbrough PCT, Redcar & Cleveland PCT and Stockton-on-Tees Teaching PCT (2008) Sexual Health Needs Assessment.

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Health Protection Agency North East: Regional Epidemiology Unit (2011) North East Quarterly Sexual Health Bulletin Quarter 3 2011. (Copy available on request).

National Chlamydia Screening Programme (2012) NCSP data.

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NICE (2007) Prevention of sexually transmitted infections and under 18 conceptions.

NICE (2005) Long-acting Reversible Contraception.

Office for National Statistics (ONS, 1998). Population Trends Autumn 1998 - Teenage Mothers and the Health of their Children.

Office for National Statistics (ONS, 2011). Estimated resident population by ethnic group and sex, mid-2009.

Office for National Statistics (ONS, 2012). Conceptions in England and Wales 2010

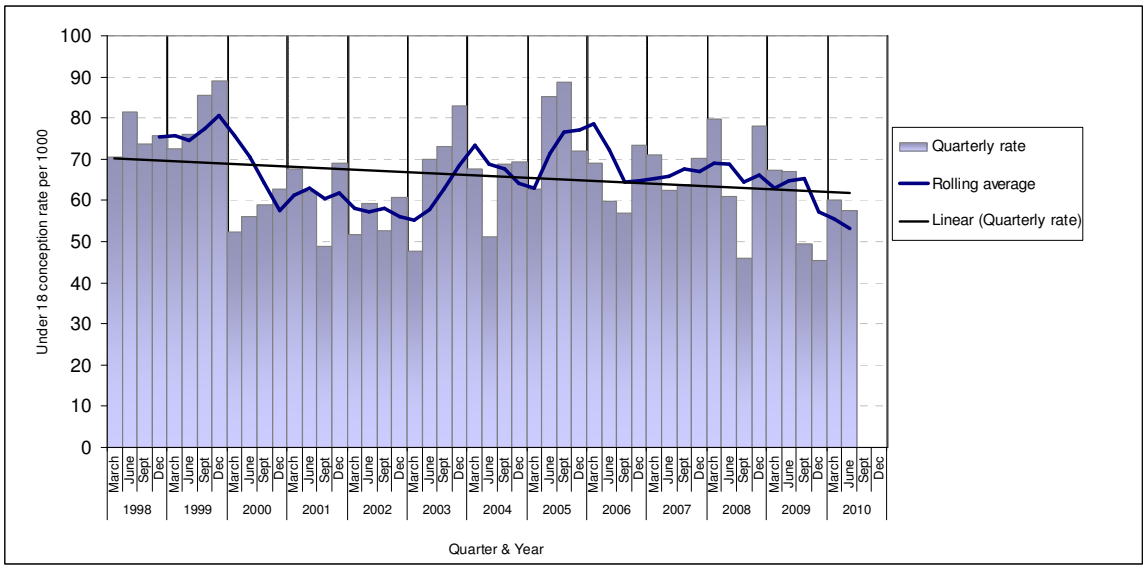
Tees JSNA

Sexual Health: Appendices Hartlepool

These appendices outline additional data and information, to supplement and further evidence the Joint Strategic Needs Assessment for sexual health in Middlesbrough. They do not constitute a full health needs assessment.

<18 Conceptions

Figure 1: Quarterly rates in Hartlepool UA



ONS cluster comparison

An ONS cluster town has also been added as a comparator for Hartlepool (Halton). ONS clusters are allocated according to similar characteristics (Hartlepool is in the 'industrial hinterland' group). Comparison with an ONS cluster is particularly useful where there may be systematic similarities between Tees localities (due to e.g. common management / commissioning arrangements or a single service provider) which make it difficult to identify good practice or areas of improvement between Tees localities. An ONS cluster can help identify areas of good practice / improvement and consider transfer of learning to its comparator locality in Tees.

ONS cluster comparators are selected by:

- Finding the Tees locality on the IMD 2010 list (sorted by rank of average rank as this is the most commonly used measure and reflects relative position of the locality to others – ranks of LSOAs are averaged).
- Identifying the locality with the next most prosperous IMD, which is in the same ONS cluster group as the Tees locality. The next most prosperous is used as this is slightly aspirational (rather than selecting the next most deprived).

Teenage parents - data

Estimates are derived from a DfE model using ONS VS2 births data by LA adjusted for parity.

Estimates include births in previous years to teenage mothers who were still under 20 on 31 December.

Figures are estimates as the model does not account for the migration of teenage mothers between LA areas following birth.

STIs

Table 7 a: England

Rates of selected STI & acute STI diagnoses per 100,000 population, by patient country & SHA: 2010

Country & SHA	Rates per 100,000 population: 2010							
	Chlamydia (by age group)			Gonorrhoea	Syphilis	Herpes	Warts	Acute STIs
	15-24	25+	Total					
East Midlands	2238.8	81.5	361.7	22.8	3.9	50.3	127.0	704.2
East of England	1823.9	67.3	271.0	15.6	1.9	45.8	121.7	637.9
London	2506.8	189.3	451.8	82.3	13.6	86.0	165.4	1196.0
North East	2618.9	81.9	427.1	23.3	3.8	48.7	172.4	795.9
North West	2579.9	91.7	422.2	28.3	5.3	55.6	157.1	802.5
South Central	1750.9	76.2	287.2	19.1	2.8	55.5	138.0	694.6
South East Coast	1657.3	63.6	243.3	15.8	2.9	53.0	135.5	596.0
South West	2037.9	60.3	304.8	12.2	2.0	45.1	130.6	642.4
West Midlands	2228.8	81.9	357.3	30.4	3.4	47.1	124.3	705.9
Yorkshire & the Humber	2415.7	82.2	410.1	25.6	3.2	50.7	143.1	769.6
England	2219.1	93.3	359.4	30.8	4.8	55.6	141.7	778.9

Data corrected 04/07/2011

Table 7 e (i): North East SHA

Rates of selected STI & acute STI diagnoses per 100,000 population, by patient LA: 2010

North East	Rates per 100,000 population: 2010							
	Chlamydia (by age group)			Gonorrhoea	Syphilis	Herpes	Warts	Acute STIs
	15-24	25+	Total					
Darlington	3032.3	78.0	414.2	11.9	3.0	94.6	169.3	896.1
Durham	2617.4	68.2	393.1	12.8	2.0	48.6	171.8	770.3
Gateshead	2863.2	120.5	447.6	32.5	7.9	72.8	198.6	878.9
Hartlepool	2663.9	71.0	405.7	9.9	2.2	47.3	150.6	692.7
Middlesbrough *	1533.3	11.0	264.8	0.7	0.0	3.6	6.4	280.4
Newcastle upon Tyne	2193.3	125.0	554.4	34.1	6.3	82.3	227.3	1070.5
North Tyneside	2740.7	92.1	390.0	38.5	1.5	65.4	190.2	763.9
Northumberland	2603.8	57.7	320.2	21.9	2.9	28.6	119.3	572.5
Redcar and Cleveland	1516.3	8.3	201.5	0.0	0.7	2.2	7.3	217.5
South Tyneside	3547.7	80.1	535.9	19.0	0.0	43.9	200.1	942.6
Stockton-on-Tees	2189.2	49.8	333.4	17.8	5.8	27.7	135.0	560.1
Sunderland	3267.9	82.2	521.6	26.3	2.1	8.9	191.7	910.3

* LA rates are underestimated due to incomplete LA mapping at some sites. Please refer to PCT or SHA data for complete diagnosis rates

Chlamydia

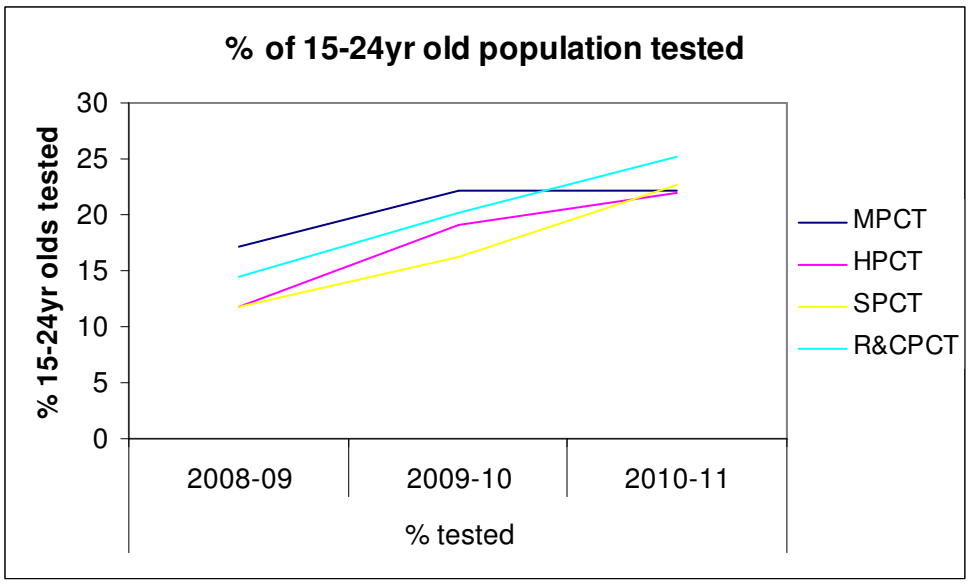
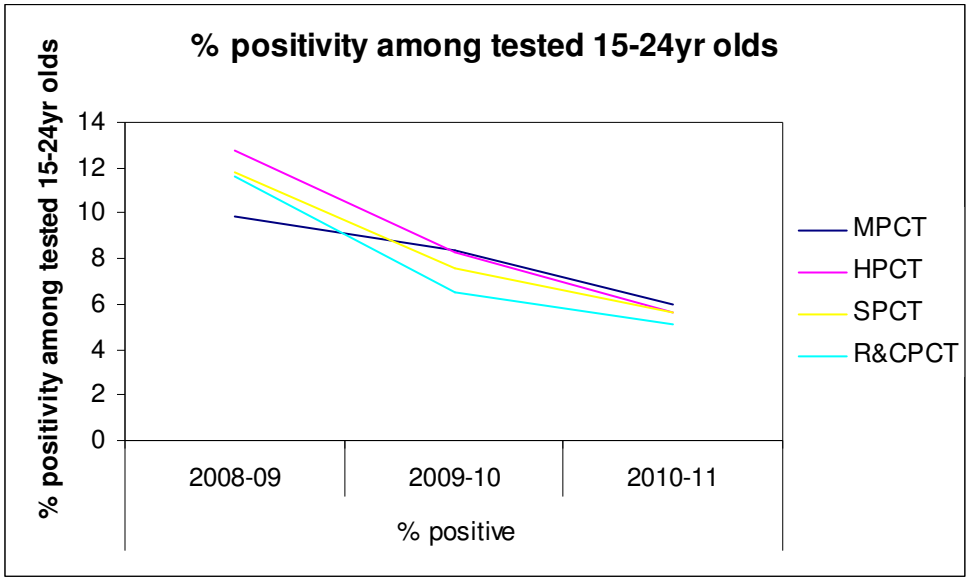


Figure 3: Chlamydia % positivity among tested 15-24yr olds



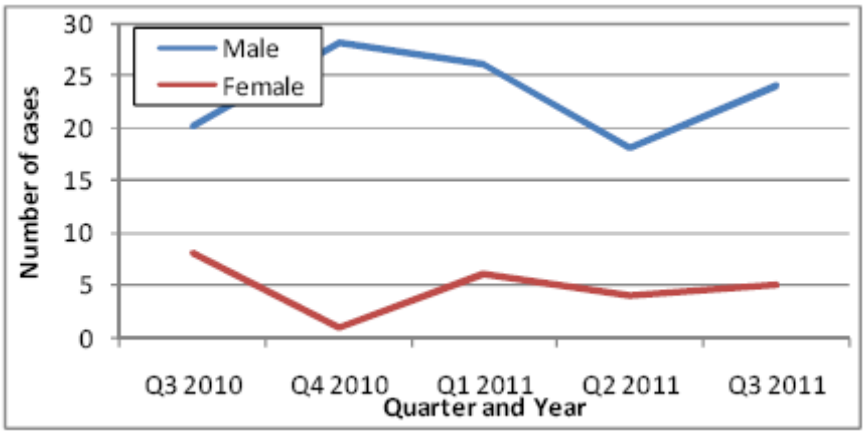
Notes on the data

It is difficult to provide projections for Chlamydia data, due to the variation in data collection systems. Vital Signs Indicator data has been collected since 2008/09 but a projection based on 3 years' data would not be sufficiently robust. A single national data collection system for Chlamydia testing and diagnosis is currently being implemented and this will facilitate consistent analysis and projection.

Reporting will need to reflect the new cluster arrangements being implemented by the NCSP – clusters are already in place in the North East.

Syphilis

Number of North East syphilis cases by gender and quarter (Reference – NE Quarterly Sexual Health Bulletin Quarter 3 2011)



Notes on data

Data are from GUM clinics only, which are open-access and do not relate to residence for specific PCT boundaries. Data correct as of 09/03/11.

Gonorrhoea: Figures include all cases of Gonorrhoea; a breakdown of complicated and uncomplicated cases is available upon request.
2009 and 2010 data use GUMCAD data only.

HIV

In 2010, there were 1305 diagnosed HIV-infected patients resident in the North East, (a diagnosed prevalence of 50.06 cases per 100,000 population), compared to 135 diagnoses in 2009 (the largest number since 2005 (156)). The diagnosed prevalence was greater in males (66.85 per 100,000) than females (33.90 per 100,000).

In the North East, the highest prevalence is in the Black African group (3317.5 per 100,000) - significantly higher than the prevalence in other ethnic groups.
The rate of new diagnosis also varies greatly between different ethnic groups. The highest rate of infection is in the Black African group (325.4 per 100,000) (significantly higher than other ethnic groups). The greatest number of diagnoses (95) was made in the White group, but due to the predominantly white population in the North East, this translated to a rate of 3.9 per 100,000.

Number and Rate (per 100,000) of New HIV Diagnoses by Ethnic group

Ethnic Group		**2010**	
Population (000's)*	**Number**		**Rate**
White	2446.5	95	3.9
Chinese	23.7	0	0.0
Other Asian	9.8	0	0.0
Other/mixed	24.6	1	4.1
Black Caribbean	5.6	0	0.0
Black African	12.6	41	325.4
Black Other	1.4	1	71.4
Indian sub-continent	59.9	1	1.7
Not known		14	
Total	2584.1	153	5.9

* ONS Population Estimate (2009)

Service data

The primary clinic in Hartlepool is based at:

One Life Hartlepool
Park Road
Hartlepool
TS24 7PW

Opening times are:

Contraception and sexual health (CASH) clinic

By appointment.

Monday: 1.30pm – 4pm and 6.30pm – 8pm
Tuesday: 6.30pm – 8pm
Wednesday: 1.30pm – 4pm and 6.30pm – 8pm
Friday: 2pm – 5pm

Contraception and sexual health (CASH) doctor procedures

By appointment.

Tuesday: 5pm – 6pm
Wednesday: 6.30pm – 7.45pm

Genito-urinary medicine (GUM) clinic

By appointment.

Monday: 9am – 1pm
Tuesday: 9am – 5pm
Wednesday: 9am – 7pm
Thursday: 9am – 5pm
Friday: 9am – 1pm

Psychosexual counselling

By appointment.

Monday: 9.30am – 12pm (second Monday of the month only)

Specialist contraception clinic

By appointment.

Friday: 10am – 12pm

All clinics provide sexual health and contraception services. All clinics can be booked by calling **0333 000 0014**. Clinics include:

- Same sex appointments
- Drop-in sessions
- Dedicated clinics
- Specialist clinics

Sexual Health Teesside also delivers a number of weekly school and college based clinics in the following venues:

Manor College of Technology
Dyke House Sports and Technology College
St Hilds Secondary School
Hartlepool College of Further Education
Brinkburn 6th Form College

Hart Gables provides support, information and assistance to lesbians, gay men, bisexual people and transgendered people of all ages. It aims to raise awareness and inform the public agencies and companies about issues relating to the gay, lesbian, bisexual and transgendered community in order to break down existing barriers between different communities so that the above feel safe and accepted and are treated equally; and undertakes awareness raising and health promotion amongst the gay, lesbian, bisexual and transgender community.

Projections

Notes on projections methods

1998-2005 <18 conception rates were accessed from the Tees Health Check 2010.

Projections were made by plotting a line graph of the rates 1998-2009 to enable as robust a projection as possible. A line of best fit was plotted, using linear regression. Other lines of best fit were considered but the linear trend was considered the best fit for the data and also reflected a realistic trend and natural population change. It was important the line enabled a realistic projection given historic data.

What evidence is there for effective intervention?

National Policy

Better Prevention, Better Services, Better Sexual Health -The National Strategy for Sexual Health and HIV (2001) set out main aims to:

- Provide clear information so that people can make informed decisions about preventing STI's, including HIV
- Reduce the transmission of HIV and, STI's with a national goal of achieving 25% reduction in the newly acquired HIV infections and gonorrhoea infections by 2007
- Reduce the prevalence of undiagnosed HIV and STI's – in particular, by setting a national standard that all GM services should offer an HIV test to clinic attendees on their first screening for STI's
- Ensure a range of contraceptive services are provided for those that need them
- Reduce unintended pregnancy rates – including setting a national standard that women who meet the legal requirements should have access to an abortion within 3 weeks for the first appointment with the referring doctor

The subsequent implementation plan in 2002 introduced the Independent Advisory Groups Sexual Health, HIV and Teenage Pregnancy and The National Chlamydia Screening Programme – an opportunistic screening programme targeting sexually active young people aged under 25.

Our Health, Our Care, Our say (2006) set out the government's vision of more effective health and social care services outside hospitals and identified the need to improve sexual health provision as a key priority and the 'Choosing Health' white paper (2004) included the commitment to modernise sexual health services.

Sexual Health and GUM services were reemphasised as one of the six national priorities outlined in 2006 by the Department of Health as part of the NHS System Reform and the 2006-2007 operating Framework

Better Prevention, Better Services, better Sexual Health: The National Strategy for Sexual Health and HIV. DH, July 2001-refreshed 2008 by the Independent advisory Group for Sexual Health

Young People 11-16 Universal Element of Healthy Child Programme schedule

Contraception and sexual health services

PCTs and LAs should work together to ensure that all young people have easy access to confidential contraceptive and sexual health services, commissioned to meet the You're Welcome quality criteria (DH, 2007). Services should be delivered by well-trained staff, offering advice, guidance and the full range of services, including prompt access to emergency hormonal contraception, choice of effective contraceptive, including LARC, unbiased support and advice for unintended pregnancy with swift referral to antenatal care or NHS-funded abortion services and treatment for all STIs (DH/MedFASH, 2005).

Information about local services should be routinely provided to all young people within PSHE and well publicised in the local area. Service information should be provided to all relevant professionals to encourage swift referrals for young people who need specialist advice. Young people should also be reminded about the continuing risk of a range of STIs, including HIV. In addition to providing young people with effective contraception, local areas should continue to promote and increase access to condoms to prevent STIs.

Chlamydia Screening

All sexually active young people under the age of 25 should be encouraged to be screened for Chlamydia annually or whenever there is a change of sexual partner. On-site services providing the full range of contraception and Chlamydia screening (alongside other health advice) are strongly recommended.

All contraception, sexual health and Chlamydia services should be integrated and meet the You're Welcome quality criteria (DH, 2007).

In additional, all professionals should seek opportunities for health promotion about sexual health and contraception, and substance misuse (including alcohol, drugs and smoking).

Responsibility: School Health Team with support from specialist providers, as appropriate.

Young People 16-19 Universal Element of Healthy Child Programme schedule

Sexual Health

Eighty per cent of under-18 conceptions are to 16 and 17 year olds, many of whom will be in the FE sector. Students should be provided with advice and support on relationships and sexual health, with information about local services. To help

increase early uptake of contraception and use of condoms, PCTs and LA's should consider with FE colleges the benefits of establishing on-site services (DfES/DH, 2007).

Young People 16-19 Progressive Element of HCP schedule

One to one sexual health interventions for highly at-risk young people

In line with NICE guidelines (NICE, 2007), it is recommended that at-risk young people under the age of 18 (e.g. from disadvantaged backgrounds, who are in – or leaving – care and/or who have low educational attainment), are offered one-to-one sexual health advice, if appropriate. The advice should cover: how to prevent and/or get tested for STIs and how to prevent unwanted pregnancies; all methods of reversible contraception, including LARC (in line with NICE clinical guideline 30); how to get and use emergency contraception; and other reproductive issues and concerns.

Responsibilities: PCTs via a range of health professionals

Other National Policy includes:

Teenage Pregnancy: Accelerating the Strategy to 2010 (DfES. 2006)

Teenage Pregnancy Next Steps: guidance for Local Authorities and PCT's (DfES. 2006)

You're Welcome Quality Criteria – making health services young people friendly (DH 2007) – Best Practice Guidance

Improving Access to Sexual Health Services for Young People in Further Education Settings (DfES & DH 2007) statutory guidance

Clinical

UK National Guidelines for HIV testing 2008

Long Acting Reversible Contraception (LARC) (NICE Clinical Guidance 30 2005) – Clinical Guidance

NICE guidance for prevention of sexually transmitted infections and under 18 conceptions 2007

Local

NHS Tees Sexual Health Needs Assessment (August 2008)

BRIEFING REPORT
FOR
HEALTH SCRUTINY FORUM

10 JANUARY 2013

1. Purpose:

1.1 The purpose of this briefing report is to provide assurance to the Health Scrutiny Forum that the PCT has ensured that the provider of Sexual Health Services "Assura" has taken on board the recommendations included in the Young Inspectors report into the Sexual Health Service at the One Life Centre.

2. You're Welcome Quality Standards

2.1 As part of the contract for the provision of Sexual Health Services Assura are contracted to achieve the You're Welcome Quality Criteria of Young People Friendly Health Services in each of the 'Hubs' across Teesside.

2.2 The Standards state that "all young people are entitled to receive appropriate health care wherever they access it". The Department of Health Quality criteria for young people friendly health services lay out principles that will help health services – both in the community and in hospitals – to 'get it right' and become young people friendly.

2.3 The quality criteria cover ten topic areas:

- Accessibility
- Publicity
- Confidentiality and consent
- Environment
- Staff training, skills, attitudes and values
- Joined-up working
- Young people's involvement in monitoring and evaluation of patient experience
- Health issues for young people
- Sexual and reproductive health services
- Specialist child and adolescent mental health services (CAMHS).

2.4 The Hartlepool Sexual Health 'Hub' is located in the One Life Centre on Park Road. As part of the You're Welcome process the Service was 'mystery shopped' by the Young Inspectors. The mystery shop exercise was the information presented to the Health Scrutiny Forum in November. The outcome of the mystery shop exercise was used to demonstrate young people's involvement and the recommendations were acted upon in order to complete the You're Welcome Work book.

2.5 The Sexual Health Service submitted their You're Welcome workbook in June 2012 and achieved You're Welcome Status in November after a

successful verification visit by the You're Welcome Lead and a group of young people. Certificates will be presented to the service in the New Year.

2.6 As achieving the You're Welcome Quality Criteria is a contract requirement this action has been monitored during contract meetings between the commissioner (Tees Public Health) and the provider (Assura).

2.7 There is ongoing discussion between the commissioner and the provider in order to explore You're Welcome accreditation of sexual health 'spokes'/outreach sties in Hartlepool. This demonstrates that Assura are dedicated to provide sexual health services that are young people friendly.

Contact Officer:

Deborah Gibbin
Health Improvement Practitioner
Health Improvement Team
Tel: 01429 523997
Email: deborah.gibbin@nhs.net

HEALTH SCRUTINY FORUM

10 January 2013

Report of: Director of Public Health

Subject: TEENAGE PREGNANCY PERFORMANCE REPORT

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1. PURPOSE OF REPORT

1.1 The purpose of this report is to inform the Health Scrutiny Forum on the current position in relation to the reduction of the under 18 conception rate.

2. BACKGROUND INFORMATION

2.1 In 1999 the national strategy for reducing teenage pregnancy was published by the Social Exclusion Unit to tackle the causes and consequences of teenage pregnancy.

2.2 Hartlepool's local 10 year strategy was agreed in 2001; a multi-agency annual action plan was produced with a range of partners contributing to its delivery. The main goal of the strategy was to reduce the under 18 conception rate by 55%

2.3 The Ten year strategy ended in 2011, however reducing teenage pregnancy still remains a priority for the Authority and is now embedded within the Early Intervention Strategy and Early Intervention Locality Teams.

3. PERFORMANCE

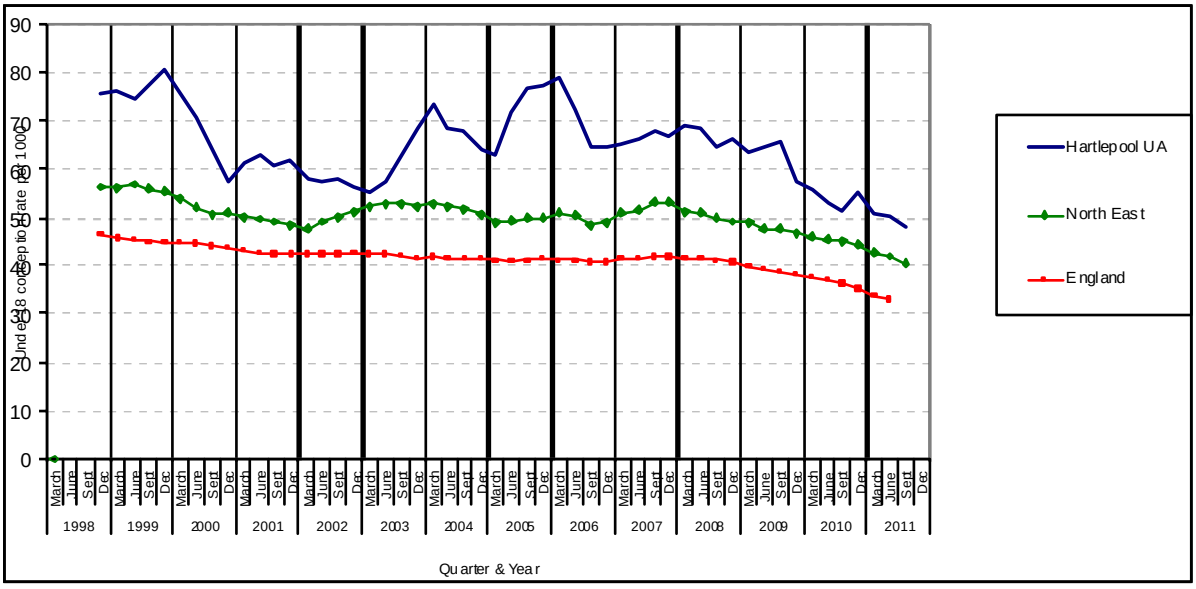
3.1 UNDER 18 CONCEPTION DATA (1999-2010)

3.1.1 For a number of years Hartlepool experienced significantly higher teenage conception rates than the rest of England. In 1999 the under 18 conception rate was **81.2** per 1000 girls aged 15 – 17 years, compared with the national rate of **45.5** per 1000. In 2010 Hartlepool achieved a rate of **55.5** per 1000 and this demonstrates a **31.7%** reduction over 10 years.

3.1.2 The table below shows the under 18 conception rates from 1999 – 2010 and compares local rates with the North East and England averages.

Year	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Number of Conceptions	146	108	120	110	133	126	149	126	129	126	106	100
Local Rate	81.2	57.4	61.8	55.9	68.2	64.1	78.0	64.5	66.8	66.1	57.3	55.5
North East Rate	55.3	50.8	48.3	51.1	52.2	50.8	50	48.8	53.2	49	46.9	43.3
National Rate	44.8	43.6	42.5	42.6	42.1	42.5	41.1	40.1	41.7	40.5	38.2	35.4

3.1.3 The third quarter of the 2011 under 18 conception data was released by the office for National Statistics (ONS) on 27 November 2012. The rate of under 18 conceptions for this quarter was 32.2 per 1000 compared to 41.9 in the same quarter in 2010. For under 18 conceptions the rolling quarterly average continues to fall (47.9) and is at its lowest since quarterly data collection began, please see chart below.



3.2 NUMBER OF LIVE BIRTHS (JANUARY 2008 – SEPTEMBER 2012)

3.2.1 The number of live births to young women from Hartlepool that have taken place during the period January 2008 to September 2012 are as follows:

Year	Number of Live births
2008	77
2009	74
2010	61
2011	56
2012 (up to Sept)	26

3.2.2 There has been a year on year reduction in the number of live births to young women under 18 since 2008.

3.2.3 The table below illustrates the rate of live births from January - September 2012 by electoral ward. The numbers of live births have not been included due to small numbers.

Ward Name	Ward Population (15-17 yr females)	Birth Rate per 1000 population
Burn Valley	175	22.9
De Bruce	167	35.9
Fens & Rossmere	145	0.0
Foggy Furze	172	5.8
Hart	179	5.6
Headland and Harbour	111	36.0
Jesmond	164	12.2
Manor House	223	9.0
Rural West	140	0.0
Seaton	165	6.1
Victoria	163	30.7

3.3 PROXY UNDER 18 CONCEPTION RATE FOR 2011

3.3.1 Under 18 conception rates are released annually in February and have a 14 month time lag. This is due to the way that rates are calculated using birth notifications and abortion data. In order that we have up to date data the PCT Business Intelligence Service provide a proxy indicator. The proxy indicator for under 18 conceptions for 2011 is 48.9 per 1000 which demonstrates a further decline in the under 18 conception rate.

3.4 ESTIMATES OF YOUNG MOTHERS (2007 – 2009)

3.4.1 The Department for Education released estimates of the number of young mothers for 2007, 2008 and 2009. They are:

	Under 18	Under 19	Under 20
2007	31	92	192
2008	33	86	177
2009	30	82	172

3.4.2 Figures show a point estimate of the number of young mothers aged 16 -19 at 31 December in a particular year.

3.4.3 Estimates are derived from a DfE model using ONS VS2 births data by LA adjusted for parity

3.4.4 Estimates include births in previous years to teenage mothers who were still under 20 on 31 December

3.4.5 Figures are estimates as the model does not account for the migration of teenage mothers between LA areas following birth

3. RECOMMENDATIONS

3.1 That Members of the Forum note the content of the report and where appropriate seek clarification.

Contact Officer:-

Louise Wallace
Director of Public Health
Tel: (01429) 523773
Email: louise.wallace@tees.nhs.uk

BACKGROUND PAPERS

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

- Under 18 conception Statistics (1999 – 2010), Office for National Statistics, (2012)
- Teenage Conceptions Report, NHS Tees Business Intelligence Service (2012)
- Teenage Conceptions Report, NHS Tees Business Intelligence Service (2011)
- Teenage Conceptions Report, NHS Tees Business Intelligence Service (2010)
- Teenage Conceptions Report, NHS Tees Business Intelligence Service (2009)
- Teenage Conceptions Report, NHS Tees Business Intelligence Service (2008)
- Estimate of teenage parents, Department for Education (2011)

HEALTH SCRUTINY FORUM

10 January 2013

Report of: Scrutiny Support Officer

Subject: SERVICE TRANSFORMATION / TRANSITION TO A NEW HOSPITAL – COVERING REPORT

---

1. PURPOSE OF THE REPORT

1.1 To introduce representatives from North Tees and Hartlepool NHS Foundation Trust who will be present at today's meeting to discuss service transformation and transition to a new hospital.

2. BACKGROUND INFORMATION

2.1 Representatives from North Tees and Hartlepool NHS Foundation Trust will be present at today's meeting to present and discuss the following information with Members:-

(a) Service transformation / the 'bigger picture' - transition to a new hospital and plans for the Holdforth Road site up until the new hospital is built and the timescale

3. RECOMMENDATION

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

Contact Officer:- Laura Stones – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
Tel: 01429 523087
Email: laura.stones@hartlepool.gov.uk

BACKGROUND PAPERS

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

(i) Minutes of the Health Scrutiny Forum – 18 October 2012

HEALTH SCRUTINY FORUM

10 January 2013

Report of: Scrutiny Support Officer

Subject: HIP REPLACEMENTS – COVERING REPORT

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1. PURPOSE OF THE REPORT

1.1 To introduce representatives from North Tees and Hartlepool NHS Foundation Trust who will be present at today's meeting to discuss information on hip replacements, as requested by Members at the Health Scrutiny Forum of 18 October 2012.

2. BACKGROUND INFORMATION

2.1 At the meeting of the Health Scrutiny Forum of 18 October 2012, Members raised concerns in relation to hip replacement surgery and the type of replacement hip utilised in some surgery. Subsequently, representatives from North Tees and Hartlepool NHS Trust will be present at today's meeting to present and discuss the subject with Members.

3. RECOMMENDATION

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

Contact Officer:- Laura Stones – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
Tel: 01429 523087
Email: laura.stones@hartlepool.gov.uk

BACKGROUND PAPERS

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

(i) Minutes of the Health Scrutiny Forum – 18 October 2012

Urgent Care – One Life Hartlepool

Overview & Scrutiny Committee

January 2013

1.0 Introduction

The purpose of this paper is to inform the Overview and Scrutiny committee of the flow and number of attendances at the One Life Centre with respect to Urgent Care. This will particularly focus upon the end point disposition of the patient

Quarter 2 – July – August will be reflected upon within this report.

The report will focus upon both the in hours and out of hour's periods and will allow the committee to reflect upon the activity and the flow of patients entering any of the three services.

The committee will be reassured that an excellent and safe service is operating from the One Life Centre.

2.0 Minor Injuries Unit (MIU)

The MIU is open to the population of Hartlepool Monday to Sunday 00.00hrs – 23.59hrs. The attendances are demonstrated below and are split between the in hours period and the out of hours period which constitutes 20.00hrs – 08.00hrs.

Nurse Practitioners and staff nurses who are highly skilled and rotate between both the A&E at North Tees and the MIU provide a triage process on **all** patients attending the One Life Centre within the out of hours' periods – 20.00hrs-08.00hrs. This cohort of staff have undertaken extensive training to enhance their skills. This ensures that all patients receive a timely and appropriate assessment, whilst promoting optimal safety. This applies to patients entering the MIU service and the Northern Doctors' remit.

2.1 Attendances

Hartlepool Minor Injuries Unit	**Month**				
Arrival Time	**Jul'12**	**Aug'12**	**Sep'12**	**Grand Total**	**Percentage Total**
00:00-07:59	113	117	125	**355**	**6.5%**
08:00 -19:59	1416	1452	1478	**4346**	**79%**
20:00 -23:59	299	273	225	**797**	**14.5%**
Grand Total	**1828**	**1842**	**1828**	**5498**	**100%**

2.2 Transfer of Patients from Minor Injuries Unit to an Acute Trust

The definition of 'transfer' includes those patients who have attended the Minor Injuries Unit and require an increased level of care from an Acute Trust.

Hartlepool Minor Injuries Unit	Month				
Arrival Time	Jul'12	Aug'12	Sep'12	Grand Total	Percentage Total
00:00 -07:59	15	9	13	**37**	**15.4%**
08:00 -19:59	47	53	49	**149**	**61.8**
20:00 -23:59	23	16	16	**55**	**22.8**
Grand Total	**85**	**78**	**78**	**241**	**100%**

An overall **4.4%** of cases assessed within the Minor Injuries Unit endured transfer to another hospital for further management.

It must be reiterated that of the above not all required ambulance transfers – a large proportion were undertaken independently by the patient.

3.0 Walk In Centre (WIC)

Virgin Medical Care is open to the population of Hartlepool during the period of 0800hrs – 20.00hrs 365 days a year and is a GP led service. This is open to all patients with or without an appointment. Attendances are demonstrated below:-

3.1 Attendances

Walk In Centre	Month			
Arrival Time	Jul'12	Aug'12	Sep'12	Grand Total
08.00 – 20.00	3245	2929	2878	**9052**
Grand Total				**9052**

4.0 Northern Doctors Out of Hours (NDUC – OOH)

Northern Doctors provide urgent care provision for Hartlepool during the hours of 18.30hrs-08.00hrs Monday-Friday and all of the weekend period. Following an initial triage performed by the Minor Injuries Unit, a telephone consultation will be undertaken by Northern Doctors and a decision will be made regarding face to face assessment requirements.

4.1 Attendances

Northern Doctors	Month			
Arrival Time	Jul'12	Aug'12	Sep'12	Grand Total
00:00-07:59	141	131	133	**405**
08:00 -19:59	354	329	348	**1031**
20:00 -23:59	295	249	231	**775**
Grand Total	**790**	**709**	**712**	**2211**

The above will constitute attendances at the One Life Centre, Home visits and telephone assessments.

5.0 North east Ambulance Service (NEAS)

The ambulance services were required to transfer only **53** cases from One Life Hartlepool to North Tees & Hartlepool NHS Foundation Trust and South Tees NHS Foundation Trust. As expected the majority of these transfers were within the 08.00hrs-19.59 time frame. These transfers encompass all three services contained within the Urgent Care Service.

	Month			
Arrival Time	Jul'12	Aug'12	Sep'12	Grand Total
00:00-07:59	5	1	1	**7**
08:00 -19:59	7	13	16	**36**
20:00 -23:59	2	4	4	**10**
Grand Total	**14**	**18**	**21**	**53**

6.0 Conclusion

To conclude**,** the report has demonstrated that an effective Urgent Care Service is offered to the population of Hartlepool from all three services within One Life.

This report has demonstrated that the attendances for Urgent Care are significant and patients are attending the correct services.

Those patients enduring transfer to an Acute Trust amount to **0.31%** of the overall activity, informing the committee that patient's are attending the correct Urgent Care Services at the right time, first time

TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE
3rd December, 2012

PRESENT:-

Representing Darlington Borough Council:
Councillors Newall (in the Chair) H. Scott and J. Taylor.

Representing Hartlepool Borough Council:
Councillors Fisher and Hall.

Representing Redcar and Cleveland Borough Council:
Councillors Kay and Mrs Wall.

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

APOLOGIES – Councillor S. Akers - Belcher (Hartlepool Borough Council), Councillor Cole, Dryden and Mrs Pearson (Middlesbrough Council), Carling (Redcar and Cleveland Borough Council) and Councillor Wilburn (Stockton-On-Tees Borough Council).

OFFICERS IN ATTENDANCE – A. Metcalfe (Darlington Borough Council), L. Stones (Hartlepool Borough Council), J. Ord (Middlesbrough), M. Ameen (Redcar and Cleveland Council) and P. Mennear (Stockton-On-Tees Borough Council).

EXTERNAL REPRESENTATIVES –

County Durham and Darlington NHS Foundation Trust – Jane Haywood, Clinical Director Adults and Integrated Services/Programme Manager, Edmund Lovell, Head of Communications and Marketing and Diane Murphy, Clinical Director of Service Transformation.
Darlington Clinical Commissioning Group – Martin Philips, Chief Officer Designate.
NHS County Durham and Darlington – Berenice Groves, Programme Director NHS 111 Service North East (Deputy Director Unplanned Care)
NHS Tees – Ann Greenly, Assistant Director – Commissioning and System Development and Jonathan Maloney, Deputy Director Contracting, Intelligence and Performance.
South Tees Clinical Commissioning Group – Amanda Hume, Chief Officer Designate and Samantha Merridale, Interim Programme Manager.

Due to there not being a representative present from each of the Tees Valley Local Authorities, the meeting was inquorate and an informal meeting was held.

23. DECLARATIONS OF INTEREST – Councillor Javed (Stockton-on-Tees Borough Council) declared a Personal and Non-Prejudicial Interest in respect of any matters

arising in relation to Tees, Esk and Wear Valleys NHS Foundation Trust as his employer.
Councillor Mrs Wall (Redcar and Cleveland Council) declared a Personal and Non-Prejudicial Interest in respect of any matters arising in relation to the North East Ambulance Service NHS Trust as she is related to a number of employees.

24. NOTES – Submitted – The Notes (previously circulated) of the informal meeting of the Tees Valley Health Scrutiny Joint Committee held on 5th November 2012.

AGREED – That the Notes be approved as a correct record.

25. WINTER PREPAREDNESS AND PLANNING – Berenice Groves, Programme Director NHS 111 Service North East (Deputy Director Unplanned Care) NHS County Durham and Darlington and Anne Greenley, Assistant Director – Commissioning and System Development, NHS Tees jointly prepared a PowerPoint presentation (slides previously circulated) providing Members with assurance of robust Action Plans in place that are timely, shared, linked to resilience, escalation and Surge Plans, communicated effectively and owned.

Anne Greenley provided an overview of winter preparedness which included the PCT and Clinical Commissioning Groups (CCG) preparing assurance plans and testing severe weather and transport contingencies, organisations and personnel changes, capacity and demand, out of hours services, critical care, staff and patient vaccination, Ambulance and Accident and Emergency (A&E) handover, liaison with Local Authorities and delayed transfer of care, Situation Reporting (SITREP) arrangements and Strategic Health Authority and Regional Office winter arrangements.

Ms Greenley reported that there are multi agency assured plans and the winter planning exercises have been carried out involving all key originations. Key points of learning and live experience have been addressed through Local Resilience Fora, Root Cause Analysis being undertaken (where necessary), Surge Groups and CCGs.

Ambulance handover at A&E was highlighted as an issue and Ms Greenley advised that there is always a high number of emergency admissions during the winter months. Members were pleased to note that the Ambulance handover to Hospital and Divert Policy has been reviewed and would continue to be implemented across the Region to ensure a consistent approach to handover arrangements to minimise delays for patients. Members highlighted issues they were aware of around ambulance issues and the Chair reported that North East Ambulance Services would be attending a future meeting of the Joint Committee to address Members concerns.

Ms Groves acknowledged that more work was required around communications and there was room for improvement in how levels of pressure are reported at an earlier stage to enable hospitals being diverted to, to be better prepared to cope with the additional demand. The Area Teams would strengthen the communications from April 2013. It was reported that the introduction of the Hospital Ambulance Liaison Officers has alleviated some of the handover pressures in hospitals, ensuring that smooth handovers take place. It was noted that in future the Surge Groups would likely amalgamate with the County Durham and Darlington Groups which would harmonise any cross boundary issues.

Members were reassured that there are sufficient numbers of 4x4 vehicles available to ensure patients receive appropriate transport and care as required in the event of adverse weather conditions. It was noted that extended access to GPs appointments are in place as part of the urgent care services and extra staff would be available for high periods of demand. CCGs are considering the ambulance activity within their own area for the winter period and a report will be produced towards the end of March 2013.

Discussion ensued on flu vaccinations and specifically staff and patient take up of vaccinations. Members were reminded of the vulnerable and at risk groups who are entitled to receive a flu vaccination and how they are encouraged to do so. Officers acknowledged that it was a challenge to encourage young people with long term conditions and pregnant women to have a flu vaccination and the messages that the NHS is currently promoting. Members were interested to learn the take up of front line staff vaccinations within the NHS and Local Authorities and it was suggested that last year's exercise of writing to each Local Authority be repeated to ascertain whether take up rates have increased.

AGREED – (a) That the Officers be thanked for their attendance at the meeting;

(b) That the presentation and discussion be noted; and

(c) That a letter be sent to each of the Tees Valley Local Authorities requesting take up figures of front line staff who have received their flu vaccinations.

26. UPDATE 111 – Berenice Groves, Programme Director NHS 111 Service North East (Deputy Director Unplanned Care) NHS County Durham and Darlington provided Members with an update (previously circulated) on the NHS 111 Services launch in NHS South of Tyne and Wear on Tuesday 11th December 2012. The launch was intended to be a soft launch, as the service needs time to bed in and therefore marketing materials would not be distributed until January 2013. Ms Groves detailed what could be expected from the service based on experience for the County Durham and Darlington pilot and subsequent roll out. During implementation there will be daily SITREPS attended by the Commissioner, Providers and local Clinical Leads to ensure that the service is robust and resilient. Part of the information reviewed will include number of calls answered, number of triaged calls, number of 999 calls and patient feedback. Ms Groves reported that NHS Tees and North of Tyne are preparing to 'go live' for 2nd April 2013 and Jonathan Maloney, Deputy Director Contracting, Intelligence and Performance, NHS Tees introduced a powerpoint presentation providing more detail.

Mr Maloney reported that a very significant proportion of attendance at both A&Es across Tees attracts the two lowest tariffs and all of the activity may be valid but more needs to be done to understand the facts. Minor cases are being seen in the most expensive place and it is hoped that 111 might improve the number of unnecessary A&E presentations. Mr Maloney listed benefits of the introduction of 111 to include improved access to services (determined by local Clinicians), patients being steered to the most appropriate local service that best meets patients needs, helps to minimise the avoidable cost of patients unnecessarily attending inappropriate services, improving the patients overall experience of using NHS services and improved management of information and intelligence to inform future commissioning decisions.

It was acknowledged that clinical support and provider collaboration has been key and as a result a robust Project Plan is in place which includes building the Directory of Services, clinical governance and readiness testing. Mr Maloney added that clinically led process to ensure that safety remains paramount across the urgent care system, to ensure a whole system approach. It is the intention to implement a process for continuous learning and improvement based on a review of feedback from local Clinicians to assist with implementing a process of assurance for CCGs that the urgent care system is fit for purpose.

Members raised the issue of access to GP appointments and Mr Philips responded that Darlington CCG have initiated a piece of work looking at access to appointments and that work was underway to match the level of supply against the demand. He commented the access to primary care needed to be flexible and right. GPs are aware that there are perceived problems, but some thought must be given to whether patients have actually tried ringing their GP Practice or have just assumed the cannot get an appointment, as they've been unable to in the past. Mr Maloney highlighted the Dr First initiative that NHS Tees are piloting which allows GPs to work in a different way and have more telephone discussions with patients which may avoid the need for them to attend the Practice / A&E.

Ms Groves reassured Members that 111 is not a way of by passing GP appointments as in hour patients would still be referred to GP Practices for an appointment if it was appropriate and work was undertaken to enable GP Practices to accept 111 referrals of patients.

AGREED – (a) That the Officers be thanked for their attendance at the meeting; and

(b) That the presentation and discussion be noted.

27. TRANSFORMING COMMUNITIES SERVICES – Samantha Merridale, Interim Programme Manager, South Tees CCG introduced a powerpoint presentation (slides previously circulated) outlining the Integrated Management and Proactive Care for the Vulnerable Elderly (IMPROVE) scheme. Ms Merridale outlined that the clinical drivers for the scheme as the rising prevalence of diseases such as COPD, Coronary Heart Disease, Stroke, Diabetes and Hypertension; an increasing elderly population and pressures around emergency and acute activity. The key principles are to provide/deliver sustainable, fully integrated, high quality care; gain better knowledge about those people and increase the potential to act upon that knowledge in a more proactive way; ensure better clinical outcome for those patients with long term conditions; descriptions of the clinical drivers for change; facilitate self-management and ensure that patients get the best functionality at the end of their health episode. A fully integrated approach across the entire health and social care system will ensure that the most appropriate interventions, in the right place, at the right time is offered.

Ms Merridale outlined the objectives is to offer a targeted and proactive individualised case management; improve routine care for all patients with long term conditions; reduce avoidable hospital admissions and readmissions following an exacerbation of condition; identify the need for, and improve access to, a range of integrated support services; meet national performance targets and outcome measures; enables better

management through early identification and risk assessment and rationalise delivery of care and support for these patients.

The successes reported so far include the introduction of a virtual ward, which is live across South Tess and involves proactive identification of those people deemed to be at risk of escalation of their long term conditions. The Rapid Response Nursing Services and additional teams of nursing resource across South Tees, to include Senior Nurses, Community Nurses and Community Therapists, aimed at helping to prevent emergency admissions, and supporting the management of patients in their own homes. The excellent engagement across the patch between primary, secondary and social care.

Members welcomed IMPROVE and queried whether it was achievable with being so aspirational. Ms Merridale advised that self-management of long term conditions was key and that there needs to be varying levels of support to enable people to self-manage their conditions. Minimal support could include providing advice and information, to a range of telehealth, telecare and telemedicine support and system monitoring. Members welcomed the use of telehealth and highlighted the successful results of the North Yorkshire pilot.

Representatives from County Durham and Darlington NHS Foundation Trust addressed the meeting and Diane Murphy, Associate Director for Transformation introduced a powerpoint presentation. The Associate Director informed Members of the Trusts' four touchstones being best outcomes, best experience, best efficiency and best employer. Now that the Trust is an integrated care organisation the focus is to shift the centre of gravity from hospital to community based services. The Trusts Clinical Strategy 2012 – 2015 includes six workstreams of which Members of Darlington Scrutiny Committee are very familiar with, following their scrutiny investigations.

Ms Murphy reported that the Trust has made progress by working with the CCGs, Local Authorities, Health and Well Boards and the Third Sector in a number of projects including working with Nursing Homes, Bariatric Surgery Pathways, End of Life Care, Liaison Psychiatry and One Point. The main benefits are to improve quality across the patient journey; integrated pathways; pathways are mapped and understood by all stakeholders to ensure whole system change with fewer handovers and silos to provide efficiency across the health and social care economy.

Reference was made to the Long Term Condition Collaborative work that has commenced with Darlington Borough Council, CCG, Tees, Esk and Wear Valley NHS Foundation Trust and the Trust, building on the achievements from the Dementia Collaborative. Ms Murphy advised it was early days with the project however, frequent flyers were currently being identified and the next stage would be to carry out discovery interviews to ascertain the pattern of behaviour.

AGREED – (a) That the Officers be thanked for their attendance at the meeting; and

(b) That the presentation and discussion be noted.