HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL BOROUGH COUNCIL

7 March 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. **TO CONFIRM THE MINUTES OF THE MEETING HELD ON 7 FEBRUARY 2013**

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 Final Draft of the Joint Health and Wellbeing Strategy – *Director of Public Health*

7. **ITEMS FOR DISCUSSION**

Health Inequalities

7.1 Female Life Expectancy in Hartlepool:-

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

(b) Presentation – *Specialist Registrar in Public Health*

Investigation into the JSNA Topic of Sexual Health

7.2 Draft Final Report – Investigation into the JSNA Topic of Sexual Health – *Health Scrutiny Forum*

8. **ISSUES IDENTIFIED FROM FORWARD PLAN**

No items.

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 4 February 2013

11. **REGIONAL HEALTH SCRUTINY UPDATE**

No items.

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

FOR INFORMATION:

Date of Next Meeting –18 April 2013, 9am in Council Chamber, Civic Centre, Hartlepool.

HEALTH SCRUTINY FORUM

MINUTES

7 FEBRUARY 2013

The meeting commenced at 9.00 a.m. in the Civic Centre, Hartlepool

Present:

Councillor Stephen Akers-Belcher (In the Chair)

Councillors: Keith Fisher, Ged Hall, Pamela Hargreaves, Geoff Lilley and Ray Wells.

Also Present: Barbara Carr - Assistant Director of Nursing and Patient and Public Involvement, North Tees and Hartlepool NHS Foundation Trust
Keith Wheldon - Quality Analyst, North Tees and Hartlepool NHS Foundation Trust
Ali Wilson, Chief Officer Hartlepool and Stockton-on-Tees Clinical Commissioning Group
Caroline Thurlbeck, Director of Operations and Delivery Durham, Darlington and Tees Area Team
Sue Prout and Nicola Jones, NHS Tees
Angie Wilcox, Paul Harriman and Rachel Maughan, Connected Care

Officers: Deborah Gibbon - Health Improvement Practitioner
Laura Stones, Scrutiny Support Officer
David Cosgrove, Democratic Services Team

121. Apologies for Absence

Councillor Brash.

122. Declarations of Interest by Members

None.

123. Minutes of the meeting held on 10 January 2013

Confirmed.

124. NHS Hartlepool and Stockton-On-Tees Clinical Commissioning Group's response to the investigation into 'Cancer Awareness and Early Diagnosis' (*Chief Officer NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group / Director of Public Health*)

The Chief Officer of the Hartlepool and Stockton-on-Tees Clinical Commissioning Group updated the forum on the progress of implementing the recommendations from the investigation into Cancer Awareness and Early Diagnosis. The Chief Officer commented that while the CCG would not be responsible for providing screening services it fully acknowledged the need to encourage take up of these services as much as possible with those called for screening or in at risk groups. It was also highlighted that the recommendations around high risk industrial workers and the contraction of cancers through the ingestion of particulates had commenced.

Members commented that it had become clear through the Tees Valley and North East Regional joint health scrutiny bodies that other authorities had conducted similar investigations reaching broadly the same conclusions. The CCG Chief Officer commented that issues such as working age men being a difficult group to target with cancer prevention messages was one that needed to be addressed across the region. The benefits of screening and early detection could not be underplayed.

Recommended

That the report be noted.

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

No Items.

126. Health and Wellbeing Strategy (*Director of Public Health*)

The Chief Officer of the Hartlepool and Stockton-on-Tees Clinical Commissioning Group submitted the second draft of the Health and Wellbeing Strategy for the forum's attention. There had been significant work in terms of the targets set within the second draft linked to national targets set by the government. The Strategy had now been circulated to all partner organisations for their input. Prior to the final version of the strategy being produced there would be some cross referencing work together with the finalisation of the targets.

Members welcomed the comments that there was to be some additional consideration within the strategy of the welfare reforms. The CCG Chief Officer indicated that all sectors were beginning to recognise that with benefit reforms there would be some families affected in new ways and new people falling into poverty. Through the strategy it was essential to ensure that these groups did not go unseen and were reflected through the plan. It

was acknowledged that this was not just a health issue and that housing and employment were major factors.

In response to Members comments the CCG Chief Officer indicated that the effect of the bedroom tax on families with children who were disabled or had learning difficulties was an issue and how this was picked up through the strategy was something the partners needed to consider. Members acknowledged that even the simple collecting of data may be important. The majority of families that would be affected through the welfare reforms were not benefit scroungers or workshy but hard working families that needed a little support. The changes could increase the numbers of children falling into poverty markedly. Members also requested that future data sets be reflective of the new ward boundaries in the town.

Recommended

That the second draft of the Hartlepool Health and Wellbeing Strategy be noted.

127. Briefing Report and Immunisation Strategy (*Director of Public Health*)

The Health Improvement Practitioner submitted a briefing update as requested by the forum on performance in immunisations in 2012. The statistics showed that performance was slightly behind the north east and national figures and the national targets. The numbers of children not receiving full immunisations was, due to the numbers involved, relatively low. Members indicated that it was believed that there were variations across the town in terms of immunisation. The Health Improvement Practitioner indicated that with the statistical figures being so low it was not known if this was the case.

Recommended

That the report be noted.

128. Health Reforms (*Scrutiny Support Officer*)

The Director of Operations and Delivery Durham, Darlington and Tees Area Team gave a presentation to the forum outlining the new structure of the NHS in the region and how the individual bodies now related to each other and their specific roles and functions.

The Chief Officer of the Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG) gave a presentation to the forum setting out the mission and strategic aims of the CCG.

Members questioned the numbers of General Practitioners (GPs) involved in commissioning. The CCG Chief Officer indicated that it had been agreed early in the process of developing the CCG that not all forty GP practices would be involved in sitting down together to commission services. There were a small number (4) GP's on the governing body but their primary role was still as a local GP seeing patients on a daily basis. The representatives

on the governing body had been elected from their professional groups, so while not being elected in the sense that most councillors would recognise, they were representative of their profession.

Members still did feel some frustration that the CCG governing body was not truly elected and it was difficult for the public to see how such a body was accountable.

The CCG Chief Officer indicated that there was guidance from Department of Health on the constitution of the governing body. There were some positions that were statutory. In terms of numbers of GPs involved, there was no stipulation and those involved were there because they want to be there and represent their body. There was no huge group of GPs pushing to be involved.

The CCG did have some very specific ways to take public opinion into account. Views were sought through the consultation and engagement strategy and commissioning plans would be shared with the forum and the Health and Wellbeing Board. When the CCG had appointed lay people to the governing body a representative of Hartlepool LINk had been involved in the process.

Members commented that there would be some very difficult commissioning decisions to be made with competing calls on limited resources and they questioned how such issues would be tackled by the Board particularly when disagreements arose. The CCG Chief Officer commented that this would happen at different levels through the new structure of the NHS but most would happen at the CCG level. The CCG had a duty to consult the public and the Health and Wellbeing Boards on their plans. While there would be some very difficult decisions to make, in the first year, the CCG had been sheltered from the worst of the funding cuts. Future years funding allocations would, however, be under closer scrutiny and there was an expectation that the review of the funding formula would adversely affect the north east. All CCGs would need to review there priorities and how and where they spent their money. It was essential that at all levels in the NHS and beyond that partner organisations worked together to ensure the best investment of funds where there were joint funding arrangements.

The CCG Chief Officer stated that this was an opportunity to do things differently and work together with partner organisations to a much greater extent than in the past. It was an opportunity for partners to work together to make a difference in the provision of health services.

Recommended

That the report and comments be noted and that the representatives of the Area Team and the Clinical Commissioning Group be thanked for their informative presentations.

129. Rollout of NHS 111 - Briefing Report (*Representatives from NHS Tees*)

The NHS Tees Representatives updated the forum on the development and roll-out of the new 111 telephone service. It was stated that the service would go live in April, though this would be a 'soft launch' to ensure the service was fully tested before a major publicity campaign was undertaken. The service in this area built upon the service that had been tested in Darlington and Durham and the clinical profiles to be adopted through the telephone triage service had been led by Dr Barlow, a Stockton GP. All out of hours services would transfer to the 111 line after launch. There had been significant testing of the service already and local providers had been engaged in this process to ensure that the triage service directed people to the right place, be that their GP, a walk-in centre such as the One Life Centre or A&E.

Members welcomed the new service and did feel that for many members of the public it would resolve issues around the One Life Centre. Members did express some grave concerns that the Police were also promoting a 101 telephone number for the reporting of low-level crime such as anti-social behaviour. Members considered that having two such similar telephone numbers showed a distinct level of short-sightedness in those responsible for the two services.

Members commented that some people had raised concern that when calling 999 for an ambulance they had had to go through quite a number of questions with the person on the line when they believed they were in an emergency situation. It was acknowledged that this was a necessary part of the triage process and Members questioned if the staff on the 111 service would through their triage process be able to very quickly identify when the situation may be an emergency warranting the immediate dispatch of an ambulance. The NHS Tees representatives indicated that the training of staff and the testing process had taken this issue into account as one of the most important aspects of the service. The staff would be able to quickly move the call onto a 999 service when it became clear that was the situation. The two services call centres were also located side by side in the same building.

The NHS Tees representatives confirmed in response to a Members question that the 111 service would be a free service even from mobile phones.

Recommended

That the update report be noted.

130. North Tees and Hartlepool NHS Foundation Trust – Quality Account 2013/14 (*Scrutiny Support Officer*)

The Assistant Director of Nursing and Patient and Public Involvement, North Tees and Hartlepool NHS Foundation Trust gave a presentation outlining

the three key priorities – Patient Safety, Effectiveness of care and Experience – and the feedback of the consultation for the Quality Accounts for 2013/14. From the feedback received, the Trust had established the following key issues under each of the priorities –

Patient safety; Dementia care, Safeguarding adults (Learning disabilities and sensory loss), and Infection control – Clostridium Difficile.

Effectiveness of care; Discharge processes – information, Discharge processes – medication, Discharge processes – Safe and Warm, and Nursing dashboard.

Patient experience; End of life Pathways and Family's voice, Is our care good (patient surveys), and Friend's and Family recommendation

The Quality Account would undergo a further period of consultation closing on 4 March 2013. Some further statistical detail was required for some of the indicators and once all the information was present and after the close of the next round of consultation the final documents would be submitted to external auditors in April and published in May 2013.

The Chair welcomed the draft document and indicated that the account showed great improvement over earlier past year's versions of the document and thanked the team. The Chair highlighted that certain issues persisted around A&E and there was a general feeling developing that people from Hartlepool still did not like having to go to North Tees Hospital for A&E services.

The Chair commented that as there was no further meeting of the Forum before the 4 March consultation close, Members should feed any comments on the draft document to the Scrutiny Support Officer who would finalise the comments with the Chair and Vice –Chair and then forward them onto the Trust.

Recommended

That the draft Quality Accounts document 2013/14 be noted and that any comments on the document be forwarded to the Scrutiny Support Officer for finalisation with the Chair and Vice-Chair and then forward onto the Trust

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

The Scrutiny Support Officer submitted the six monthly update report on the implementation of recommendations from scrutiny investigations approved by the Forum.

At a meeting of the Forum in late 2012, Members had requested that an update report on the progress being made on the roll out of the connected care approach across Hartlepool. Representatives of Connected Care were in attendance at the meeting and gave a presentation updating the Forum on the roll out of the connected care approach and the services being

delivered including some examples of the individual one-to-one casework undertaken for Members information.

Members commented that they had been very impressed with the services provided by Connected Care and some Members relayed their experience of referring constituents to the services provided by Connected Care and the positive outcomes achieved. Members queried the advice centres used and the provision of advice and support for people facing tribunals, particularly those as a result of the welfare reforms. The Connected Care representatives indicated that advice and support was offered through a number of venues including the West View Advice and Resource Centre. There was no remaining support for people facing tribunals in Hartlepool and while some support was provided through the West View Advice and Resource Centre, demand was outstripping supply greatly.

Members queried the structure and governance of the organisation and the appointment of directors of the community interest company, Who Cares (NE), as it was understood a number of directors had resigned. The representatives indicated that some amended governance policies had been put in place following an interim review.

Members questioned the source of the referrals into Connected Care. The representatives indicated that the majority of the referrals (52%) originated from the south of thw town which was to be expected as the service was originally established in this area. 33% of referrals came form the north of the town with the remaining 15% from the centre. It was acknowledged that further work was required in the centre of the town to increase referrals and an outreach office had recently opened in the Burbank Centre.

The Forum welcomed the report and commented that the services provided were of high quality. Utilising the service to provide as wide a range of support as possible was seen as being extremely positive as could be seen from the handyman service which looked beyond the simple jobs people may have requested. There still remained questions around the commissioning of the service, which had been an issue recently re-visited by Cabinet but Members supported the work that was being done.

Recommended

1. That the six-monthly monitoring report be noted.
2. That the revised conclusion date of 30 September 2013 for recommendation SCR-HSF/3h relating to the securing of 'purple flag' status in relation to the nigh-time economy be agreed.
3. That the update report from Connected Care be noted and the representatives thanked for their presentation.

132. Investigation into the JSNA Topic of Sexual Health - APAUSE AND C-Card (*Scrutiny Support Officer*)

The Health Improvement Practitioner updated the Forum on the APAUSE programme and the C-card services as part of the investigation into the JSNA topic of Sexual Health. The APAUSE programme was delivered by

Tees Health through the secondary schools in the town and involved teachers and health professionals in its delivery. There had been a cost of approximately £35,000 to deliver the service, based mainly on the cost of training and a coordinator for the programme. The programme did have a coordinated approach to delivering sexual health messages to young people and had a strong evidence base through the use of peer education methods. Members expressed disappointment that this programme had been withdrawn and questioned why. It was confirmed that the withdrawal of the programme was due to cost and resource issues . Schools currently offered 'The Bumpy Rides' programme which was a web based resource which offered a wider holistic risk and resilience curriculum for years 7 to 10 pupils.

The C-Card scheme was a free and confidential service providing free condoms, advice and information to young people. The C-Card was recognised at a number of outlets where young people could show their card and be given new supplies without the need for further consultation. There were currently 45 sites in Hartlepool with 119 youth workers/volunteers trained to deliver the C-Card scheme. The C-Card scheme was currently provided by Assura Virgin Care.

Members commented that the general feedback from the APAUSE programme was that it did work with young people primarily due to peer involvement. It was suggested that from within the overall budget, the APAUSE scheme should be restarted. The Health Improvement Practitioner commented that the APAUSE programme did work as a preventative educational scheme rather than the current alternatives which were more centred around clinical provision. Support for the provision of a service based on prevention would be welcomed by many professionals delivering the services. Members indicated that they would support the reintroduction of the APAUSE scheme.

The Chair commented that he would also wish to see the delivery of the C-Card programme more accessible as some groups were experience difficulties in getting their volunteers trained. There were also issues around venues and groups becoming C-Card accredited.

Recommended

1. That the report and Members discussions be noted.
2. That a recommendation on the reintroduction of the APAUSE programme be included in the final report of the investigation into the JSNA topic of Sexual Health.

133. Investigation into the JSNA Topic of Sexual Health - Written Evidence from St Hild's Church of England School (*Scrutiny Support Officer*)

The Scrutiny Support Officer submitted written evidence from St Hild's School for consideration as part of the investigation into the JSNA topic of Sexual Health. Members queried whether other schools had been given the

opportunity to comment on the investigation and the Chair assured Members that all schools had been invited to submit their comments.

Recommended

That the evidence form St Hild's School be noted.

134. Investigation into the JSNA Topic of Sexual Health - 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

The Scrutiny Support Officer tabled a draft list of recommendations for Members consideration as the investigation into the JSNA topic of Sexual Health drew towards its conclusion. Members indicated that the comments made in this meeting would also need to be added to the recommendations listed. The Chair indicated that the list of recommendations would form the basis of the draft recommendations to be considered by the Forum in the Draft Final Report at the meeting in March.

Recommended

That the report be noted.

135. Feedback Report: Visit to Bournemouth Borough Council (*Chair of the Health Scrutiny Forum*)

The Chair submitted a feedback report following the visit to Bournemouth Borough Council, an early implementer of a Health and Wellbeing Board for the Forum's information. Members noted that from the report the importance of a jointly agreed JSNA to tackle local priorities with partners.

Recommended

That the report be noted.

136. North East Ambulance Services (NEAS) Quality Account (*Scrutiny Support Officer*)

The Scrutiny Support Officer submitted for the Forum's information the draft Quality Account 2013/14 from the North East Ambulance Service (NEAS). The Chair commented that the document had only been received with very short notice before the meeting and if any members had any specific comments they should contact the Scrutiny Support Officer who could then feed them back to NEAS.

Recommended

That the report be noted.

137. Issues identified from the Forward Plan (*Scrutiny Support Officer*)

The Scrutiny Support Officer submitted details of key decisions contained within the Executive's Forward Plan February to may 2013 relating to the Health Scrutiny Forum.

Recommended

That the report be noted.

138. Minutes of Recent Meetings of the Shadow Health and Wellbeing Board

The minutes of the meeting of the Shadow Health and Wellbeing Board held on 10 December 2012 were submitted for the Forum's information.

Recommended

That the minutes of the Shadow Health and Wellbeing Board be noted.

139. Minutes of Recent Meetings of Tees Valley Health Scrutiny Joint Committee

The minutes of the Tees Valley Health Joint Scrutiny Meeting held on 7 January 2013 were submitted for the Forum's information.

Recommended

That the minutes of the Tees Valley Health Joint Scrutiny Meeting be noted.

140. Regional Health Scrutiny Update

No items.

141. Any Other Items which the Chairman Considers are Urgent

Members commented that in light of the large amount of paperwork submitted to the meeting, future issues such as the development of the Health and Wellbeing Strategy for example, should be based on reports providing an update rather than a total resubmission of the strategy documentation. The Chair requested that officers note and act upon this request where possible.

The meeting concluded at 11.40 a.m.

CHAIR

HEALTH SCRUTINY COMMITTEE REPORT

Report of: Director of Public Health

Subject: FINAL DRAFT OF THE JOINT HEALTH AND WELLBEING STRATEGY

1. PURPOSE OF REPORT

1.1 The purpose of this report is to present to Health Scrutiny Forum the final draft of the joint Hartlepool Health and Wellbeing Strategy (JHWS) for comment.

1.2 Members requested at a previous meeting, that they wished only to be updated on the changes since the second draft of the strategy in the interests of efficiency. Therefore, the changes that have been made are highlighted in section 3. A copy of the final draft of the strategy is available in the member's library and online.

2. BACKGROUND

2.1 NHS reforms require the Local Authority with partner agencies including the NHS to develop a joint Health and Wellbeing Strategy based on the Joint Strategic Needs Assessment (JSNA). The final strategy must be adopted by April 2013. The strategy should focus on not only protecting the health of the population but improving it through a range of evidence based interventions.

2.2 The strategy is based on the Marmot Report (2010) focusing on the following policy areas:

- Give every child best start in life
- Enable all children and young people to maximise capabilities
- Enable all adults to maximise capabilities
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places
- Strengthen the role and impact of ill health prevention

3. CONSIDERATIONS FOR HEALTH SCRUTINY FORUM

3.1 The following amendments have been made to the draft Health and Well Being Strategy since the second draft was presented to the Forum in January 2013:

- Foreword added
- Section 3. The Case for improving Health and Wellbeing in Hartlepool.

  The map showing life expectancy within our old wards has been replaced with two new maps. The first (figure 1) shows levels of deprivation within our new wards and the second (figure 2) shows the Standard Mortality Ratio within the new Wards and the correlation between poor health and deprivation.
- Section 7. Strategic Priorities

  The Key Outcomes and Objectives of the strategy have been added to this section.
- Section 8. Strategy Ownership and Review.

  This section has been added to explain the strategy ownership and how the Annual Action Plan will be managed and reviewed.
- Appendix 3 - The NHS Hartlepool Stockton on Tees CCG Plan on a page has been updated.

3.2 The annual action plan for the strategy is still being revised and the final version of this plan will be presented with the strategy to full Council in April 2013.

4. NEXT STEPS - PROCESS AND TIMESCALES

4.1 The following timetable below outlines the next steps in final political approval of the Strategy.

Step 4 - Political Approval for Strategy. March – April 2013.		
Where	**Description**	**Date of Meeting**
Health Scrutiny Forum	Final Strategy for approval	7 March 2013
Scrutiny Co-ordinating Committee	Final Strategy for approval	8 March 2013
Shadow Health & Wellbeing Board	Final Strategy for approval	11 March 2013

Cabinet	Final Strategy for approval	2 April 2013
Council	Final Strategy for approval	11 April 2013

5. RECOMMENDATIONS

5.1 Health Scrutiny Forum is asked to comment on the final version of the Hartlepool Health and Wellbeing Strategy and note that the strategy and final action plan will be presented to Council in April 2013.

6. APPENDICES AVAILABLE ON REQUEST, IN THE MEMBERS LIBRARY AND ON-LINE

Appendix A - Draft Hartlepool Health and Wellbeing Strategy and Action Plan.
Appendix B - Equality Impact Assessment of Draft Health and Wellbeing Strategy.

7. BACKGROUND PAPERS

7.1 Report to Health Scrutiny Forum on 27th July 2012 regarding consultation process for Health and Well Being Strategy.

Report to Health Scrutiny Forum on 19th October 2012 regarding first draft of Health and well Being Strategy.

Report to Health Scrutiny Forum on 18th January 2013 on second draft of Health and Well Being Strategy.

8. CONTACT OFFICER

Louise Wallace
Director of Public Health
4th Floor Civic Centre
Hartlepool Borough Council

HARTLEPOOL HEALTH AND WELLBEING STRATEGY 2013-18

Foreword

Healthy people living longer, healthier lives is the aspiration of the Hartlepool Health and Wellbeing Board.

This newly created Board brings together a range of agencies, including the Council and the Clinical Commissioning Group for the NHS, with a joint ambition to support people to make healthier choices, maximise opportunities for wellbeing and ensure a healthy standard of living for all.

This Strategy sets out how the Health & Wellbeing Board for Hartlepool intends to achieve this ambition.

The Strategy is not all about treating illness, although high quality accessible services are vital when needed; it is also about helping people to make healthier choices. Detecting illness early and ensuring people get effective and timely treatment is essential. Equally important for health is the need for people to live in good quality, affordable housing, with education and employment opportunities to maximise control and capabilities, as well as achieving a good standard of living for all.

This Strategy intends to address the challenges of ill health and premature death in Hartlepool. In Hartlepool there is a 9 year gap between affluent and deprived communities in how long a man might expect to live. This life expectancy gap is 7 years for women. This is a great social injustice, which is unfair and needs tackling through all of the interventions and actions proposed through this Strategy.

This Strategy is based on what you, the people of Hartlepool, have told the Health & Wellbeing Board matters. The public consultation that was undertaken when developing this Strategy showed that the people of Hartlepool wanted their children to have the “best start in life”.

Through the energy, effort and drive of all involved in this Strategy, that is what we aim to do. Not only give the “best start in life”, but the best health and wellbeing throughout life and make Hartlepool a healthier, happy and vibrant town.

Partnership organisations
To be added: Sign-up page with organisations’ logos.

1. Vision

The vision of the Hartlepool Health & Wellbeing Strategy is to:

> ***Improve health and wellbeing and reduce health inequalities among the population of Hartlepool.***

This will be achieved through integrated working, focusing on outcomes and improving efficiency.

2. Purpose

The Joint Health and Wellbeing Strategy (JHWS) is a strategic document outlining how Hartlepool Borough Council, Hartlepool and Stockton Clinical Commissioning Group and other key organisations, through the Health and Wellbeing Board, will address the health and wellbeing needs of Hartlepool and help reduce health inequalities.

The Health and Social Care Act (2012) establishes Health and Wellbeing Boards as statutory bodies responsible for encouraging integrated working and developing a Joint Strategic Needs Assessment and Health and Wellbeing Strategy for their area[1]. The Strategy is underpinned by the Joint Strategic Needs Assessment (JSNA) and together they will provide a foundation for strategic, evidence-based, outcomes-focused commissioning and planning for Hartlepool[2].

3. The case for improving health and wellbeing in Hartlepool

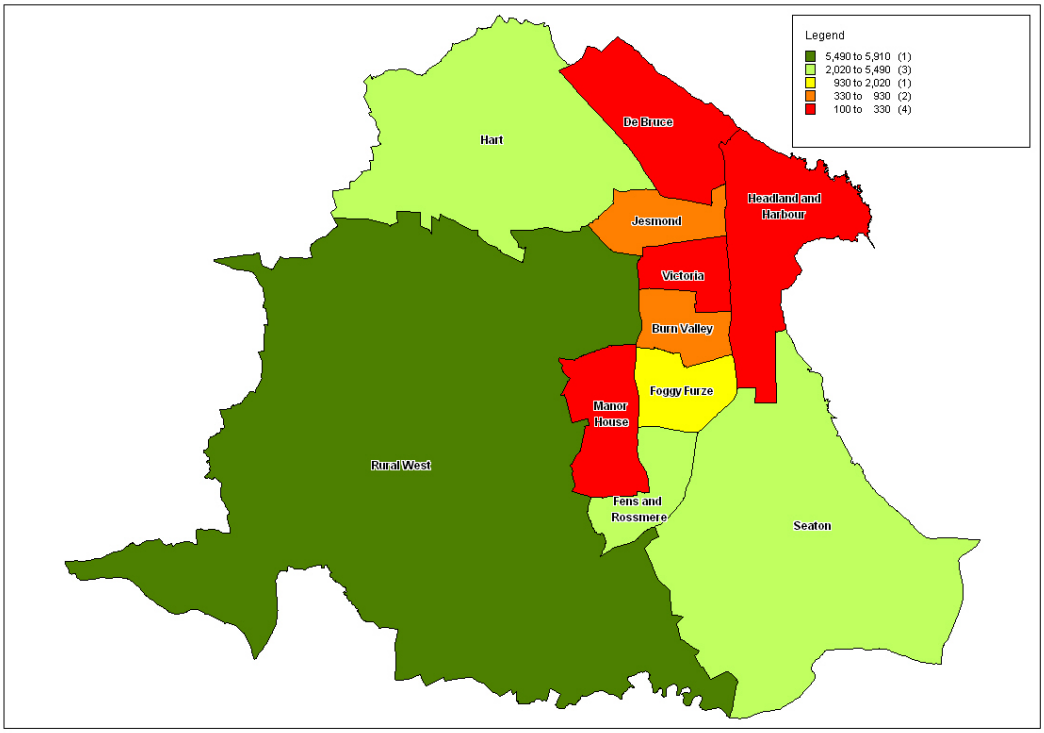
Health in Hartlepool is generally improving. There has been a fall in early deaths from heart disease and stroke; and the rate of road injuries and deaths is better than the England average[3].

However, there is still much to do (**Box 1**). Health in Hartlepool is still worse than the national average. Levels of deprivation are higher and life expectancy is lower than the national average. **Figure 1** shows the levels of deprivation in Hartlepool and **Figure 2** shows the difference in Standard Morality Ratio (SMR) between the deprived and more affluent areas of the Borough.

Box 1: At a glance: Health initiatives and challenges in Hartlepool[3]

- Levels of deprivation are higher and life expectancy is lower than the England average.
- Inequalities exist: life expectancy is 9 years lower for men living in the most deprived areas, compared to least deprived areas. The difference is 7 years for women.
- Over the last 10 years, the death rate from all causes has fallen for men but has fluctuated for women.
- The early death rate from cancer has changed little over the last 10 years.
- Both the death rate from smoking and the percentage of mothers smoking in pregnancy are worse than the England average.
- Alcohol-related hospital admissions are higher than the national average.
- Childhood immunisations rates are significantly lower than the national average.
- 25% of Year 6 pupils are classed as obese, this is the highest in the Tees Valley.

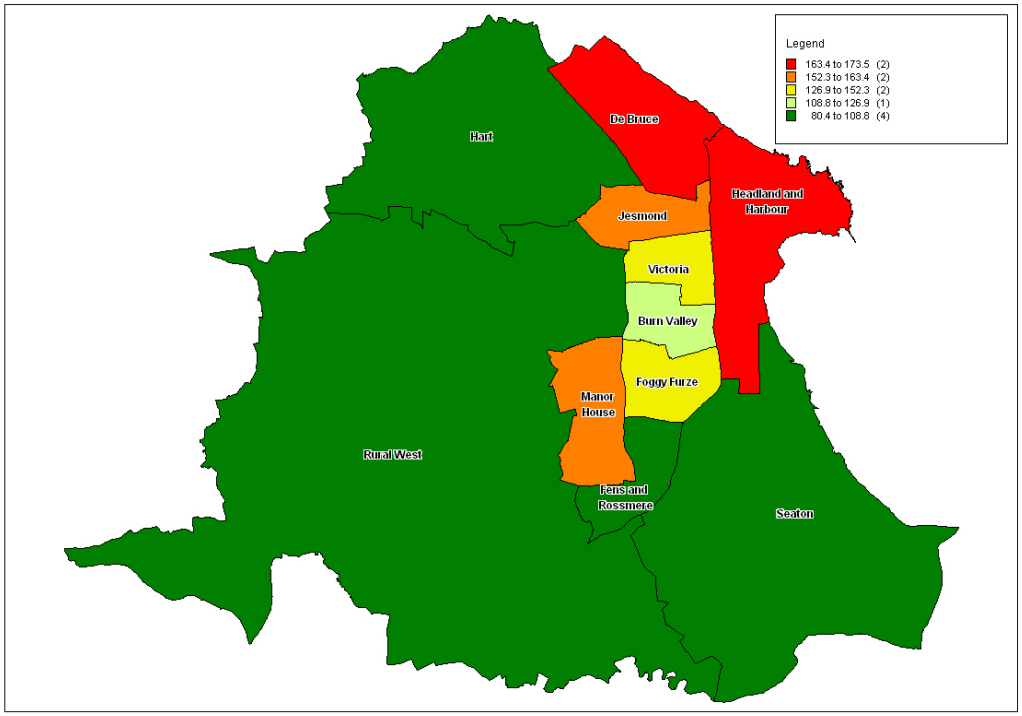
Figure 1: Index of Multiple Deprivation at Ward level in Hartlepool



The Index of Multiple Deprivation provides a relative measure of deprivation in small areas across England. They are based on the concept that deprivation consists of more than just poverty. Poverty is not having enough money to get by on whereas deprivation refers to general lack of resources and opportunities. The above map shows the levels of deprivation within Hartlepool by Ward. The IMD 2010, tells us that there are high levels of deprivation within six of Hartlepool's eleven wards; those being De Bruce, Headland and Harbour,

Victoria, Manor House, Jesmond and Burn Valley. There is a clear correlation between levels of deprivation and poor health. The lower a persons social position the more likely it is that his or her health will be worse.

Figure 2: Standard Mortality Ratio in Hartlepool (Ages 0 – 64)

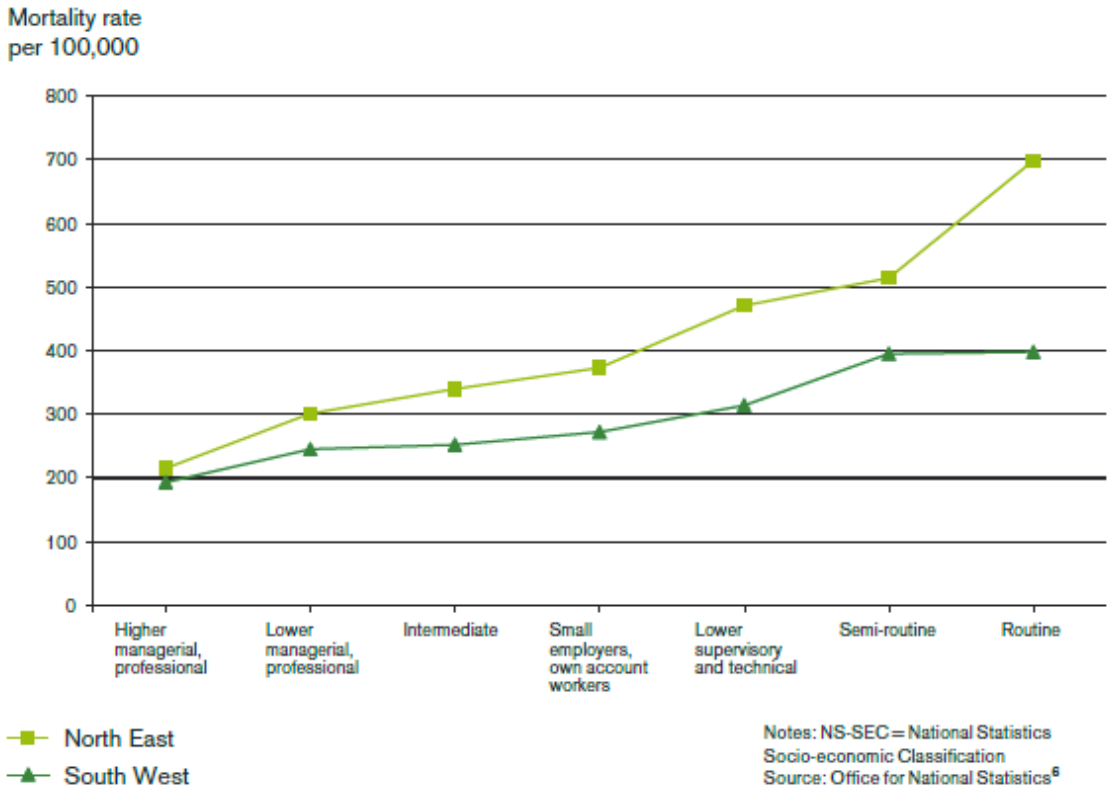


The Standard Mortality Ratio (SMR) compare local death rates with national ones. They are calculated by dividing the actual number of deaths in an area by the number that would be expected using National death rates by ages and sex of the population. The resulting number is multiplied by 100. If an area has an SMR of 100, this indicates that local death rates are similar to National rates. If they are greater than 100, this indicates higher death rates than the national average and vice versa. SMRs are often used as proxy indicators for illness and health within an area. Clearly there is a link between SMR and levels of deprivation with Hartlepool's most disadvantaged Wards having a significantly higher score than the national average.

There is a 9 year difference in male life expectancy between the most advantaged and the most disadvantaged wards in Hartlepool[3,14]. We know that socio-economic inequalities lead to inequalities in life expectancy and disability-free life expectancy. Furthermore, the relationship between these is finely graded – for every decrease in socio-economic conditions, both life expectancy and disability-free life expectancy drop. Social and economic inequalities are important causes of this relationship[4]. In his *Strategic Review of Health Inequalities in England* (2010)[4], Prof. Sir Michael Marmot argues that fair distribution of health, wellbeing and sustainability will impact positively on the country's economic growth. To improve health and wellbeing, action is needed

across all social determinants of health to reduce health inequalities; and to make a difference, action to improve health and wellbeing should be across all socio-economic groups but tailored to a greater scale and intensity as the level of disadvantage increases[4]. As demonstrated in **Figure 3**, the effect of socioeconomic disadvantage on life expectancy is greater in more disadvantaged areas. However, the effect is also more pronounced in the North East compared to the South West, for all socioeconomic groups.

Figure 3: Age-standardised mortality rates by socioeconomic classification (NS-SEC) in the North East and South West regions, men aged 25-64, 2001-2003[4]



We also know that focusing on early years interventions – giving children the best start in life – helps deliver the greatest benefits in health inequalities and economic terms. Health and wellbeing improvements delivered during childhood can reap benefits both in early life and throughout the individual's life-course[4].

4. What does this Strategy cover?

This Strategy outlines the strategic health and wellbeing priorities for Hartlepool. It builds on the good work already underway, whilst maximising the opportunity for better integration of services and closer partnership working presented by moving much of the NHS Public Health services, into Local Authorities. Working together with other areas in the North East will help achieve better outcomes and

value, for the 'big issues' in health and wellbeing[5]. The Strategy supports the ten themes of *Better Health, Fairer Health* (2008)[5,6] – the North East's vision and 25 year plan for improving Health and Wellbeing which is supported by other Local Authorities across the North East (**Box 2**).

Box 2: *Better Health, Fairer Health* (2008)[6]

- Economy, culture and environment
- Mental health, happiness and wellbeing
- Tobacco
- Obesity, diet and physical activity
- Alcohol
- Prevention, fair and early treatment
- Early life
- Mature and working life
- Later life
- A good death

'Health and Wellbeing' has a broad remit and it will be important for a range of partner organisations to work together, to deliver improvement. This Strategy focuses on areas of work impacting directly on health and wellbeing, or acting as clear 'wider determinants' of health and wellbeing.

The National Review of Health Inequalities, 'Fair Society, Healthy Lives', led by Prof. Sir Michael Marmot, drew on extensive global research into Health inequalities. Reflecting on inequalities in our society and health inequalities in particular, Prof. Sir Marmot stated: *'To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. Greater intensity of action is likely to be needed for those with a greater social and economic disadvantage. But focussing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem'.*

The Marmot review identified six 'Areas for Action'. These are:

- Give every child the best start in life;
- Enable all children, young people and adults to maximise their capabilities and have control over their lives;
- Create fair employment and good work for all;
- Ensure a healthy standard of living for all;
- Create and develop healthy and sustainable places and communities;
- Strengthen the role and impact of ill health prevention.

To focus activity in these areas, the key outcomes within this strategy reflect these wider determinants.

Other elements of health and wellbeing (initially summarised by Dahlgren and Whitehead in their social model of health[7] - **Appendix 1**) will be outside the direct remit and influence of the Health and Wellbeing Board and its partner organisations. They will be delivered through associated strategies and work programmes within Hartlepool Borough Council, the NHS and associated partners. Communication and governance processes will ensure links between departments and strategies to limit duplication, further build joint working and integration and enable economies of scale. The action plan underpinning the Strategy will define the activities needed to deliver the outcomes in the Strategy, and the partners responsible. The work will take place in the context of local service provision, including the Momentum project, which focusses on redesigning services and providing care closer to home.

5. Our Values

To work together successfully and achieve the vision set out in this Strategy, it is important that all organisations involved sign up to and work within, a set of shared values[8,9]. For Hartlepool, these values fit with the proposed operating principles for Boards[8] and the Board Terms of Reference. The values are:

- Partnership working and increased integration[2,8] across the NHS, social care and Public Health
- Focus on health and wellbeing outcomes
- Focus on prevention
- Focus on robust evidence of need and evidence of 'what works'
- Ensure the work encompasses and is embedded in the three 'domains' of Public Health practice: Health Protection, Health Services and Health Improvement[10]
- Shared decision-making and priority-setting, in consultation with CCGs and other key groups
- Maintain an oversight of and work within the budgets for health and wellbeing
- Support joint commissioning and pooled budget arrangements, where all parties agree this makes sense
- Maximise the process of democratic accountability and develop the Strategy and related plans in consultation with the public and service users

The Health and Wellbeing Board and the Health and Wellbeing Strategy provide the opportunity to maximise partnerships and evidence base, generating new ways of tackling health and wellbeing challenges. This includes recognising and mobilising the talents, skills and assets of local communities to maximise health and wellbeing[11].

6. Identifying our key outcomes

The Strategy's key outcomes and objectives have been developed in consultation with stakeholders and with the following in mind:

- Services Hartlepool Borough Council will be mandated to provide from April 2013[12]. The services are listed in **Appendix 2**.

- Clinical Commissioning Group draft plans

The Strategy has been developed in close liaison with the Clinical Commissioning Group for Hartlepool and Stockton-on-Tees, whose draft Clear and Credible plan[13] has highlighted key challenges: cardiovascular disease; cancer; smoking –related illness e.g. COPD; alcohol-related disease. These areas reflect the results of a 2010 public engagement campaign, which recorded the views of 1883 people regarding priorities for them and their families. See **Appendix 3** for an overview of the draft CCG commissioning plan.

- The Health and Wellbeing Strategy should be read in conjunction with the Joint Strategic Needs Assessment (JSNA). The JSNA is currently being refreshed through engaging partners and will outline the commissioning intentions for health and social care. The JSNA website address is http://www.teesjsna.org.uk/hartlepool/

- Hartlepool Public Health Transition Plan

The transition plan outlines the proposed activity to be funded through the Public Health budget (**Appendix 4**).

Stakeholder engagement and consultation

It is very important that this Strategy reflects both the evidence available about population health and wellbeing need; and the views and priorities of stakeholders. Stakeholders have been involved throughout the development of the Strategy, including the public, service users and partner organisations. The Shadow Health and Wellbeing Board membership which owned the Strategy included LINkS representation, democratically elected members, NHS organisations and Local Authority representation.

A full consultation process provided the opportunity to identify the public's priorities for health and wellbeing in Hartlepool; and the outcomes of the consultation have been reflected in the priorities for the Strategy. The consultation process and a summary of its outcomes is outlined in **Appendix 5**.

7. Strategic priorities and objectives

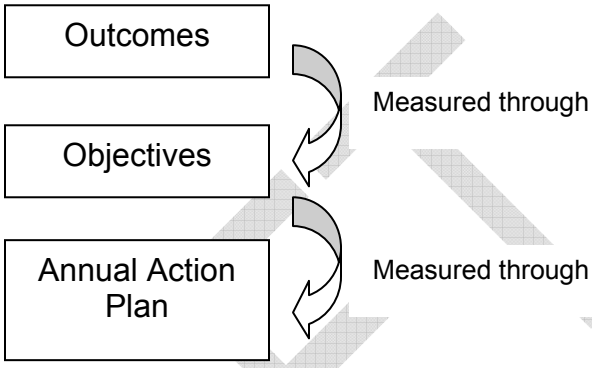
The outcomes outlined within the Strategy reflect the 'areas for action' identified by Marmot reflecting the wider determinants of health and wellbeing.

The key objectives that sit beneath each outcome are aligned with a number of key strategies being delivered across the Borough to ensure the effective coordination of delivery. The objectives show how the Health and Wellbeing Board for Hartlepool will deliver on the outcomes identified, and meet the challenge set out by Marmot's suggested 'areas for action'. The key objectives are:

Outcome 1: Give every child the best start in life	
Objective A	Reduce child poverty
Objective B	Deliver early intervention strategy
Outcome 2: Enable all children and young people to maximise their capabilities and have control over their lives	
Objective A	Children and young people are empowered to make positive choices about their lives
Outcome 3: Enable all adults to maximise their capabilities and have control over their lives	
Objective A	Adults with health and social care needs are supported to maintain maximum independence.
Objective B	Vulnerable adults are safeguarded and supported while having choice and control about how their outcomes are achieved.
Objective C	Meet Specific Housing Needs
Outcome 4: Create fair employment and good work for all	
Objective A	To improve business growth and business infrastructure and enhance a culture of entrepreneurship
Objective B	To increase employment and skills levels and develop a competitive workforce that meets the demands of employers and the economy
Outcome 5: Ensure healthy standard of living for all	
Objective A	Address the implications of Welfare Reform
Objective B	Mitigate against the impact of poverty and unemployment in the town
Outcome 6: Create and develop healthy and sustainable places and communities	
Objective A	Deliver new homes and improve existing homes, contributing to Sustainable Communities
Objective B	Create confident, cohesive and safe communities
Objective C	Local people have a greater influence over local decision making and delivery of services
Objective D	Prepare for the impacts of climate change and takes action to mitigate the effects
Objective E	Ensure safer and healthier travel
Outcome 7: Strengthen the role and impact of ill health prevention	
Objective A	Reduce the numbers of people living with preventable ill health and people dying prematurely
Objective B	Narrow the gap of health inequalities between communities in Hartlepool

Delivery on the objectives will be ensured through an annual action plan which supports this Strategy. The action plan specifies the detailed initiatives to deliver on the objectives and will also include, amongst others, the indicators identified in the Public Health Outcomes Framework[15]. **Figure 2** summarises the mechanism for ensuring delivery on the key outcomes.

Figure 2: Delivering on the key outcomes



Due to the broad nature of health and wellbeing, improvements will only be seen if the health and wellbeing agenda is also embedded in wider relevant Local Authority strategies and services. The action plan outlines how this is being done.

8. Strategy ownership and review

This Strategy is owned by the Health and Wellbeing Board. Although the Strategy is a 5 year document it will be reviewed by the Board every 3 years to ensure that it remains relevant and continues to reflect local priorities.

Each year the Board will agree an action plan setting out how the Strategy will be delivered. The action plan will set out agreed timescales for delivery and clear ownership for the actions. The action plan will also include a number of performance indicators which will be used to assess the progress being made. The key risks for implementing the Strategy will also be identified. The Board will monitor progress through quarterly performance reports and seek to maximise resources and secure new resources into the Borough.

The next review of the Health & Wellbeing Strategy will take place by April 2016.

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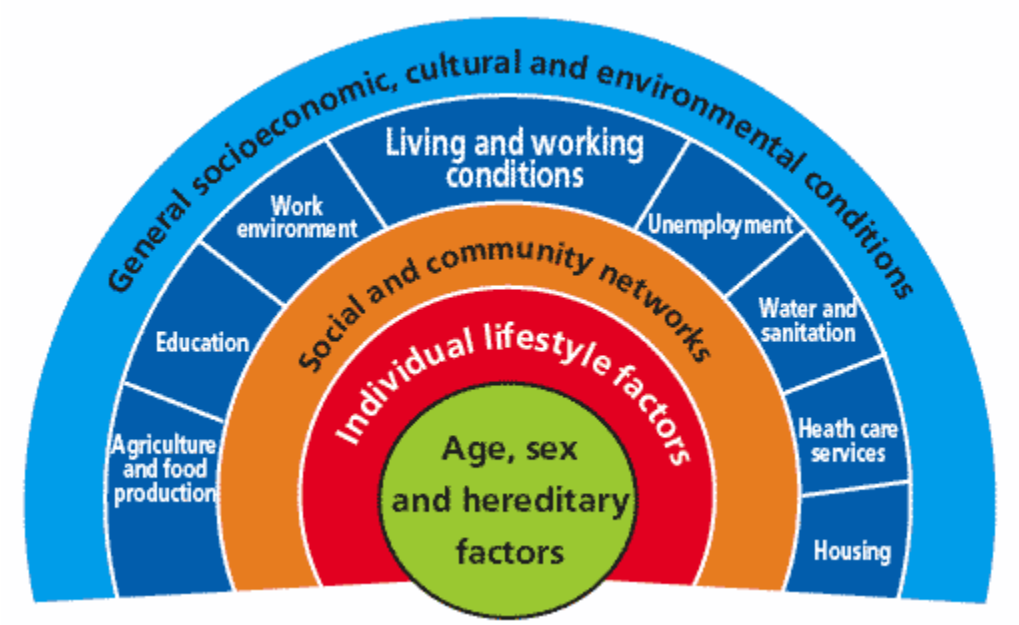
Appendices

Appendix 1: Social model of health (Dahlgren and Whitehead, 1998)[7]



Appendix 2:

Local Authority mandated services[12]

Under the coalition government's proposals for the new Public Health system, Local Authorities will be mandated to provide the following from April 2013:

- Appropriate access to sexual health services
- Steps to be taken to protect the health of the population, in particular, giving the Director of Public Health a duty to ensure there are plans in place to protect the health of the population
- Ensuring NHS commissioners receive the public health advice they need
- The National Child Measurement Programme
- NHS Health Check assessment

Consideration is also being given locally to the various additional services not covered by this list, which would be important to continue to provide e.g. stop smoking services.

Appendix 3: NHS Hartlepool and Stockton-On-Tees CCG – Plan on a Page 2013/14

Vision (CCP page 7)

To build 21st century health services for and with the Stockton-On-Tees and Hartlepool communities so that health inequalities reduce and wellbeing continuously improves.

Strategic Aims (CCP page 12)

- Bringing care closer to home
- Tackling Health Inequalities
- Caring for an aging population
- Addressing our priority health conditions
- Improving quality in primary care
- Ensuring quality and patient safety
- **Improving patient experience**
- Seeking best value for money within budget

Transformational Work Streams & Cross cutting themes (CCP page 12)

- **Health and Wellbeing**
  - ***Priority***
  - Maternal smoking at delivery
- **Out of Hospital Care**
  - ***Priority***
  - Emergency Readmissions within 30 days of discharge From hospital
- **Acute In-Hospital Care**
- **Mental Health, Learning Disabilities and Dementia**
  - ***Priority***
  - Estimated diagnosis Rate for people with Dementia
- **Medicines Optimisation**

Personalisation; Carers; PPI; Prevention; Innovation

Prioritised Initiatives (Commissioning Intentions) [link to outcome framework domains]

- Commission sufficient capacity to meet the demand of the screening programmes
- Work with Primary Care Providers to increase uptake of bowel screening
- Reduce Hospital Admissions in relation to alcohol;
  - Signposting to support services offered to patients identified
  - Collaborate with Public Health in relation to delivery of the alcohol strategy and determine future requirements for commissioned services
- Reduce smoking prevalence;
  - Collaborate with Public Health to develop a joint strategy in relation to smoking cessation services to improve access and attendance and focus on improving the quit rate of women smoking at time of delivery
  - Ensure the smoking cessation services are linked to the Community Renaissance Teams
- Reduce COPD Admissions
  - Carry out a review of acute and community respiratory services
  - Commission a range of preventative initiatives such self care packs and patient education

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- Improve the Quality of Care within Residential and Nursing Homes
  - All residential/ nursing home patients will have a regularly reviewed Health Care Plan (HCP)
- Triage and signpost patients who are not appropriate to be seen in A&E to the relevant care provider in order to support the re-education programme
- Implement management plans for all patients identified by the LACE tool as being at high risk of readmission
- Review and audit of the new community services model
- Developing integrated health care facilities in Stockton, Billingham, Hartlepool and Yarm
- To improve the quality and capacity in Primary Care
  - Better understand capacity and demand within Primary Care to determine future commissioning intent
  - Continue to support Primary Care in reducing variation in General Practice, both in terms of quality and financial spend
- Reduction in readmissions

- Continued Reduction in C2C Referrals
- Reduction in N:R ratio and review of Nurse delivered clinics
- Extend the Hartlepool plastics service to include access for Stockton patients
- Choose & Book
  - Ensure letters are reviewed prior to clinics to ensure patients are attending correct clinics
  - Ensure patients are redirected to most appropriate clinics where wrong referral has been made
  - Ensure advice and guidance is available via Choose and Book
- Implement revised MSK pathway
  - Pathway to include direct access to core Physiotherapy and direct access to MSK
  - The CCG expects where referral is sent to incorrect, referral will automatically refer on to appropriate service without sending back to GP or requesting a re-referral
- Work with providers to reduce the number of delayed discharges
- Review of Commissioner Requested Services (CRS) to establish any additional services the CCG required
- Work with Provider to ensure that routine services are offered 7 days a week

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- Robust and accurate registers of patients with Dementia
- Development of a pilot memory clinic within a primary care setting
- Perinatal Mental Health – to ensure compliance with NICE guidance including potential for specialist community service
- Continued development of Mental Health Payment by Results
- Ensure CAMHS services meet NICE requirements and improves assessment to diagnosis waiting times
- Review of 'Stepping Forward' model for vulnerable, high activity MH patients
- Out of Area specialist placements/rehab services - to identify potential opportunities for developing services for low volume/high cost cases closer to home
- TEWV Primary Care Therapy Services - align both the funding and contract management to the existing Any Qualified Provider
- Development of alternative rehabilitation and recovery services to support complex individual residents
- Review current commissioning arrangements for specialist sensory assessments and develop local pathway
- E-Communications
  - Implementation of e-discharge solution which transfers information directly into clinical system (inpatient and outpatients)
  - Implementation of Choose and Book, including advice and guidance
- Provide independent assessments of individuals with Learning Disabilities to establish to most appropriate packages of care that fulfils their needs
- Movement of patients from autism inpatient and assessment of treatment beds into community based settings
- Work collaboratively with Social Care Commissioners to deliver improved, joined up services to people whose needs are complex and whose behaviour is challenging to services
- Identify all young people that require a Health Action Plan
- Support Health funded individuals through bridging packages
- Support the us of quality checkers to advise on and highlight areas that may require reasonable adjustment

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- Improve Costs in relation HCD spend
  - Commissioned services will continue to use defined and standard list of drugs and indications that will be accepted for pass-through payment
  - Existing contracts held by providers will be reviewed, and the CCG will be consulted on these prior to entering or re-negotiating a contract, for the provision of specialist drugs via a third party provider
- To improve the quality of discharge information and medication supply
  - Patients will be provided with at least 28 days supply of long-term medicines, appliances and nutritional supplements on discharge
  - Patients will be supplied a "monitored dosage system" where this was in use prior to admission, or has been deemed necessary by valid assessment during the in-patient stay
  - Patients will be supplied full treatment course for all drugs where a defined treatment course is indicated e.g. antibiotics, steroids
- Self administration of medication in secondary care

Outcome framework

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions.
- Helping people recover from episodes of ill health or following injury
- Ensuring that people have positive experience of care
- Treating and caring for people in a safe Environment and protecting them from harm:

Risks

- Monitoring effective partnership and membership engagement
- Balancing capacity and demand to counter the financial pressures of an ageing and growing population and technological advances
- Contract Signature for 13/14
- Impact of transition of specialist commissioning to NHSCB
- Transition and pace of change
- Delay in implementing Momentum: Pathways to Healthcare

Appendix 4: Hartlepool Public Health Transition Plan: Proposed activity to be funded from the Public Health budget

NB: Subject to confirmation of the budgets available.

Public health topic	Proposed activity to be funded from Public Health budget
Sexual health	Testing and treatment of sexually transmitted infections, fully integrated termination of pregnancy services, all outreach and preventative work
Immunisation against infectious disease	School immunisation programmes, such as HPV.
Seasonal mortality	Local initiatives to reduce hospital admissions and seasonal excess deaths
Accidental injury prevention	Local initiatives such as falls prevention and reducing childhood injuries
Public mental health	Mental health promotion, mental illness prevention and suicide prevention
Nutrition	Locally led initiatives
Physical activity	Local programmes to reduce inactivity; influencing town planning such as the design of built environment and physical activities role in the management / prevention of long tram conditions
Obesity programmes	Local programmes to prevent and treat obesity, e.g. delivering the National Child Measurement programme; commissioning of weight management services
Drug misuse	Drug misuse services, prevention and treatment
Alcohol misuse	Alcohol misuse services, prevention and treatment
Tobacco control	Tobacco control local activity, including stop smoking services, prevention activity, enforcement and awareness campaigns
NHS Health check	Assessment and lifestyle interventions
Health at work	Local initiatives on workplace health and responsibility deal
Prevention and early presentation	Behavioural/ lifestyle campaigns/ services to prevent cancer, long term conditions, campaigns to prompt early diagnosis
Children's public health 5-19	The Healthy Child Programme for school age children, school nurses, health promotion and prevention interventions by the multi professional team
Community safety and violence prevention and response	Specialist domestic violence services that provide counselling and support services for victims of violence including sexual violence
Social exclusion	Support for families with multiple problems, such as intensive family based interventions
Dental Public Health	Targeting oral health promotion strategies to those in greatest need.

Appendix 5: Consultation process for identifying objectives

The Strategy consultation ran from June – October 2012, in line with Local Authority consultation processes and statutory responsibilities. It consisted of:

A 'Face the Public' event
Approximately 70 people attended, representing a range of organisations from the community, voluntary and statutory sector and elected members.

A resource-allocation exercise
Set up in a range of venues including the shopping centre, the library, children's centres, GP surgeries and youth centres. The exercise asked members of the public to allocate £25 'virtual pounds' across the Marmot policy areas. 465 members of the public took part. 'Giving every child the best start in life' was the most popular priority amongst participants with almost 30% of the total budget allocated to this area.

When broken down by the type of venue, 'giving every child the best start in life' is the most popular priority across all venues, however this percentage is significantly less in the results obtained within libraries, where there was a more even spread across each priority area.

The next most popular was 'ensure a healthy standard of living for all' (16%).

An online survey
Open to the general public, the survey asked respondents to prioritise a range of suggested interventions listed under each Marmot policy area. Respondents were asked to choose the 3 most important issues under each Marmot area. They were:

- Give every child the best start in life – levels of child poverty (60%) and better parenting (62%). Next most popular: early years education (up to age 5) 25%
- Enable all children and young people to maximise their capabilities and have control over their lives – employment and training (60%), educational attainment (48%), aspirations of young people
- Enable all adults to maximise their capabilities and have control over their lives – employment and training opportunities (81%), aspiration levels (58%), educational attainment (57%)
- Create fair employment and good work for all – access to good jobs (78%), access to good quality training (52%), young people not in education or training (46%)
- Ensure a healthy standard of living for all – job opportunities (63%), having the level of income needed for leading a healthy life (55%), unemployment levels (43%)
- Create and develop healthy and sustainable places – levels of anti-social behaviour (53%), access to good quality housing for all (48%), good quality transport (37%)

- Strengthen the role and impact of ill health prevention – levels of obesity (62%), smoking levels (56%), alcohol intake (48%)

Free-text comments generally fitted with the areas of work that were presented as options for responders in the rest of the survey.

Consultation was also carried out with existing members of the LINkS. The draft Strategy was also shared with the CCG, through discussion at the CCG locality meeting, and through CCG membership on the Health and Wellbeing Board.

Outcome 1: Give every child the best start in life	
Objective A	Reduce child poverty
Objective B	Deliver early intervention strategy
Outcome 2: Enable all children and young people to maximise their capabilities and have control over their lives	
Objective A	Children and young people are empowered to make positive choices about their lives
Outcome 3: Enable all adults to maximise their capabilities and have control over their lives	
Objective A	Adults with health and social care needs are supported to maintain maximum independence.
Objective B	Vulnerable adults are safeguarded and supported while having choice and control about how their outcomes are achieved.
Objective C	Meet Specific Housing Needs
Outcome 4: Create fair employment and good work for all	
Objective A	To improve business growth and business infrastructure and enhance a culture of entrepreneurship
Objective B	To increase employment and skills levels and develop a competitive workforce that meets the demands of employers and the economy
Outcome 5: Ensure healthy standard of living for all	
Objective A	Address the implications of Welfare Reform
Objective B	Mitigate against the impact of poverty and unemployment in the town
Outcome 6: Create and develop healthy and sustainable places and communities	
Objective A	Deliver new homes and improve existing homes, contributing to Sustainable Communities
Objective B	Create confident, cohesive and safe communities
Objective C	Local people have a greater influence over local decision making and delivery of services

Objective D	Prepare for the impacts of climate change and takes action to mitigate the effects
Objective E	Ensure safer and healthier travel
Outcome 7: Strengthen the role and impact of ill health prevention	
Objective A	Reduce the numbers of people living with preventable ill health and people dying prematurely
Objective B	Narrow the gap of health inequalities between communities in Hartlepool

**** Identifies Public Health Outcome Framework Indicators**

OUTCOME 1: GIVE EVERY CHILD THE BEST START IN LIFE

LEAD OFFICER: SALLY ROBINSON, ASSISTANT DIRECTOR (PREVENTION, SAFEGUARDING AND SPECIALIST SERVICES), HBC

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Immunisation Strategy
- Breastfeeding Strategy
- Stop Smoking Maternal Action Plan
- Healthy Schools
- Teenage Pregnancy Strategy & Action Plan
- Children & Young People's Plan
- Child Poverty Strategy
- Clinical Commissioning Group Commissioning Plan
- Public Health Transition Plan
- Early Intervention Strategy

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- North Tees & Hartlepool NHS Foundation Trust
- Hartlepool & Stockton Clinical Commissioning Group
- Children's Strategic Partnership
- Teenage Pregnancy Strategy Group
- 'Be Healthy' Group
- Immunisation Strategy Group
- Child Poverty Strategy Group
- Cleveland Casualty Reduction Group
- Tees health Childhood Injury Prevention Group

- Living Streets – LSTF Hartlepool Walk to School Project.

OBJECTIVE A – REDUCE CHILD POVERY

Performance Indicator		Data Source & Responsible Organisation	Collection Period	Annual Target
**NI 116	**NI 116 Proportion of Children living in poverty	HMRC	Annually	No current target as government reviewing measurement
	Proportion of children living in workless households	DWP	Annually	
	Rate of family homelessness	DCLG	Annually	

ACTION	ASSIGNED TO	DUE DATE
Ensure that children who live in poverty are safe	Sally Robinson	March 2015
Deliver Family-wise project	Anthony Steinberg	March 2015
Improve skill levels in parents and children	Danielle Swainston	March 2015
Increase benefit take up rate including in work and out of work benefits	Danielle Swainston	March 2015
Prevent those at risk falling into poverty	Danielle Swainston/John Robinson	March 2015
Where it is evident that a family is experiencing poverty, take action to mitigate its effects	Danielle Swainston/John Robinson	March 2015

RISK			
Code	**Risk**	**Assignee**	**Dept**
CAD R025	Failure to meet statutory duties and functions in relation to childcare sufficiency	Danielle Swainston	CAD
RND R088	Failure to achieve sufficient uptake of school meals	Karen Oliver	RND

OBJECTIVE B – DELIVER EARLY INTERVENTION STRATEGY

Performance Indicator		Data Source & Responsible Organisation	Collection Period	Annual Target
	**School Readiness	TBC (Placeholder)	TBC	TBC
	**low birth weight of term babies	ONS	TBC	TBC
NI53a	** Prevalence of breast-feeding at 6-8 wks from birth - Percentage of infants for whom breastfeeding status is recorded	TBC	Financial Year	Monitor
LAAHW P001	**Percentage of women smoking at time of delivery	HBC	Financial Year	19%
NI 55 (iv)	**The percentage of children in reception who are obese	HBC	Financial Year	Monitor
NI59 (ix)	**The percentage of children in year six who are obese	HBC	Financial Year	Monitor
New	Children achieving a good level of development at age 5	HBC	Academic Year	Monitor

NI 117	**Percentage of 16 – 18 year olds who are not in education, employment or training (NEET)	HBC	Financial Year	6.8%
NI 112	**The change in rate of under 18 conceptions per 1000 girls aged 15 – 17, as compared to 1998 rate.	DoH	Financial Year	Monitor
	**Infant Mortality	ONS	Annual	Annual
	**Tooth decay in children aged five years	TBC	4 Yearly	
NI 75	Percentage of pupils achieving 5 or more A* - C grades at GCSE or equivalent including English and Maths	HBC	Academic Year	60%
New	Number of children defined as defined as Child In Need, rate per 10,000 per population	HBC	Financial Year	Monitor
	**Child development at 2 – 2.5 Years	TBC (Placeholder)		

ACTION	ASSIGNED TO	DUE DATE
Implement Early Intervention Strategy	Danielle Swainston	March 2015
Embed common assessment as a means to identify and respond to need	Danielle Swainston	October 2013
Provide a multi agency single point of contact for information, advice, guidance and access to services for children and their families	Danielle Swainston	March 2013
Implement the Early Years Pathway delivering targeted support to children pre birth to five	John Robinson	September 2013
Deliver an integrated 0-19 multi agency family support service for children who require support additional to that provided by universal services.	John Robinson	March 2013
Provide integrated support for young people via the One Stop Shop	Mark Smith	March 2013
Promotion and delivery of the Hartlepool Independent Travel Training scheme.	Paul Watson/Jayne Brown	March 2014

RISKS			
Code	**Risk**	**Assignee**	**Dept**
CAD R026	Failure to deliver Early Intervention Strategy	Sally Robinson	CAD
CAD R017	Failure to recruit & retain suitable staff in children's services (Actively Managed)	Sally Robinson	CAD
CAD R019	Failure to plan for future need and ensure sufficient placement provision to meet demand (Actively Managed)	Sally Robinson	CAD
CAD R020	Insufficient capacity in the independent sector to meet placement demand (Actively Managed)	Ian Merritt	CAD
CAD R021	Increased demand on services due to socio-economic pressures (Actively Managed)	Sally Robinson	CAD
CAD R022	Failure to provide statutory services to safeguard children and protect their well-being (Actively Managed)	Sally Robinson	CAD
CAD R023	Impact of change to funding arrangements across Children's Services (Actively Managed)	Sally Robinson	CAD
CAD R024	Failure to meet statutory duties and functions in relation to the Youth Offending Service (Actively Managed)	Mark Smith	CAD
CAD R029	Failure to effectively manage risks exhibited by young people and families (Actively Managed)	Sally Robinson	CAD
CAD R030	Failure to deal with sensitive, personal or confidential information in a secure way, resulting in loss of data with associated fines, loss of public confidence and/or damage to reputation.	Kay Forgie, Trevor Smith	CAD
CAD R054	Failure to ensure awareness and training of staff regarding safeguarding (Actively Managed)	John Mennear	CAD

OUTCOME 2: ENABLE ALL CHILDREN AND YOUNG PEOPLE TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

LEAD OFFICER:

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Children's & Young people's Plan
- Child Poverty Strategy
- Public Health Transition Plan
- Stop Smoking Maternal Action Plan
- Teenage Pregnancy Strategy & Action Plan
- Carers Strategy
- Clinical Commissioning Group Community Plan
- Mental Health / CAM HS Strategy

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- Children's Strategic Partnership
- Teenage Pregnancy Strategy Group
- Child Poverty Strategy Group
- North Tees, Hartlepool NHS Foundation Trust
- Tees, Esk and Wear Valley NHS Health Foundation Trust
- NHS Hartlepool & Stockton-on-Tees CCG

OBJECTIVE A: CHILDREN AND YOUNG PEOPLE ARE EMPOWERED TO MAKE POSITIVE CHOICES ABOUT THEIR LIVES

Performance Indicator		Data Source & Responsible Organisation	Collection Period	Annual Target
	**Pupil Absence	School Absence record	6 Monthly	TBC
NI 111	**Number of first time entrants to the Youth Justice System aged 10-17 per 100,000 population (aged 10-17)	PNC	Annual	TBC
NI 112	**The change in rate of under 18 conceptions per 1000 girls aged 15 – 17, as compared to 1998 rate.	ONS	Annual	TBC
	**Child development at 2-2.5 years	TBC (placeholder)	TBC	TBC
NI 117	**Percentage of 16 – 18 year olds who are not in education, employment or training (NEET)	HBC	Financial Year	6.8%
NI 70	**emergency hospital admissions caused by unintentional and deliberate injuries to children and young people	Hospital Episodes Stats	Annual	TBC
NI58	**Emotional and behavioural health of looked after children	HBC (placeholder)	Annual	TBC
	**Smoking prevalence – 15 year olds	TBC		
	**Hospital admissions as a result of self harm	Hospital Episode Stats	Annual	
NI 106	Percentage gap between those young people from low income backgrounds and those that are not progressing to higher education	HBC	Annual	20%
NI 79	Percentage of young people achieving a Level 2 qualification by the age of 19	HBC	Annual	78.5%
NI 80	Percentage of young people achieving a Level 3 qualification by the age of 19	HBC	Annual	49.5%

NI 81	Percentage gap in the achievement of a Level 3 qualification by the age of 19 between those claiming free schools meals at academic age 15 and those that were not	HBC	Annual	21%
NI 82	Percentage of young people who were in receipt of free school meals at academic age 15 who attained Level 2 Qualifications by the age of 19	HBC	Annual	21%
	Unplanned hospitalisation for asthma, diabetes & epilepsy in under 19's	CCG	Quarterly	TBC
	Emergency Admissions for Children with lower respiratory tract infections	CCG	Quarterly	TBC
	SEN children or those with disability with personal budgets and single assessment across health, social care & education	CCG, HBC, SCHOOLS	Quarterly	TBC
RPD 045	Employment rate (16-24) – proportion of 16-24 year olds who are in employment	NOMIS, HBC	Annual	2014 target 46.5%
NI 117	% of 16-18 year olds who are not in education, employment or training (NEET)	HBC	Annual	2014 target 6.5%
RPD 054	Youth unemployment rate – the proportion of economically active 18-24 year olds who are unemployed.	HBC	Annual	2014 target 14.1%

ACTION	ASSIGNED TO	DUE DATE
Reduce the level of young people who are Not in Employment, Education or Training (NEET) by implementing NEET Strategy.	Mark Smith	March 2014
Ensure access to high quality learning opportunities that increase the skills and qualifications of local residents via implementing the Adult Education Service Plan	Maggie Heaps	July 2014
Increase the take up of Apprenticeships by liaising with local employers to increase opportunities	Maggie Heaps	July 2014
Work collaboratively with LA & Schools to review and develop single assessment arrangements for children with SEN or disability	TBC	March 2014
Develop plans to increase the number of SEN and disabled children with personal budgets	TBC	March 2014

Develop plans to improve education and support to families and children/young people with chronic health conditions	TBC	March 2014

SECTION			
Code	**Risk**	**Assignee**	**Dept**
CAD R001	Service issue as a result of insufficient budget allocation or changes in national funding/grants (Actively Managed)	Jill Harrison	CAD
CAD R004	An increase in the number of schools falling below Performance Achievement Standard (Actively Managed)	Dean Jackson	CAD
CAD R005	Failure to meet the statutory duties and requirements vested within the Child and Adult Services department (Actively Managed)	Dean Jackson	CAD
CAD R012	Failure to plan school provision appropriately	Peter McIntosh	CAD
CAD R015	Failure to carry out specific duties and/or comply with regulatory codes of practice	Dean Jackson	CAD
CAD R031	Failure to recruit and retain staff in educational support services (Actively Managed)	Dean Jackson	CAD
CAD R032	Increase in the number of schools falling below national average for pupil attendance (Actively Managed)	Dean Jackson	CAD

OUTCOME 3: ENABLE ALL ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

LEAD OFFICER: JILL HARRISON, ASSISTANT DIRECTOR (ADULT SOCIAL CARE), HBC

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Vision for Adult Social Care in Hartlepool
- Carers Strategy
- Mental Health Strategy
- Housing, Care & Support Strategy
- Reablement Strategy
- Telecare Strategy
- Clinical Commissioning Group Commissioning Plan

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- North Tees & Hartlepool NHS Foundation Trust
- Hartlepool & Stockton Clinical Commissioning Group
- Learning Disabilities Partnership Board
- Safeguarding Vulnerable Adults Board
- Mental Health Consultation Group
- Carers Strategy Group
- Champions of Older Lifestyles Group
- Teesside Vulnerable Adults Board
- 50+ Forum
- Housing Care & Support Group
- Long Term Conditions Planning Group

OBJECTIVE A: ADULTS WITH HEALTH AND SOCIAL CARE NEEDS ARE SUPPORTED TO MAINTAIN MAXIMUM INDEPENDENCE

Performance Indicator		Data Source & Responsible Organisation	Collection Period	Annual Target
NI 125	Achieving independence for older people through rehabilitation / intermediate care.	HBC	Financial Year	Monitor
NI 131	Delayed transfers of care attributable to social care	HBC	Financial Year	0%
NI 135	Carers receiving needs assessment or review and a specific carers service or advice and information.	HBC	Financial Year	25%
NI 136	People supported to live independently through social services.	HBC	Financial Year	Monitor
P0 50	Access to equipment: percentage delivered within 7 days	HBC	Financial Year	91%
P0 51	Access to equipment: users with telecare	HBC	Financial Year	1000
P0 66	Admissions to residential care age 65+	HBC	Financial Year	90%
	Patients with a LOS<24hrs with an overnight stay NEL admissions via A&E NEL admissions via GP/Bed bureau A&E attendances ALOS (excl O LOS) ALOS for patients discharged to a different location to admitting location Delays to transfer of care (Bed days) Acute admissions from care homes Emergency readmissions within 30 days of discharge from hospital Emergency readmission rate within 30 days of discharge from hospital	CCG		TBC

	No of ambulatory care patients			
	Carer-reported quality of life	ASC Outcome Framework		
	Health related quality of life for carers	NHS Outcome Framework		
	The proportion of people who use services who feel safe	ASC Outcome Framework		
	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	ASC Outcome Framework		
	Improving people's experience of integrated care	ASC & NHS Outcome Framework Placeholder		
	**Health related quality of life for people with long-term conditions	NHS Outcome Framework		
	Social care related quality of life	ASC Outcome Framework		

ACTION	ASSIGNED TO	DUE DATE
Continue to work in partnership with health partners to develop robust reablement services that promote maximum independence, facilitate people living in their own homes, avoid unnecessary admissions to hospital and enable timely and safe hospital discharges.	Geraldine Martin, HBC	March 2014
Increase the number of people using assistive technology as a means to remain independent.	Neil Harrison, HBC	March 2014
Develop services to provide information and support to carers	Geraldine Martin, HBC	March 2014

with a focus on short breaks and access to employment opportunities.		
Implement the recommendations from the Hearing Loss Strategy, as well as supporting people with a disability into employment.	Neil Harrison, HBC	March 2014
Work collaboratively with partners to implement the National Dementia Strategy in Hartlepool.	John Lovatt, HBC	March 2014
Improve the transitions process to ensure every child and young person in transition (aged 14-25) with a disability has a person centred outcome focused plan for adulthood.	Neil Harrison, HBC	March 2014
Continue to promote independence and facilitate recovery for people with mental health needs by increasing the numbers of personal budgets and direct payments, promoting independence and increasing volunteering and employment opportunities.	Geraldine Martin, HBC	
Development and implementation of Hartlepool Independent Travel Training Programme	Paul Watson/Jayne Brown, HBC	March 2014

OBJECTIVE B: VULNERABLE ADULTS ARE SAFEGAUREDED AND SUPPORTED WHILE HAVING CHOICE AND CONTROL ABOUT HOW THEIR OUTCOMES ARE ACHIEVED.

Performance Indicator		Data Source & Responsible Organisation	Collection Period	Annual Target
NI 130b	Social care clients receiving self directed support	HBC	Financial Year	TBC
NI 146	Adults with learning disabilities in employment.	HBC	Financial Year	Monitored
NI 150	Adults in contact with secondary mental health services in employment.	HBC / TE&WV FT	Financial Year	Monitored

	Estimated diagnosis rate for people with dementia	NHS Outcome Framework		
	Dementia: effectiveness of post diagnosis care in sustaining independence and improving quality of life	NHS Outcome Framework (Placeholder)		
	**People in prison who have a mental illness or significant mental illness	TBC	TBC	TBC
	**Employment for those with a long-term health condition including those with a learning difficulty / disability or mental illness	Labour Force Survey	TBC	TBC

ACTION	ASSIGNED TO	DUE DATE
Continue to increase the number of people accessing personal budgets through focused work in mental health services, developing personal budgets for carers and continued work with health partners.	Geraldine Martin, HBC	March 2014
Further develop local arrangements to safeguard vulnerable adults, ensuring the engagement of all strategic partners and an appropriate and timely response to any new legislation that is introduced.	John Lovatt, HBC	March 2014

RISKS			
Code	**Risk**	**Assignee**	**Dept**
CAD R011	Failure to work in effective partnerships with NHS, including risk of cost shunting. (Actively Managed)	Jill Harrison	CAD
CAD	Failure to deal with sensitive, personal or confidential information in a secure way, resulting in loss of	Kay Forgie,	CAD

R030	data with associated fines, loss of public confidence and/or damage to reputation.	Trevor Smith	
CAD R033	Failure to plan for future need and ensure sufficient placement provision to meet demand within adult social care. (Actively Managed)	Jill Harrison	CAD
CAD R034	Insufficient capacity in the independent sector to meet placement demand within adult social care. (Actively Managed)	Phil Hornsby	CAD
CAD R035	Increased demand on adult social care services due to demographic pressures. (Actively Managed)	Jill Harrison	CAD
CAD R037	Failure to achieve targets in relation to assessments within 28 days and annual reviews, due to increased pressures on services. (Actively Managed)	John Lovatt	CAD
CAD R038	Failure to provide statutory services to safeguard vulnerable adult. (Actively Managed)	Jill Harrison	CAD
CAD R039	Impact of change to funding arrangements across adult social care services. (Actively Managed)	Jill Harrison	CAD
CAD R040	Failure to deliver the Reablement Strategy. (Actively Managed)	Jill Harrison	CAD
CAD R041	Failure to recruit & retain suitable staff in adult social care. (Actively Managed)	Jill Harrison	CAD
CAD R043	Delayed transfers of care from hospital due to reduced capacity and changing working arrangements for hospital discharge. (Actively Managed)	John Lovatt	CAD
CAD R054	Failure to ensure awareness and training of staff regarding safeguarding (Actively Managed)	John Mennear	CAD

OBJECTIVE C: MEET SPECIFIC HOUSING NEEDS

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
NI 145 Adults with learning disabilities in settled accommodation.	HBC	Financial Year	73%
NI 149 Adults in contact with secondary mental	HBC	Financial Year	70%

health services in settled accommodation.			
**Statutory homelessness: Homelessness applications	HBC		
**Statutory homelessness: Households in temporary accommodation	HBC		
Average waiting time for a Disabled Facilities Grant to be completed	HBC	Financial Year	95 Days

ACTION		ASSIGNED TO	DUE DATE
HS3B2	Improve partnership working with health and social care in service planning and delivery for older people through the Housing Care and Support Strategy Steering Group	Housing Services Manager Nigel Johnson Head of Service (C&A) Phil Hornsby	March 2013
3B5	Monitor access to new and existing housing care and support schemes for people with disabilities	Head of Service (C&A) Neil Harrison	March 2015
3B9 (proposed replacement action)	Undertake a review of the current Housing Adaptations Policy and gather data to inform the new Policy and Implementation Plan.	Karen Kelly	December 2013
Proposed new action	Assist people to maintain independent living through the provision of minor adaptations.	Karen Kelly	March 2014
HS3B10	Increase the use of Assisted Technology by case finding as a preventative measure	All Registered Providers Head of Service (C&A) Phil Hornsby	March 2014

RISKS			
Code	**Risk**	**Assignee**	**Dept**
RND R070	Failure to provide correct housing advice to the public.	Lynda Igoe	RND

OUTCOME 4: CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL
LEAD OFFICER: DENISE OGDEN, DIRECTOR OF REGENERATION & NEIGHBOURHOODS, HBC

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Economic Regeneration Strategy
- 14 - 19 Strategy

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- Economic Regeneration Forum

OBJECTIVE A: TO IMPROVE BUSINESS GROWTH AND BUSINESS INFRASTRUCTURE AND ENHANCE A CULTURE OF ENTREPRENEURSHIP

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
Business stock (business units in Hartlepool)	Annual Business Register / NOMIS, HBC	Annual	2014 target of 2,400
Percentage of newly born enterprises surviving two years	Annual Business Register / NOMIS, HBC	Annual	2014 target of 77.4%

New business registration rate – the proportion of new business registration per 10,000 resident population	Annual Business Register / NOMIS, HBC	Annual	2014 target of 30

ACTION	ASSIGNED TO	DUE DATE
Deliver Business Advice and Brokerage – Programme of targeted account management with key businesses. Develop and maintain relationships with individual businesses.	Mick Emerson	March 2014
Continued provision of Incubation support service including mentoring, pre-start support (Enterprise Coaching), financial assistance, brokerage and other initiatives.	Mick Emerson	March 2014
Undertake 'Get Serious' awareness raising activities including marketing campaigns and events.	Mick Emerson	March 2014
Engage with DWP Providers to offer unemployed individuals a wider package of support where appropriate to enter into self-employment.	Mick Emerson	March 2014
Provision of personalised journey/travel plans to increase employment options.	Paul Watson	On-going programme.

OBJECTIVE B: TO INCREASE EMPLOYMENT AND SKILL LEVELS AND DEVELOP A COMPETITIVE WORKFORCE THAT MEETS THE DEMANDS OF EMPLOYERS AND THE ECONOMY.

Performance Indicator		Data Source & Responsible Organisation	Collection Period	Annual Target
NI 151	Overall employment rate (proportion of people of working	Annual Population	Annual	2014 target of

	age population who are in employment)	Survey, NOMIS, HBC		63%
RND P090	Self-employment rate	NOMIS, HBC	Annual	2014 target of 9%
RPD 045	Employment rate (16-24) – proportion of 16-24 year olds who are in employment	NOMIS, HBC	Annual	2014 target of 46.5%
NI 117	Percentage of 16 to 18 year olds who are in not in education, employment or training (NEET)	Department for Education, HBC	Annual	2014 target of 6.5%
RPD 054	Youth unemployment rate (Hartlepool) – The proportion of economically active 18 to 24 year olds who are unemployed	NOMIS, HBC	Annual	2014 target of 14.1%

ACTION	ASSIGNED TO	DUE DATE
Full implementation of the Raising Participation Age (RPA) Strategy	Mark Smith/Tom Argument	March 2014
Develop the 14-19 curriculum pathways in conjunction with employers from new industries and identified growth sector areas	Tom Argument	March 2014
Fully implement the 11-19 Operational Plan to raise education standards at key stage 4 and 5	Tom Argument	March 2014
Development of new partnership arrangements between Hartlepool Borough Council and the National Apprenticeship Service (NAS) to promote apprenticeship programmes to employer	Patrick Wilson	April 2013
Implementation of the Hartlepool Youth Investment Project	Patrick Wilson/Tom Argument	September 2014

RISKS			
Code	**Risk**	**Assignee**	**Dept**
RND R071	Failure to deliver local economic objectives as a result of shifts in policies and priorities of external partners.	Antony Steinberg	RND

CAD R027	Failure to meet statutory duties and functions in relation to the post 16 cohort and raising of the participation age	Mark Smith	CAD

OUTCOME 5: ENSURE A HEALTHY STANDARD OF LIVING FOR ALL
LEAD OFFICER: LOUISE WALLACE – DIRECTOR OF PUBLIC HEALTH, HBC

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Child Poverty Strategy
- Children's and Young People's Plan
- Public Health Transition Plan
- Clinical Commissioning Group Commissioning Plan

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- Hartlepool and Stockton Clinical Commissioning Group

OBJECTIVE A: ADDRESS THE IMPLICATIONS OF WELFARE REFORM

ACTION	ASSIGNED TO	DUE DATE
Implement and review Discretionary Council Tax Support Framework	Julie Pullman	December 2013
Respond to Welfare Reform changes by engaging and supporting affected households	Julie Pullman	March 2014
Develop partnership outreach process to ensure that families understand and plan for Welfare Reform	Danielle Swainston	March 2014
Support workforce to identify risk factors re: child poverty/welfare reform and implement appropriate packages of support	Danielle Swainston	March 2014
Implement a programme of Benefits and Free School Meals take	Julie Pullman	March 2014

up initiatives		
Develop referral channels for adults to access financial advice services and financial products	John Morton	March 2014

OBJECTIVE B: MITIGATE AGAINST THE IMPACT OF POVERTY AND UNEMPLOYMENT ACROSS THE TOWN

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
**Fuel Poverty	HBC	TBC	TBC
Proportion of children living in workless households	DWP	Annually	

ACTION	ASSIGNED TO	DUE DATE
Develop training package for family workforce to identify poverty issues and support parents in poverty	Danielle Swainston	March 2014
Deliver Familywise project	Anthony Steinberg	March 2015
Improve skill levels in parents and children	Danielle Swainston	March 2015

OUTCOME 6: CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

LEAD OFFICER: DENISE OGDEN; DIRECTOR OF REGENERATION AND NEIGHBOURHOODS, HBC

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Housing Strategy
- Housing, Care & Support Strategy
- Fuel Poverty Strategy
- Public Health Transition Plan
- Crime & Disorder Strategy
- Local Transport Plan
- Community Cohesion Strategy
- Climate Change Strategy
- Neighbourhood Management and Empowerment Strategy
- Parks and open space
- Cleveland Casualty Reduction Group
- Tees Health Childhood Injury Prevention Group
- Cleveland Strategic Road Safety Partnership

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- Housing Partnership
- Safer Hartlepool Partnership

OBJECTIVE A: DELIVERING NEW HOMES AND IMPROVE EXISTING HOMES, CONTRIBUTING TO SUSTAINABLE COMMUNITIES

Performance Indicator	Data Source &	Collection Period	Annual Target

	Responsible Organisation		
New homes constructed to lifetime homes standard	Housing Monitoring System HBC	Quarterly	50
Sustainable homes constructed	Housing Monitoring System HBC	Quarterly	50
Number of properties improved through the grants or loans schemes	Authority Public Protection (APP) System HBC	Quarterly	None – the numbers of properties improved will depend on funding – the overall aim to reduce waiting list
Number of long term (over 6 months) empty homes brought back into use	Authority Public Protection (APP) System and Council Tax data HBC	Quarterly	10% of long term (over 6 months) empty homes brought back into use annually
Number of social rented houses fitted with renewables such as Photo Voltaic panels and/or cells, solar hot water and air source heat pumps	RP Management Systems All Registered Providers	Annually	50
Number of excess cold HHSRS Category 1 hazards rectified	Authority Public Protection (APP) System HBC	Quarterly	None – the number of complaints received on an annual basis will vary

ACTION		ASSIGNED TO	DUE DATE
HS1A4 (proposed replacement	Monitor the schemes included in the 2011-15 NAHP programme and report any changes to the Housing Partnership.	Nigel Johnson	March 2015

action)			
1B1	Encourage developers to meet lifetime home standards and relevant Government energy efficiency levels through negotiation and planning conditions where appropriate	Planning Services Manager Chris Pipe	March 2014
HS1C3 (proposed replacement action)	Monitor the progress of acquisition on the Carr/Hopps Street regeneration scheme	Amy Waller; Nigel Johnson	March 2015
New proposed action from 2D4	Work with landlords to prevent homes from becoming long-term empty through early intervention.	Amy Waller	March 2015
HS2E2	Support landlords to carry out energy efficiency works to deal with excess cold hazards through education and promotion of the benefits	Housing Services Manager Nigel Johnson	March 2015
HS2E4	Explore opportunities and options for encouraging property owners to retrofit homes with renewables such as Photo Voltaic panels and/or cells solar hot water and air source heat pumps	Principal Policy Officer Valerie Hastie	March 2015

SECTION 4 RISKS			
Code	**Risk**	**Assignee**	**Dept**
RND R057	Reduction in funding for housing investment	Nigel Johnson	RND
RND R061	Inability to meet very high levels of local housing needs including affordable housing	Nigel Johnson	RND
RND R062	Effective delivery of housing market renewal affected by external decisions and funding	Nigel Johnson	RND

RND R015	Failure to secure funding for delivery of empty homes strategy	Nigel Johnson	RND
RND R061	Inability to meet very high levels of local housing needs including affordable housing	Nigel Johnson	RND
RND R062	Effective delivery of housing market renewal affected by external decisions and funding	Nigel Johnson	RND
RND R053	Failure to respond to and implement changes to selective licensing	Nigel Johnson	RND

OBJECTIVE B: CREATE CONFIDENT, COHESIVE & SAFE COMMUNTIES

	Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
	Reduce perceptions of anti-social behaviour	Viewpoint Hartlepool Borough Council	Biannual	Reduce in comparison to baseline year – 29%
	Maintain perception level of drunk/rowdy behaviour as a problem	Viewpoint Hartlepool Borough Council	Biannual	Maintain in comparison to baseline year – 25%

	Reduce anti-social behaviour (asb) incidents reported to the police	Police recorded (asb) incidents – Cleveland Police	Quarterly	Reduce in comparison to baseline year – 8,779
	Increase the number of recorded hate incidents	Recorded Crimes and Incidents – Cleveland Police, Housing Hartlepool and Hartlepool Borough Council	Quarterly	Increase in comparison to the baseline year – 98
NI 32	**Repeat incidents of Domestic violence	NI32		
	**Violent Crime (including sexual offence)	TBC		
NI 30	**Reoffending rate of prolific and other priority offenders	HBC		
	**Percentage of population affected by noise	TBC		
	** Utilisation of green space for exercise / health reasons	National Environment Survey		
	**Social connectedness	TBC (placeholder)		
	**Older Peoples perception of community safety	TBC (placeholder)		

ACTION	ASSIGNED TO	DUE DATE
Implement the PREVENT action plan as guided by the Silver group.	Sally Forth	March 2014
Develop new Anti-Social Behaviour Strategy and action plan in line with Government policy	Sally Forth	March 2014
Monitor the implementation of the community cohesion framework action plan	Adele Wilson	March 2014
In conjunction with partners improve reporting, recording, and responses/interventions to vulnerable victims and victims of hate crime.	Nicholas Stone	March 2014

Introduce restorative practice across Safer Hartlepool partners to give victims a greater voice in the criminal justice system.	Sally Forth	March 2014
Development of route/community based local safety schemes to incorporate 20mph zones.	Peter Frost	March 2014
Reduce the anti-social impact that speeding traffic has on communities.	Paul Watson/Peter Frost	March 2014
Deliver the domestic violence action plan	Sally Forth	March 2014
Embed the Think Families / Think communities approach to reducing crime and anti social behaviour, improving educational attendance and reducing worklessness, resulting in reduced costs to the public purse.	Lisa Oldroyd	March 2014

RISKS			
Code	**Risk**	**Assignee**	**Dept**
RND R032	Failure of officers to fully embrace their responsibilities under the terms of Section 17, Crime and Disorder Act 1998	Sally Forth	RND

OBJECTIVE C: LOCAL PEOPLE HAVE A GREATER INFLUENCE OVER LOCAL DECISION MAKING AND DELIVERY OF SERVICES

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
Percentage of residents feeling that they can influence decisions that affect their local area	HBC	Annual	Monitored

ACTION	ASSIGNED TO	DUE DATE
Support the delivery of Face the Public Events by the Strategic Partners Group and Theme Groups	Catherine Grimwood	March 2014
Facilitate involvement of residents on a neighbourhood level by supporting existing and newly emerging resident, 'friends of' and interest groups	Adele Wilson	
Address and monitor progress on priorities outlined in the eleven ward profiles developed across the town with a particular focus on areas falling in top 5% most disadvantaged	Adele Wilson	
Address and monitor progress on priorities outlined in the eleven ward profiles developed across the town with a particular focus on areas falling in top 5% most disadvantaged	Adele Wilson	
Support the development and implementation of the Voluntary and Community Sector Strategy and Action Plan	Fiona Stanforth	
Deliver the Community Pool Funding Programme	Fiona Stanforth	

4 RISKS			
Code	**Risk**	**Assignee**	**Dept**
RND R056	Failure of service providers to focus resources on Hartlepool deprived areas	Clare Clark	RND

OBJECTIVE D - PREPARE FOR THE IMPACTS OF CLIMATE CHANGE AND TAKE ACTION TO MITIGATE THE EFFECTS

Performance Indicator		Data Source & Responsible Organisation	Collection Period	Annual Target
NI 185	CO_2 reduction from local authority operations	NI185 outturn produced by Council	Financial Year	7% (currently under review, and will be smaller for 2013/14)
NI 186	Per capita CO_2 emissions from the local authority area	NI186 outturn produced by Department for Energy & Climate Change	Calendar Year	3.75%
NI 188	Planning to Adapt to Climate Change	NI188 outturn produced by Council	Financial Year	Level 4 by end 2013/14
	**Air Pollution	TBC		
	**Public Sector organisations with board approved sustainable development management plan	TBC		

ACTION	ASSIGNED TO	DUE DATE
Implement actions of the Joint Strategic Needs Assessment	Paul Hurwood	Mar 2014

(JSNA) Scrutiny review with regard to the environment.		
Consult and promote a community 'Collective Energy Switching' programme throughout the borough	Dave Hammond / Paul Hurwood	Mar 2014
Development of travel plans and promotion of walking and cycling as an alternative to the private motor car.	Paul Watson	Mar 2014

SECTION 4 RISKS			
Code	**Risk**	**Assignee**	**Dept**
RND R067	Failure to achieve recycling targets resulting in loss of income and additional costs.	Fiona Srogi	RND
RND R076	Consequences of climate change through the failure of the Council to tackle climate issues locally	Paul Hurwood	RND
RND R087	Income fluctuations in the market for recyclable materials resulting in difficulties in budget planning and forecasting.	Fiona Srogi	RND

OBJECTIVE E - ENSURE SAFER HEALTHIER TRAVEL

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
NI47- People killed or seriously injured in road traffic accidents	Cleveland Police & Hartlepool Borough Council	Annually	Yes
NI48- Children killed or seriously injured in road traffic accidents	Cleveland Police & Hartlepool Borough Council	Annually	Yes

ACTION	ASSIGNED TO	DUE DATE
Develop Safer Routes to Schools to incorporate 20 mph zones, safer walking and cycling routes and local safety schemes.	Paul Watson/Peter Frost	March 2014 (Annual programme)
Develop minor safety schemes to reduce road danger and casualties and encourage safer road user behaviour.	Peter Frost	March 2014 (Annual programme)
Identify schemes to implement signalised crossings	Peter Frost	March 2014 (Annual programme)
Identify roads and routes where speeding vehicles contribute to community Safety Camera Partnership	Paul Watson	March 2014 (Annual programme)
Identify schools to benefit from 20mph zones through the safer routes to school programme	Peter Frost/Paul Watson	March 2014 (Annual programme)
Delivery of a comprehensive education, training and publicity programme in schools and to neighbourhoods.	Paul Watson	March 2014 (Annual programme)
Contribution to the management and delivery of Ridewell Tees Valley Motorcycle Training Scheme	Paul Watson	March 2014 (Annual programme)
Delivery of National Standard Bikeability Cycle Training in schools to improve safety, reduce collisions and reduce reliance on the private motor vehicle.	Paul Watson	March 2014 (Annual programme)
Development and continuation of the Schools Practical Pedestrian Training Scheme	Paul Watson	March 2014 (Annual programme)
Development and support of the Living Streets – LSTF Hartlepool Walk to School Outreach Project to promote walking to school	Paul Watson	3 Year Programme commenced September 2012.

RISKS			
Code	**Risk**	**Assignee**	**Dept**

RND R054	Failure to maintain infrastructure to acceptable standard resulting in additional cost implications through insurance claims	Mike Blair	RND
RND R078	Failure to develop an integrated transport strategy	Paul Robson	RND

OUTCOME 7: STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

LEAD OFFICER: LOUISE WALLACE, DIRECTOR OF PUBLIC HEALTH, HBC

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Immunisation Strategy
- Alcohol Harm Reduction Strategy
- Stop Smoking Action Plan
- Tobacco Alliance Plan
- Cardiovascular Disease Programme Plan
- National Early Detection & Awareness of Cancer Plan
- Flu Plan (Seasonal)
- Clinical Commissioning Group Commissioning Plan
- Public Health Transition Plan
- Breastfeeding Strategy
- Health Schools
- Healthy Weight, Healthy Lives Strategy
- Vision for Adult Social Care in Hartlepool
- Mental Health Strategy
- Drug Treatment Plan
- Health & Safety Service plan
- Food Law Enforcement Plan

- Alcohol Licensing Policy
- Trading Standards Service Plan
- Food Sampling Policy
- North East Outbreak Control Policy

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- North Tees & Hartlepool NHS Foundation Trust
- Hartlepool & Stockton Clinical Commissioning Group
- Immunisation Strategy Group
- Coronary Heart Disease Local Implementation Team
- Diabetes Local Implementation Team
- British Heart Foundation Group
- 'Be Healthy' Groups
- Alcohol Strategy Group
- HPA / Public Health England
- FRESH
- BALANCE

OBJECTIVE A: REDUCE THE NUMBER OF PEOPLE LIVING WITH PREVENTABLE ILL HEALTH AND DYING PREMATURELY

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target

**Healthy life expectancy	ONS		
** Sickness absence rate: Percentage of employees who had at least one day off sick in the previous week / Number of working days lost due to sickness absence.	TBC		
** Sickness absence rate: Rate of fit notes issued per quarter	TBC		
**Differences in life expectancy and health expectancy between communities	TBC		
**Diet	TBC (placeholder)		
**Excess weight in adults	TBC		
**Successful completion of drug treatment	National drug treatment monitoring system		
**People entering prison with a substance dependence issue who are not previously known to community treatment	TBC		
2.18 Alcohol related admissions to hospital	Hospital Episode Stats		
2.17 recorded diabetes	Quality management analysis system		
2.18 Alcohol related admissions to hospital	Hospital Episode stats		
**Access to non cancer screening programmes : infectious disease testing in pregnancy – HIV, syphilis, hepatitis B, and susceptibility to rubella	TBC		
**Access to non cancer screening programmes : Antenatal sickle cell and thalassaemia screening	TBC		
**Access to non cancer screening programmes : Newborn blood spot screening	TBC		
**Access to non cancer screening programmes : Newborn hearing screening	TBC		

**Access to non cancer screening programmes : Newborn physical examinations	TBC		
**Access to non cancer screening programmes :Diabetic retinopathy	TBC		
**Take up of the NHS Health Check programme – by those eligible	TBC		
**Self reported wellbeing	TBC		
**Chlamydia diagnoses	TBC		
**Population vaccination coverage	TBC		
**People presenting with HIV at a late stage of infection	TBC		
**Treatment completion for tuberculosis	TBC		
**Comprehensive inter-agency plans for dealing with public health incidents	TBC (placeholder)		
**Mortality rate from causes considered preventable	ONS		
**Under 75 mortality rate from all cardiovascular diseases	ONS		
**Under 75 mortality from cancer	ONS		
**Under 75 mortality from liver disease	ONS		
**Under 75 mortality from respiratory disease	ONS		
**Mortality from infectious and parasitic diseases	ONS		
**Emergency readmissions within 30 days of discharge from hospital	ONS (placeholder)		
**Preventable sight loss	Certificate of Visual impairments		
**Health related quality of life for older people	TBC		

ACTION	ASSIGNED TO	DUE DATE
Commission a comprehensive healthy heart check	Director of Public Health	March 2014

programme for all eligible people across Hartlepool		
Commission a comprehensive range of accessible and equitable sexual health services	Director of Public Health	March 2014
Develop a comprehensive health protection plan for Hartlepool and provide assurance that the health of then population is comprehensively protected	Director of Public Health	March 2014
Commission a comprehensive range of services to reduce the individual and community impact of alcohol related harm	Substance Misuse Joint Strategy Group / Director of Public Health	March 2014
Commission services to ensure people maintain a healthy weight and a healthy life.	Healthy Weight Healthy Lives Strategy Group	March 2014
Deliver a comprehensive programme to improve workplace health	Director of Public Health	March 2014
Ensure effective integrated treatment of drug and alcohol services	Chris Hart	March 2014
Develop and implement a school, families and community based Safe and Active Travel programme with targeted walking and cycling promotion schemes.	Paul Watson	March 2014
Develop an active travel GP referral scheme to encourage and promote cycling as a weight management and cardiovascular disease prevention measure	Paul Watson	March 2014
Develop and implement a school, families and community based Safe and Active Travel programme with targeted walking and cycling promotion schemes.	Paul Watson	March 2014

OBJECTIVE B: REDUCE THE HEALTH INEQUALITY GAP BETWEEN COMMUNITIES ACROSS HARTLEPOOL

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
**Fuel Poverty	English Housing Survey		
**Proportion of physically active and inactive adults	TBC		
**Smoking prevalence adults	Integrated Health Survey		
**Cancer diagnosed at stages 1 & 2	TBC (placeholder)		
**Cancer screening coverage	TBC		
**Injuries due to falls in people aged 65 and over	TBC		
**Under 75 mortality rate from al cardiovascular diseases	ONS		
**Under 75 mortality from liver disease	ONS		
**Under 75 mortality from respiratory disease	ONS		
**under 75 mortality rate from cancer	ONS		
**Excess under 75 mortality rate in adults with serious mental illness	TBC (placeholder)		
**Suicide rate	ONS		
**Hip fractures in people aged 65 and over	Hospital Episode Stats		
**Excess winter deaths	ONS		
**Dementia and its impacts	TBC		
** Mortality rate from communicable diseases	TBC (placeholder)		

ACTION	ASSIGNED TO	DUE DATE
Commission a comprehensive range of services to enable people to stop smoking	Director of Public Health	March 2014
Develop a comprehensive systematic approach for addressing excessive winter deaths	Director of Public Health	September 2014
Commission services to promote positive mental health and well being	Director of Public Health	March 2014
Promote the early detection and awareness of signs and symptoms of cancer across Hartlepool	Director of Public Health	March 2014
Develop a comprehensive programme of accident prevention	Director of Public Health	March 2014
Develop a programme of adult cycling promotion and training.	Paul Watson	

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

HEALTH SCRUTINY FORUM

7 March 2013

Report of: Scrutiny Support Officer

Subject: FEMALE LIFE EXPECTANCY IN HARTLEPOOL – COVERING REPORT

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1. PURPOSE OF REPORT

1.1 To introduce the Specialist Registrar in Public Health, who will be present at today's meeting to provide an update in terms of Female Life Expectancy in Hartlepool.

2. BACKGROUND INFORMATION

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

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

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

2.3 Subsequently the Specialist Registrar in Public Health will be in attendance today to provide a presentation to Members in relation to:

(a) Female Life Expectancy in Hartlepool;
(b) Life expectancy in each Ward;
(c) Major causes of early deaths in each Ward; and
(d) Provision of services across Wards

2.4 **Table1** below provides a comparison between the Health Profile for Hartlepool in 2009, 2010, 2011 and 2012 in relation to female life expectancy:-

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

Year	Average Female Life Expectancy in Hartlepool	Average Female Life Expectancy in England	Worst Average Female Life Expectancy in England
2009[1]	78.1	81.1	78.1
2010[2]	79.0	82.0	78.8
2011[3]	79.8	82.3	79.1
2012[4]	81.0	82.6	79.1

3. RECOMMENDATIONS

3.1 That Members note the content of this report and the presentation by the Specialist Registrar in Public Health, seeking clarification on any relevant issues where felt appropriate.

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:-

(a) Minutes of the Health Scrutiny Forum held on 6 October 2009 and 5 April 2012

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

(c) The Association of Public Health Observatories (2010), *Health Profile 2010 Hartlepool*, Available from

[1] APHO, 2009
[2] APHO, 2010
[3] APHO, 2011
[4] APHO, 2012

http://www.apho.org.uk/default.aspx?QN=HP_METADATA&AreaID=50333 (Accessed 8 November 2010)

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

(e) The Association of Public Health Observatories (2012), Health Profile 2012 Hartlepool, Available from http://www.apho.org.uk/default.aspx?QN=HP_METADATA&AreaID=50333 (Accessed 20 February 2013)

HEALTH SCRUTINY FORUM

7 March 2013

HARTLEPOOL BOROUGH COUNCIL

Report of: **HEALTH SCRUTINY FORUM**

Subject: **DRAFT FINAL REPORT – INVESTIGATION INTO THE JSNA TOPIC OF 'SEXUAL HEALTH'**

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1. PURPOSE OF REPORT

1.1 To present the draft findings of the Health Scrutiny Forum following its investigation into the Joint Strategic Needs Assessment (JSNA) topic of Sexual Health.

2. BACKGROUND

2.1 The Health Scrutiny Forum met on the 15 June 2012 to consider their Work Programme and agreed that the Forum would in 2012/13 focus on the following JSNA topic:-

Sexual Health - This key health protection issue is a priority within the JSNA as nationally over recent years there has been a rise in sexually transmitted infections. Prevention and education are key to supporting people to make healthy and safe choices. Improving access and increasing provision (particularly in areas of disadvantage) to meet the needs of all ages including young people, over 35s and minority groups.

2.2 The Marmot principle, 'Strengthen the role and impact of ill health prevention' was the overarching principle which the Forum used to measure the provision of Council Services throughout their investigation into Sexual Health. The priority objectives and policy recommendations in relation to this principle being:-

Priority Objectives:-

(1) Prioritise prevention and early detection of those conditions most strongly related to health inequalities.

(2) Increase availability of long-term and sustainable funding in ill health prevention across the social gradient.

Policy Recommendations

(1) Prioritise investment in ill health prevention and health promotion across government departments to reduce the social gradient.

(2) Implement an evidence-based programme of ill health preventive interventions that are effective across the social gradient by:

- Increasing and improving the scale and quality of medical drug treatment programmes

- Focusing public health interventions such as smoking cessation programmes and alcohol reduction on reducing the social gradient

- Improving programmes to address the causes of obesity across the social gradient.

(3) Focus core efforts of public health departments on interventions related to the social determinants of health

3. MEMBERSHIP OF THE HEALTH SRUTINY FORUM

3.1 The membership of the Scrutiny Forum was as detailed below:-

Councillors S Akers-Belcher (Chair), Brash, Fisher, Hall (Vice-Chair), Hargreaves, G Lilley and Wells

4. OVERALL AIM OF THE SCRUTINY INVESTIGATION

4.1 The overall aim of the Scrutiny investigation was to strategically evaluate and contribute towards the development of the 'Sexual Health' topic within Hartlepool's Joint Strategic Needs Assessment, whilst reflecting (where possible / appropriate) on the Marmot principle to 'Strengthen the role and impact of ill health prevention'

5. FINDINGS

5.1 The terms of reference for the investigation were based on the ten key questions outlined in the JSNA. Members received evidence from a wide range of sources relating to these key questions and the findings are detailed in paragraphs 5.2 to 5.41 of this report. Details of evidence presented to the Forum are attached as **Appendix A.**

Setting the Scene

5.2 At the meeting of the Health Scrutiny Forum held on 20 September 2012, Members received a setting the scene presentation from the Council's

Health Improvement Practitioner and the Speciality Registrar in Public Health from NHS Tees. The presentation covered the following JSNA questions:-

- What are the key issues?
- What is the level of need?
- Who is at risk and why?

What are the key issues and what is the level of need?

5.3 Amongst the key issues and the level of need identified within the JSNA, Members raised particular concerns in relation to teenage pregnancy and how this was a key issue for Hartlepool.

5.4 The statistics within the JSNA illustrated that there had been a year on year reduction in the number of births. However, Members were concerned that although the numbers were reducing, the under 18 conception rate still remained higher than the national average. Members believed that more targeted intervention work was required within schools, and it was suggested that an external trainer may be better placed to deliver sexual health education rather than a teacher. Currently, teachers were being relied upon to provide sexual health advice to young people.

Who is at risk and why?

5.5 Members recognised that the people most at risk from sexual transmitted infections (STI's) were young people; men who have sex with men; over 35's who have been in long-term relationships; people who participate in risk-taking behaviour, for example, alcohol and substance misuse; people from identified socio-economic groups and black and minority groups. Members were supportive of the need to reduce STI's within these high risk groups.

5.6 Members acknowledged the concern that there were growing rates of STI's in the over 35's; often the 'second time singles'. The Forum questioned whether information in relation to the types of STI's, prevention and the services available was targeted at people through the use of social media, internet sites and blue tooth. It was indicated that wherever possible, the Public Health Team linked into any national or regional campaigns, as funding and materials were allocated to promote such campaigns. Members recommended utilising social media sites, internet sites and blue tooth at every opportunity to increase awareness of good sexual health and promote services. Through internet sites, Members suggested that short surveys could be carried out, which would not only raise awareness but also be a valuable tool to collect data.

Service Provision

5.7 At the meeting of the Health Scrutiny Forum held on 18 October 2012, Members received a presentation from the Consultant in Health Protection at the Health Protection Agency and the Service Manager at Assura, (the provider of sexual health services across Teesside). The presentation covered the following JSNA questions:-

- The services that are currently provided;
- The projected level of need / service use; and
- How effective is the current intervention.

What services are currently provided?

5.8 The Forum was informed that sexual health services, which in the past had generally been hospital based, were now moving towards more community based settings. Members emphasised the importance of early intervention work with young people and how targeted support within communities was invaluable. It was recognised that not all people were confident visiting clinics, therefore, in order to encourage testing Members were of the opinion that services should also be delivered within communities.

5.9 The Service Manager from Assura provided Members with details of the range of services provided by Assura, as referenced within the JSNA.

5.10 The Forum was strongly of the opinion that raising awareness amongst young people was extremely valuable and that schools were an excellent place to do this. Members commented that the spread of STI's could be combated with the greater use of condoms and suggested the wider distribution of condoms, for example, using 'bins' in the One Life Centre for people to access without having to attend a clinic appointment. Members also suggested utilising the counselling / advisory services offered to people participating in the night time economy to distribute condoms and provide advice, as it is a valuable resource.

5.11 The services provided by other organisations and groups are detailed in section 5.18 of this report.

What is the projected level of need / service use?

5.12 The data presented to Members by the Consultant in Public Health highlighted that sexual health was a key issue for the North East. Outbreaks of specific infections had been confirmed in certain areas of the North East and in specific at risk groups. For example, outbreaks of syphilis have been identified around the Newcastle area with men who have sex with men. The Consultant in Public Health identified that one of the main problems within Teesside was that people were not presenting to the sexual health services and it was becoming increasingly difficult to get the 'safe sex' messages heard.

5.13 Members recognised these difficulties and fully supported the need to encourage screening. Members questioned whether services had sufficient capacity to manage peaks in demand when outbreaks arose. Members were reassured by the Consultant in Public Health that capacity was not an issue and postal testing kits were also an option to alleviate direct pressure on services.

5.14 The Forum noted that syphilis infections had increased in the North East and there had been some reported cases of congenital transmission, (4 cases in the past 2 years), which had not been reported in many years. Members questioned why this infection had not been detected during antenatal screening. It was explained that it was often the case that the mother may have had new 'exposure' and therefore been re-infected following previous screening.

5.15 The Forum was informed that the North East had a low prevalence of HIV with no newly diagnosed cases in Hartlepool in 2012. Members raised concerns regarding HIV tests and what the impact of having a test had on insurance premiums. The Consultant in Public Health confirmed that there was no impact on insurance; however, it was still proving very difficult to encourage people in hard to reach groups to access HIV testing services. For example, working age men. The data provided by Assura highlighted that the majority of people accessing services were females and the service use was most prominent in the 20 -24 age range.

What evidence is there for effective intervention?

5.16 The Forum was presented with a range of reports that provided localised information and data in relation to STI's. This data had been used to inform the JSNA.

Views and Comments

5.17 The Forum at their meeting of 29 November 2012 and 10 January 2013 received evidence in relation to the JSNA question 'What People Say'. Evidence was received from Hartlepool's Young Inspectors, the Council's Portfolio Holder for Adult and Public Health Services, local schools, the Council's Youth Service and representatives from the voluntary and community sector.

What do people say?

Young Inspectors

5.18 The Young Inspectors acted as 'mystery shoppers' at the Sexual Health Clinic provided at the One Life Centre. Members were very impressed with the recommendations produced by the Young Inspectors, which were included as part of the JSNA, and thanked them for carrying out their investigation. Members were assured that all recommendations that were made by the Young Inspectors were acted upon in order for Assura to achieve 'Your Welcome Status', which was achieved in November 2012.

5.19 The Young Inspectors commented on confidentiality and thought that this could be improved within the Sexual Health Clinic, for example, by re-instating a number appointment system as opposed to calling people's names out in the waiting room. The Portfolio Holder considered that people should have a choice of both bookable and walk-in appointments.

5.20 Members were very supportive of reviewing opening times at the Sexual Health Clinic, as the service had to be accessible. Members felt that the opening hours should coincide with the running times of public transport in order to help people access the service. Members recommended integrating 'easy access' to sexual health services into the Youth Offer. The Youth Offer aimed to 'provide impartial information advice and guidance to help young people make more informed choices, about learning, raise their aspirations and equip them to make safe and sensible decisions about sexual health and substance misuse but to achieve this services must be accessible'. The Portfolio Holder suggested holding clinics at venues that were convenient and easily accessible to young people. Members supported this view and were also supportive of encouraging colleges to develop clinics within their facilities and the development of dedicated young people's clinics.

5.21 The Young Inspectors considered that making condoms more freely available at the Sexual Health Clinic would be beneficial.

Schools

5.22 Members expressed their concerns at the standard of sexual health education provided in schools. The school representative confirmed that all secondary schools in Hartlepool delivered a sexual education programme which was incorporated into Personal Social and Health Education. The content of the programmes were similar across the schools and were delivered by teachers with some input from health professionals. The benefits of delivering this type of programme were highlighted to Members, they included:-

(a) sex education being taught in the wider context of 'risk';

(b) schools were not wholly reliant on external agencies to deliver the programme; and

(c) schools were able to choose what they deliver and when so that it fits with the curriculum.

5.23 However, the challenges of this programme included:-

(a) that there was no co-ordinated approach, therefore it appeared fragmented,

(b) schools struggled to get outside agencies in to deliver; and

(c) young people did not acknowledge that they had sex education as it was part of a 'risk and resilience' approach.

5.24 The school representative highlighted that some young people were reluctant to ask questions or seek further guidance or clarification from a

member of school staff who taught the programme and some school staff did not feel confident in delivering the programme.

5.25 It was highlighted to Members that Hartlepool had once had a well-developed sexual education programme that was delivered to all young people from years 9 to 11. This was the APAUSE programme, which ran in all secondary schools from 1997 – 2009/10. The programme provided a co-ordinated approach to delivery and an evidence based programme utilising team teaching and peer education methods. A designated role to support the schools in the training, planning and delivery of sex and relationship education was provided.

5.26 Members expressed disappointment that this programme had been withdrawn and questioned why such a successful programme was withdrawn. It was confirmed that the withdrawal of the programme was due to cost and resource issues. Members acknowledged the challenges in delivering the APAUSE programme, which included:-

(a) the cost of purchasing the programme and the cost of the APAUSE Co-ordinator (approximately £35,000 per year);

(b) the fact that schools currently delivered sexual health education in different ways;

(c) capacity within the school nursing service may be limited; and

(d) the cost of commissioning 'others' to deliver.

5.27 The representative from the school was asked by Members what the Local Authority could do to help support schools with sex and relationship education. In response the representative said that it would be beneficial for health professionals to work with teachers and play a much more active role in the delivery of sex and relationship education in schools.

5.28 Members were strongly of the view that the APAUSE programme was a successful and well–developed programme and recommended that this programme be re-implemented and commissioned through the £800,000 annual budget allocated to sexual health services. This would link into the commissioning priority identified in the JSNA, which is to 'improve the quality and opportunities for sex and relationship and risk-taking behaviour education in schools and other settings'.

5.29 Members were of the opinion that rather than introducing other programmes or improving existing programmes, that this was an excellent opportunity to invest in a 'tried and tested' successful programme.

Youth Service

5.30 The Council's Youth Service shared details of their services with the Forum. It was highlighted that 361 young people had registered with the Youth Service in 2012. Members referred to the C-Card scheme and how this was a

valuable provision. The scheme provided young people (13 -25) with access to free condoms, Chlamydia screening and pregnancy tests and was delivered by a range of groups within Hartlepool, including the Youth Support Service. The Forum expressed concern that it was very difficult for voluntary and community sector youth groups who wanted to deliver the C-Card provision to access the training and become part of the scheme. The Forum recommended that all voluntary and community sector youth groups within Hartlepool should be able to access the training and join the scheme if they meet the requirements.

Voluntary and Community Groups

5.31 The evidence received from Teesside Positive Action (TPA) highlighted that rapid testing clinics for HIV, syphilis and hepatitis C were provided every fortnight in the One Life Centre and if staffing capacity could be increased TPA would increase the number of clinics in Hartlepool to extend the provision to other venues.

5.32 A representative from Hart Gables outlined the services that they provided and highlighted that they were keen to extend the current sexual health service provision and work more closely with Teesside Positive Action.

5.33 A representative from the Wharton Trust informed Members that sexual health advice and teenage pregnancy support was provided by the Trust to young people, however, the support was limited due to limited resources.

5.34 The potential impact of funding reductions was raised as a concern by Members. Representatives at the meeting advised that funding for tests was available but no funding was available in terms of prevention and awareness raising.

5.35 Members questioned what sexual health information was available in terms of literature, such as leaflets and booklets. Representatives highlighted that a range of literature was available in hard copy and on the internet but has decreased over the years, as a result of funding restrictions. Members did not want to see literature reduced any further and suggested that the Council worked with partner organisations and groups to produce appropriate marketing material in order to raise awareness and publicise the services available. This material could then be used in schools, colleges and placed on school buses to publicise sexual health.

5.36 Members were of the view that voluntary and community sector youth groups were often overlooked and not included in the delivery of sexual health services, advice and support. Members expressed concerns about services working in isolation and suggested that statutory services should work more closely with voluntary and community sector youth groups. Members commented that all voluntary and community sector youth groups should be able to easily access sexual health training and resources. The Forum suggested that by improving communication between all services that deliver

sexual health services, advice and support, both statutory and non-statutory, would improve partnership working.

Needs and Commissioning

5.37 The Forum at their meeting of 10 January 2013 received a presentation from the Director of Public Health. The presentation covered the following JSNA questions:-

- What needs might be unmet?
- What additional assessment is required?
- What are the recommendations for commissioning?

What needs might be unmet?

5.38 Members agreed with the unmet needs identified within the JSNA and placed specific emphasis on the need to deliver effective sex and relationship education.

What additional needs assessment is required?

5.39 The Forum was supportive of the additional needs assessment identified within the JSNA.

What are the recommendations for commissioning?

5.40 The Forum was supportive of the commissioning priorities detailed within the JSNA.

5.41 In addition to the priorities identified in the JSNA, the Forum formulated the recommendations, identified in section 6, to inform the development and delivery of the Health and Wellbeing and Commissioning Strategies.

6. RECOMMENDATIONS TO INFORM THE DEVELOPMENT AND DELIVERY OF THE HEALTH AND WELLBEING AND COMMISSIONING STRATEGIES

6.1 The Health Scrutiny Forum has taken evidence from a wide range of sources to assist in the formulation of a balanced range of recommendations. The Forum's key recommendations to inform the development and delivery of the Health and Wellbeing and Commissioning Strategies are:-

1) The need to raise awareness of good sexual health and the services available is highlighted within the JSNA 'Sexual Health' entry and Hartlepool Borough Council undertakes the following:-

   (a) Increases awareness and understanding of the types of sexually transmitted infections, prevention and the services available through:-

      (i) social media / internet sites / blue tooth;

(ii) schools / colleges / literature on school buses; and

(iii) counselling / advisory services available to those individuals participating in the night time economy

(b) Works with partner organisations to produce marketing material in order to raise awareness and publicise the sexual health services available

2) Accessibility to services is identified as a key issue within the JSNA 'Sexual Health' entry and Hartlepool Borough Council improves accessibility to services by:

(a) Commissioning services that are accessible to all and have good transport links;

(b) Integrating easy access to sexual health services into the 'Youth Offer' to ensure that all young people can easily access sexual health services; and

(c) Making condoms freely available at the Sexual Health Clinic in the One Life Centre, for people to access without having to attend a Clinic appointment

3) That partnership working is integrated into the JSNA 'Sexual Health' entry and that Hartlepool Borough Council:

(a) Improves communication links between all services that delivery sexual health services, advice and support in order to increase partnership working and improve working relationships; and

(b) Makes the C-Card scheme and other sexual health training and resources widely available to all voluntary and community sector youth groups who want to provide sexual health services, advice and support

4) That Hartlepool Borough Council commissions the APAUSE programme through the allocated budget for sexual health

COUNCILLOR STEPHEN AKERS-BELCHER
CHAIR OF THE HEALTH SCRUTINY FORUM

ACKNOWLEDGEMENTS

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

Hartlepool Borough Council:

Cllr John Lauderdale – Portfolio Holder for Adult and Public Health Services

Louise Wallace – Director of Public Health

Deborah Gibbin – Health Improvement Practitioner

Hartlepool Young Inspectors

Youth Service

External Representatives:

Sarah Bowman - Registrar in Public Health, NHS Tees

Dr Kirsty Foster – Consultant in Public Health / Lead for Sexual Health, Health Protection Agency

David Pratt, Service Manager – Sexual Health Teesside, Assura

Anne Malcolm – Headteacher, Manor College

Teresa Driver – Wharton Trust

Mike Kay – Service Manager, Teesside Positive Action

Joanne Fairless – Hartgables

Appendix A

Evidence provided to the Forum

The following evidence was presented to the Health Scrutiny Forum throughout the course of the investigation into the JSNA topic of 'Sexual Health':-

Date of Meeting	Evidence Received
23 August 2012	Scoping Report – *Scrutiny Support Officer*
20 September 2012	Setting the Scene Presentation – *Health Improvement Practitioner and Speciality Registrar in Public Health.*
18 October 2012	Presentation - Service Provision – *Service Manager, Assura* STI's – *How do we know what is going on and why does it matter – Consultant in Health Protection, Health Protection Agency*
29 November 2012	Verbal Evidence – *Portfolio Holder for Adult and Public Health Services* Presentation – Mystery Shop – *Young Inspectors*
10 January 2013	Evidence from voluntary and community groups, schools and the youth service Written Report – The Teaching and Support of Sexual Health in Hartlepool Secondary Schools – *Headteacher, Manor College* Hartlepool JSNA Entry Report – You're Welcome Quality Standards – *Health Improvement Practitioner* Report - Teenage Pregnancy Performance Report – *Director of Public Health* Presentation – Need and Commissioning Priorities – *Director of Public Health*

7 February 2013	Written Report – APAUSE and C-Card – *Health Improvement Practitioner* Written evidence from St Hild's Church of England School

TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE
4th February, 2013

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 Carling and Kay.

Representing Stockton-On-Tees Borough Council:
Councillor Wilburn.

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

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

EXTERNAL REPRESENTATIVES –

Cameron Ward, Area Team Director, Durham, Darlington and Tees;
Mark Cotton, Assistant Director Communications and Engagement and Claire Mills Business Manager, Patient Transport Services, North East Ambulance Services NHS Foundation Trust.

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.

32. DECLARATIONS OF INTEREST – There were no declarations of interest reported at the meeting.

33. MINUTES – Submitted – The Minutes (previously circulated) of the meeting of the Tees Valley Health Scrutiny Joint Committee held on 7th January 2013

The Chair requested that a reminder be sent to the Local Authorities who have yet to respond to the Joint Committee's request regarding winter pressures in relation to seasonal flu.

The Chair and Councillor Wilburn provided a verbal report on their recent visit to the Prosthetic Unit at James Cook Hospital and suggested that the matter be reconsidered at a future meeting of the Joint Committee to provide Members with assurance that the service is meeting the needs of all its services users.

AGREED – (a) That the Minutes of the meeting be noted as a correct record.

(b) That a reminder letter be sent to Redcar and Cleveland Borough Council and Stockton-On-Tees Borough Council in relation to winter pressures in relation to seasonal flu.

(c) That an update on Prosthetics Services be added to a future meeting of the Joint Committee.

34. OVERVIEW OF AREA TEAM – The Area Team Director, Cameron Ward for Durham, Darlington and Tees submitted a presentation (slides previously circulated) which outlined the role of the NHS Commissioning Board, Area Teams in England, the role and function of the Area Teams and the progress so far within the Durham, Darlington and Tees Team.

The Director provided an overview of the NHS Commissioning Board and reminded Members that the Board is an Executive Non Departmental Public Body with a mandate from the Department of Health to improve outcomes through the total of £80bn commissioning budget, with oversight and development of the commissioning system. It also has direct commissioning responsibility for primary care commissioning, offender and military health, specialised commissioning and some screening programmes. It would set key time frames with outcomes, local accountability, offer a range of choice and have a role in emergency preparedness, but not respond directly but ensure that local NHS organisations actively respond. There will be one national operating model who will buy in support from Commissioning Support Units and also some key bodies including senates.

Mr Ward advised that senates were a new initiative which would bring together multidisciplinary clinical teams considering standards and a view would be taken to advise commissioners. It was noted that local expertise would be fed into the senates and that views of local Health and Well Being Boards, HealthWatch and Overview and Scrutiny Committees would also be taken into account. The intention is to establish the senates before the end of March 2013 and focus discussions around clinical based evidence with involvement of national clinical experts. Membership will allow for members to be co-opted depending on the subject matter and their area of expertise. It was anticipated that the Francis II report would also influence the senate and its operations.

The Director explained the role and functions of the Area Teams in the North of England and how different Teams would take on the lead for different health specialisms. For example; Durham, Darlington and Tees Area Team would be the lead on primary care commissioning and offender health for Cumbria, Northumberland, Tyne and Wear.

Mr Ward reported that one of his Directors would regularly attend each local Health and Well Being Board and that he would attend whenever possible. He believed that as a commissioner of services especially specialised and primary care being a member of the Health and Well Being Board would be essential and also provide a health system oversight role, this would assist and support the local NHS to maximise the local health system to achieving the objectives within the agreed Health and Well Being Strategy. Members queried the role of the Area Team if a disagreement arose between local

Health and Well Being Boards and the Clinical Commissioning Groups (CCG). Mr Ward explained that the CCG would need to take account of the Joint Strategic Need Assessment (JSNA) and need to agree its three local priorities with the Health and Well Being Board. If the CCG wanted to set a priority contrary to the Health and Well Being Board, the Area Team would question the CCG and request evidence for the priority. The plans will be signed off by the Director of the Area Team and if the priorities don't support the plans the plans cannot be agreed. The plans must be in alignment as both the CCG and Health and Well Being Board serve the same local population.

Members were pleased to note that the majority of the Area Team staff have been recruited and robust transition arrangements are in place with NHS County Durham and Darlington and NHS Tees. The aim is to develop a positive working culture for new staff through engagement, staff events and implementation of agreed working behaviours and Members recognised that there would be a huge culture change for a high number of staff.

The long term aim of the Area Team is to support and deliver an ambitious health improvement of health outcomes and reduction in health inequalities in the Durham, Darlington and Tees locality. Assist and implement recommendations from the Francis II report in respect of quality and safety and continue to develop positive working relationships with key stakeholders. The Area Team will also support the development of CCGs, conclude the contracting process for 2013/14 and ensure the financial sustainability of the areas, while acknowledging the budget pressure all organisations are experiencing.

Discussion ensued about the potential difficult decisions that need to be made and whether some areas may be financially neglected; how the focus of commissioning must remain centred around the JSNA and outcomes, and the commissioning process must be transparent and feature public engagement events.

The Chair thanked the Director for his detailed presentation and attendance at the meeting and the Director undertook to report back to a future meeting of the Joint Committee progress of the Area Team and provide assurance those relationships and communications are in place and remain strong and positive.

AGREED – (a) That the presentation be noted.

(b) That the Director be thanked for the attendance; and

(c) The Director be invited to provide a further update at a future meeting of the Joint Committee.

35. PATIENT TRANSPORT SERVICE STRATGEY 2012 – 2017 – The Patient Transport Service Strategy 2012 – 2017 (previously circulated) offered Members the opportunity to comment on and challenge the Patient Transport Service (PTS) Strategy. Claire Mills, Business Manager, PTS, North East Ambulance Services NHS Foundation Trust (NEAS) guided Members through the document explaining that the Strategy sets out the vision for PTS in the North East of England and the changes that would be implemented over the next five years to achieve the vision.

The Business Manager reminded Members that PTS provides vital access to planned appointments and involves approximately one million journeys every year. It was noted that in Tees, the service model operates around patients' appointment times. As this system has been successful, it was planned to implement this across the rest of the North East focusing transport arrangements based around patient appointment times which would benefit the patients. Members acknowledged that the market for PTS has grown sustainably over the recent five years and that commissioners expect ever higher quality standards that represent high value for money.

Mrs Mills explained that the Trust's rationale for change was based upon feedback from patients, carers, commissioners and hospital providers have determined what elements of the PTS service model need to change. The Trust are also exploring new markets - integrated transport models and working in partnerships with other statutory, voluntary and community agencies to deliver services to a wide set of clients. The opportunities include; provision of Special Educational Needs and adult social care transport provision, partnerships approaches to maximise volunteering opportunities to enhance our social capital bringing people into work from unemployment and education and the creation of sustainable community transport partnerships with Local Authorities, voluntary and community and private sector transport providers thus improving access to services for people where transport is a barrier to access.

Mrs Mills highlighted the five projects that would drive forward the Implementation Plan and influence the Business Planning, those being; PTS Business Improvement, Better Fleet, Better Planning, More Mobile Patients and PTS Workforce Re-Design. The aspiration is for the Trust to ensure that 90% of patients spend less than 60 minutes travelling to their appointments and are collected within 60 minutes of their appointed end or when telephoned ready for collection.

Mr Mark Cotton, Assistant Director Communications and Engagement shared Members concerns about future provision of PTS and the potential of other companies winning tenders for PTS for example, Voluntary Sector, Local Authority and/or Private Companies i.e. Arriva. Mr Cotton reported that Arriva have been awarded the contract for PTS in Greater Manchester and advised that NEAS has recognised the potential of competition and are focused to ensuring that the PTS they provide is robust and cost effective to withstand competitors. The benefits of ambulance services providing PTS enables them to treat patients if an emergency situation arises and avoids the need for an additional ambulance and provides flexibility and adaptability to the service. Members expressed further concerns about the possibility of the service becoming defragmented and service specification being weighed towards cost rather than quality of service.

Particular reference was made to Eligibility Criteria for PTS in Tees and whether this would have a huge impact. Mrs Mills commented that would be dependent on how the criteria were applied and whether NEAS would be implementing the criteria on the commissioner's behalf. Members expressed concerns about commissioners preparing the service specification and suggested that consultation was required and hoped that GPs would be involved in the process.

Reference was also made to cancelled or aborted journeys and Members were surprised to note that 18% of journeys are aborted, the reasons for this being varied and the responsibility of a range of organisations. Journeys are also aborted because

patients have already been admitted to hospital, are too ill to travel, patients are still waiting to be discharged or for medications or remaining in hospital. NEAS are keen to work with Acute Hospitals to be part of the Discharge Policy and consideration is being given for electronic communications for when patients are ready for collection.

Discussion ensued about the use of electric cars and ambulances; poor staff morale, when there is good client feedback; hospital providers' forums in early discussions about booking transport and standards that NEAS currently achieve.

AGREED – (a) That the discussion be noted.

(b) That the Officers be thanked for their attendance at the meeting.