# HEALTH AND WELLBEING BOARD AGENDA

HARTLEPOOL BOROUGH COUNCIL

**Monday 5 August 2013**

**at 10.00 a.m.**

**in Committee Room 'B'**
**Civic Centre, Victoria Road, Hartlepool.**

MEMBERS: HEALTH AND WELLBEING BOARD

**Prescribed Members:**
Elected Members, Hartlepool Borough Council – Councillor C Akers-Belcher (substitute Councillor Richardson), Councillor Hall, Councillor G Lilley and Councillor Simmons
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group (2) – Dr Pagni and Alison Wilson
Director of Public Health, Hartlepool Borough Council (1); - Louise Wallace
Director of Child and Adult Services, Hartlepool Borough Council (1) – Jill Harrison/Sally Robinson
Representatives of Healthwatch (2). Margaret Wrenn and Stephen Thomas
**Other Members:**
Chief Executive, Hartlepool Borough Council (1) – Dave Stubbs
Director of Regeneration and Neighbourhoods, Hartlepool Borough Council (1) – Denise Ogden
Representative of the NHS England (1) – Caroline Thurlbeck
Representative of Hartlepool Voluntary & Community Sector (1) – Tracy Woodhall
Representative of Tees Esk and Wear Valley NHS Trust (1) – Martin Barkley
Representative of North Tees and Hartlepool NHS Foundation Trust – Alan Foster
Representative of North East Ambulance NHS Trust (1) – Nicola Fairless
Representative of Cleveland Fire Brigade (1) – Ian McHugh

Observer – Representative of the Audit & Governance Committee, Hartlepool Borough Council (1) – Councillor Fisher

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

3.1 To confirm the minutes of the meeting held on 24 June 2013

**4. ITEMS REQUIRING DECISION**

4.1 Declaration on Tobacco Control – *Director of Public Health*
4.2 Constitutional and Structural Arrangements for the Children's Strategic Partnership as a Subgroup of the Health and Wellbeing Board - *Assistant Director (Children's Services)*
4.3 Tees Autism Strategy – *Assistant Director, Adult Services*
4.4 The Challenging Behaviour Charter – *Assistant Director, Adult Services*

**5. ITEMS FOR INFORMATION**

5.1 Scrutiny Investigation into Selected Joint Strategic Needs Assessment (JSNA) Topics – Final Report and Agreed Actions (Scrutiny Manager)
5.2 Securing Quality in Health Services – Chief Officer, Hartlepool and Stockton on Tees Clinical Commissioning Group and Project Director, Securing Quality in Health Services
5.3 Feedback from Chairs of Health and Wellbeing Boards Regional Meeting - Chair

**6. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT**

**Date of next meeting – 16 September 2013 at 10 a.m. in Committee Room B, Civic Centre, Hartlepool**

# HEALTH AND WELLBEING BOARD

## MINUTES AND DECISION RECORD

24 June 2013

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

**Present:**

Councillor Richardson (substitute for Councillor C Akers-Belcher, Leader of Council) (In the Chair)

**Prescribed Members:**
Elected Members, Hartlepool Borough Council, Councillors Hall, G Lilley and Simmons
Representing Hartlepool and Stockton-on-Tees Clinical Commissioning Group; Alison Wilson
Director of Public Health, Hartlepool Borough Council, Louise Wallace
Representatives of Healthwatch, Margaret Wrenn and Steve Thomas

**Other Members:**
Chief Executive, Hartlepool Borough Council; Dave Stubbs
Director of Regeneration and Neighbourhoods, Hartlepool Borough Council, Denise Ogden
Representative of the NHS England Area Team; Caroline Thurlbeck
Representative of Hartlepool Voluntary & Community Sector, Tracy Woodhall
Representative of North Tees and Hartlepool NHS Foundation Trust; Alan Foster

Also Present:

Michael Slimings, Director, Incontrol-able CIC
Dr Emerton, North Tees and Hartlepool NHS Foundation Trust

Officers: Catherine Grimwood, Hartlepool Borough Council, Performance and Partnerships Manager
Neil Harrison, Hartlepool Borough Council, Head of Service
Donna Owens, NHS North of England Commissioning Support Unit
Alastair Rae, Hartlepool Borough Council, Public Relations Manager
Joan Stevens, Hartlepool Borough Council, Scrutiny Manager
Amanda Whitaker, Democratic Services Team

Also in attendance:

Councillor Loynes and Healthwatch members

The Deputy Leader of the Council, Councillor Richardson, advised the Board that he would be acting as a permanent substitute for the Leader of the Council due to a potential conflict of interest by Councillor Christopher Akers-Belcher.

## 1. Apologies for Absence

Councillor C Akers-Belcher, Leader, Hartlepool Borough Council
Martin Barkley, Tees Esk and Wear Valley NHS Trust
Councillor Fisher, Chair, Audit and Governance Committee (Observer)
Jill Harrison, Hartlepool Borough Council, Assistant Director (Adult Services)
Dr Pagni, Hartlepool and Stockton-on-Tees Clinical Commissioning Group
Sally Robinson, Hartlepool Borough Council, Assistant Director (Children's Services)

## 2. Declarations of interest by Members

None

## 3. Minutes

The minutes of the meeting of the Shadow Health and Wellbeing Board held on 11 March 2013 were received.

## 4. Health and Wellbeing Board Terms of Reference

(*Director of Public Health*)

The Board was reminded that the Health and Social Care Act 2012 set out the statutory requirement for unitary authorities to establish Health and Wellbeing Boards from April 2013. As a Committee of Hartlepool Borough Council the responsibilities and functions of the Board were set out within the Council's Constitution. The Board's specific responsibilities were set out in the report.

The Health and Wellbeing Board had been meeting in shadow form since October 2011. From 1st April 2013 the Board had taken on its formal role as set out in the Constitution. However, in order to provide further detail about the role and responsibilities of the Board and its members a new Terms of Reference had been prepared. The draft Terms of Reference for the Health and Wellbeing Board were appended to the report. It was highlighted that the codes and protocols of the Voluntary and Community Sector (VCS) Strategy were referred to in the Terms of Reference and were therefore also appended to the report.

At the development day the Board had considered the Local Government Association and Association of Democratic Services Officer joint publication 'Health and wellbeing boards - A practical guide to governance and constitution issues'. It was agreed that the structure of the Health and

Wellbeing Board for Hartlepool should follow a similar structure to the Luton model with three delivery groups covering children, adults and health inequalities. All other health related groups would feed into the work of one of the three delivery groups. The sub structure of the Health and Wellbeing Board was set out in the Terms of Reference and was illustrated in the report.

**Decision**

(i) The Board agreed the Terms of Reference as appended to the report.
(ii) In accordance with the terms of reference, it was agreed that the Vice Chair of the Board would be a representative of the Clinical Commissioning Group.

## 5. Communication and Engagement Strategy (*Director of Public Health*)

The report set out the draft Communication and Engagement Strategy and sought agreement to the establishment of a Communications and Engagement group that would lead on the delivery of the strategy. The Board was also asked to note the proposed draft action plan, appended to the report, together with the draft campaign calendar for 2013 / 14.

Partners had been asked to provide information to the Council's Performance and Partnerships Team identifying their existing channels for communications and public engagement. The exercise had identified a broad range of mechanisms that partners currently utilised including; magazines, publications, bulletins, websites, social media, local press and resident forums / focus groups.

The draft Communication and Engagement Strategy had been circulated. The Board was requested to agree the draft Strategy and provide feedback. In order to drive forward the delivery of the strategy it was proposed that the Board establish a Communications and Engagement Group which would be led by the Council's Public Relations Team. The group would consist of representatives from communication teams from partner organisations. The proposed group would be responsible for the development and delivery of the communication Strategy Action Plan (Appendix B) together with the planning and delivery of the annual campaign calendar (Appendix C). The group would also undertake evaluations of campaigns to monitor their effectiveness and feedback to the Board on a regular basis.

Board Members recognised the opportunities which were available in terms of public health communication together with important social care and commissioning messages. It was highlighted that communication should be transparent, for lessons to be learnt from previous experiences and that appropriate resources be allocated to deliver the Strategy. Board Members

received an assurance from the Council's Director of Regeneration and Neighbourhoods regarding the operation of those work streams applicable to this Board and those of the Safer Hartlepool Partnership.

**Decision**

(i)The draft Communications and Engagement Strategy was approved and it was agreed that appropriate level of resources should support the Strategy.

(ii)That the establishment of a Communication and Engagement group was approved.

(iii) The draft action plan and campaign calendar was approved and it was agreed that the proposed Communication and Engagement group develop these further.

## 6. Work Programme (*Director of Public Health*)

The report set out a proposed work programme for 2013/14 which provided an opportunity for the Board to consider a work programme for 2013/14. The need for a work programme had been identified at the Board development session held on 22nd April 2013. Members of the Board had considered a work programme would allow the Board to be focused on key health and well being issues and plan dedicated time into the Board agenda to address these issues. It was noted that the work plan did not replace the Council's Forward Plan.

Members of the Board noted that development of the work programme was an iterative process and members were urged to bring forward items for inclusion in the work programme as they became aware of them.

**Decision**

The Board work programme was endorsed subject to consideration of the Children's Strategic Partnership Terms of Reference being brought forward to the August meeting of the Board.

## 7. Potential Topics for Inclusion in the Audit and Governance Statutory Scrutiny Health Work Programme (*Scrutiny Manager*)

The Board was invited to suggest topics for consideration / inclusion in the work programme for the Audit and Governance Committee in relation to the statutory scrutiny area of health. The Audit and Governance Committee was

due to set its work programme at its meeting of 27 June 2013. The role of the Audit and Governance Committee was highlighted together with the success of previous health scrutiny investigations. The Scrutiny Manager assured Board Members that the monitoring of recommendations of previous scrutiny investigations would continue under the Council's new governance arrangements.

Suggested topics had been sought from the Council's Director of Public Health, Hartlepool and Stockton-on-Tees Clinical Commissioning Group and North Tees and Hartlepool NHS Foundation Trust. The topic that had been suggested was Chronic Obstructive Pulmonary Disease (COPD). The Hartlepool Joint Strategic Needs Assessment (JSNA) had identified COPD as a key issue. The topic has been suggested because it would help improve services and raise awareness of COPD. The key issues relating to COPD were highlighted in the report.

Dr Emerton explained the reasons that COPD was a particularly important issue. During the discussion which followed, reference was made to the importance of early detection of the disease, the appointment of a new Consultant to ensure the best possible management of patients, the primary care role together with the role of Healthwatch. The identification of COPD as an effective topic suggestion was welcomed by Board Members and it was highlighted that the topic incorporated the whole spectrum covered by Members of the Board.

**Decision**

The Board agreed that COPD is an effective topic suggestion to put forward to the Audit and Governance Committee for consideration as part of the Committee's 2013/14 work programme.

## 8. Centralisation of Emergency Medical and Critical Care Services at University Hospital North Tees – Public Consultation (*Chief Officer, Hartlepool and Stockton-on-Tees Clinical Commissioning Group*)

The report provided the Board with an update on the public consultation, the rationale for the proposed changes and provided an opportunity for discussion by the Board in respect of the implications of the proposals.

The Board was advised that following proposals put forward by North Tees and Hartlepool NHS Foundation Trust in relation to the reconfiguration of services to ensure sustainability of Critical Care and Acute Medical services

at the University Hospital Hartlepool, Hartlepool and Stockton-on-Tees Clinical Commissioning Group (HaST) had commissioned an independent review by the National Clinical Advisory Team (NCAT). The NCAT review had confirmed that the proposals were necessary to maintain safety and quality of services for the local community and that there was no other option but to centralize services on the North Tees hospital site. The team provided assurance that the changes would result in safer services for local people that would be sustainable and affordable. The change was expected to be an interim arrangement until the new single site hospital was in place. The commissioners and the Trust had therefore commenced a 12 week public consultation on the proposals.

It was proposed that Critical Care, Acute Medical Services and some complex surgery be centralised on the North Tees Hospital site. This would also mean that in addition some support staff from pharmacy, radiology and estates would also need to be transferred to North Tees. The change would affect about 30 Hartlepool and Easington patients per day. 97% of health care contacts would remain in Hartlepool. The Public Consultation had commenced on the 20th May and would run until 11th August 2013. The consultation aimed to gather views on the proposals and to understand concerns about the proposed changes. A copy of the consultation document was appended to the report and details of consultation questions were included in the report.

Members of the Board highlighted the importance of addressing transport issues. Board Members expressed their contentment that the options available in terms of transport were being considered by the Foundation Trust and that the Trust was committed to addressing those issues. It was highlighted, however, that it was essential to ensure effective public communication of transport services available to patients/visitors. It was confirmed that the provision of transport services was commissioned by the Clinical Commissioning Group from North East Ambulance Service (NEAS). The Voluntary & Community Sector representative referred to transport services provided by the voluntary sector. It was agreed that it would be interesting to obtain an indication of the number of mini buses available in the voluntary sector and for discussions to be held with NEAS.

**Decision**

The Board received the update on the consultation and discussed the implications of the proposed changes with particular reference to transport issues.

## 9. Equality and Diversity in Service Provision DVD

(*Incontrol-able CIC)*)

The Board viewed a dvd entitled **"***Freddie's Story";* a new 20-minute training film about people with learning disabilities for everyone working in

healthcare including medical students, nurses, doctors, and receptionists.

The film was inspired by Mencap's Death by Indifference report and aimed to help provide the mandatory training in learning disability recommended by Sir Jonathan Michael's Inquiry into Healthcare For All. The DVD addressed many different aspects of the hospital environment through a narrative based on real experiences. The film gave simple steps to good practice in improving care and diagnosis with a focus on improving communication and inspiring everyone to respect and value people with a learning disability.

At the conclusion of the DVD Michael Slimings responded to clarification sought from Members of the Board. Reference was made to the powerful nature of the film. It was recognised that it was essential to continue to share the message conveyed in the film to ensure quality in health care provision.

**Decision**

The issues highlighted by the DVD were noted

## 10. Winterbourne View (*Chief Officer, Hartlepool and Stockton-on-Tees Clinical Commissioning Group and Assistant Director, Adult Social Care)*

The report provided an update on actions identified following publication of the Winterbourne View Hospital report and Concordat (Dec 2012) to provide assurance of collaboration between Health and the Local Authority. The Department of Health review had responded to criminal abuse at Winterbourne View hospital revealed by the BBC Panorama programme in May 2011. The main actions identified for commissioners through the review and concordat were identified in the report.

A letter received from Chris Bull, Chair of the Winterbourne View Joint Improvement Board, had asked Clinical Commissioning Groups (CCG's) and Health and Wellbeing Boards to assess their progress against commitments in the Concordat and to allow for good practice and progress from local areas to be shared nationally. A copy of the letter had been appended to the report. A joint plan would be developed to deliver this work once the individual patient requirements were known; this would also include the review of existing inpatient assessment and treatment bed requirements for the future. It was highlighted that this work would be on-going. Transitions' planning was in place between Health and Local Authority partners with the aim of mapping future demand, informing investment requirements and preventing out of area placements.

The Board was provided with a progress update. It was highlighted that the timescales which had been identified nationally for Winterbourne were a particular pressure given the complexity of the people who had been

identified and the risk of re-admission throughout this programme remained high.

It was noted that impact assessment work was underway with Tees Esk and Wear Valley NHS Trust which could potentially suggest that the current investment in assessment and treatment provision be re-provided into community services to support delivery of this work and prevent re-admission through placement breakdown. Any additional resource requirements were unknown at this point.

Officers responded to questions raised by Board Members and gave assurances regarding monitoring and accountability with particular reference to community settings.

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**Decision**

(i) The update was received by the Board and the assurance that plans are in place to work collaboratively between the Clinical Commissioning Group and the Local Authority to develop the long term solutions for these patients was noted.

(ii) The update of progress against key winterbourne view concordat commitment was agreed.

**Prior to consideration of the following item of business, representatives of North Tees and Hartlepool NHS Foundation Trust left the meeting.**

## 11. Any Other Items which the Chairman Considers are Urgent

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

## 12. Development of a New Hospital

The Council's Chief Executive advised the Board that Alan Foster was due to attend a meeting later in the week with the Secretary of State for Health regarding funding arrangements for a new hospital. The support of the Board was sought to letters being sent from the Board and the Council's Chief Executive, to the Minister, in support of plans to build a new hospital in Hartlepool.

Councillor G Lilley advised the Board that he would not object to letters of support being sent to the Minister. However, he highlighted

that the letters would not reflect his personal views. Councillor Lilley requested that his grave misgivings be recorded.

During a debate which followed, Members of the Board referred to long term considerations in terms of 'what was best' for the residents of Hartlepool. Board Members were reminded of the consultation which had been undertaken when thousands of people had agreed that a new hospital should be built. In the context of Momentum Pathways to Healthcare, the delivery of services locally had been recognised.

**Decision**
It was agreed, on a consensus basis, that letters supporting the building of a new hospital in Hartlepool be sent to the Secretary of State for Health.

CHAIR

# HEALTH AND WELL BEING BOARD

**5th August 2013**

**Report of:** Director of Public Health

**Subject:** Declaration on Tobacco Control

## 1. TYPE OF DECISION/APPLICABLE CATEGORY

NON KEY

## 2. PURPOSE OF REPORT

2.1 The purpose of this report is to present to the Health and Well Being Board a proposed declaration on tobacco control.

## 3. BACKGROUND

3.1 The attached charter on tobacco control has been adopted by Newcastle Council in May 2013 and is being shared with the Hartlepool Health and Well Being Board to consider whether the Board would also wish to make this declaration for Hartlepool.

3.2 Smoking is still the single preventable killer across the North East and causes a significant burden of ill health including cancer and respiratory disease in communities.

3.3 Around 23% of the adult population of Hartlepool smoke cigarettes and in some of the more socio-economically deprived wards over 50% of adults smokes.

3.4 Therefore, there is still an ongoing public health challenge to tackle smoking rates and ensure sustained effort in an attempt to eradicate smoking.

## 4. RECOMMENDATIONS

4.1 Members of the Board are asked to support the declaration on tobacco control for Hartlepool.

## 5. REASONS FOR RECOMMENDATIONS

5.1 To address the public health impact caused through smoking in Hartlepool.

## 6. CONTACT OFFICER

6.1 Louise Wallace
Director of Public Health
Hartlepool Borough Council
4th Floor Civic Centre
louise.wallace@hartlepool.gov.uk

# The Newcastle Declaration on Tobacco Control

We acknowledge that:

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people, two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

As local leaders in public health we welcome the:

- Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Commitment by the government to live up to its obligations as a party to the World Health organization's framework convention on Tobacco control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry; and
- Endorsement of this declaration by central government and Public Health England.

We commit our Council from this date ……to

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use;
- Participate in local and regional networks for support;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities;
- Protect our tobacco control work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Monitor the progress of our plans against our commitments and publish the results; and

- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reducing the harm caused by tobacco.

Signatories for the Council

Leader of the Council

Director of Public Health

Chief Executive

# HEALTH AND WELLBEING BOARD

**5TH AUGUST 2013**

**Report of:** Assistant Director, Children's Services

**Subject:** CONSTITUTIONAL AND STRUCTURAL ARRANGEMENTS FOR THE CHILDREN'S STRATEGIC PARTNERSHIP AS A SUBGROUP OF THE HEALTH AND WELLBEING BOARD

## 1. PURPOSE OF REPORT

1.1 The purpose of this report is to inform members of the Health and Wellbeing Board of the changes to the Children's Strategic Partnership, arising from the implementation of amendments to Hartlepool Borough Council's Constitution and; the establishment of the statutory Health and Wellbeing Board from 1st April 2013.

## 2. BACKGROUND

2.1 Children's Trusts were originally established by the Children Act 2004. Whilst a number of sections of the Act were repealed by the current government, including the revocation of the Children and Young People's Plan (CYPP) Regulations, the requirement to have a forum that brings all services for children and young in an area together remains with following guidance being issued by the Department for Education:

*The Children's Trusts' duty to cooperate remains in force. Local Children's Trust arrangements are underpinned by the 'duty to cooperate' (section 10 of the Children Act 2004) and there are no plans to repeal this duty. But there is now considerable flexibility in how local partners may implement it.*

*There is still a requirement for each local authority to have a Children's Trust Board which must include representatives of the local authority and each of the Children's Trust 'relevant partners' (apart from the Strategic Health Authority). But there are no longer any regulations or central guidance on how this should be done.*

*Local areas are free to ensure the Children's Trust Board fits within newly emerging structures in ways that best reflect and meet local needs. There is no longer a requirement on the Children's Trust Board to prepare a Children*

*and Young People's Plan. However, in those areas where a Children's Trust Board prepared and published a CYPP before October 2010 then the Board is still required to monitor the plan until the end of the plan period. In this case the Children's Trust Board will still have to prepare an annual report about the extent to which persons and bodies have acted in accordance with the plan that year - but how they undertake this activity is up to them.*

*Boards have autonomy and flexibility in the way they work. For example:*

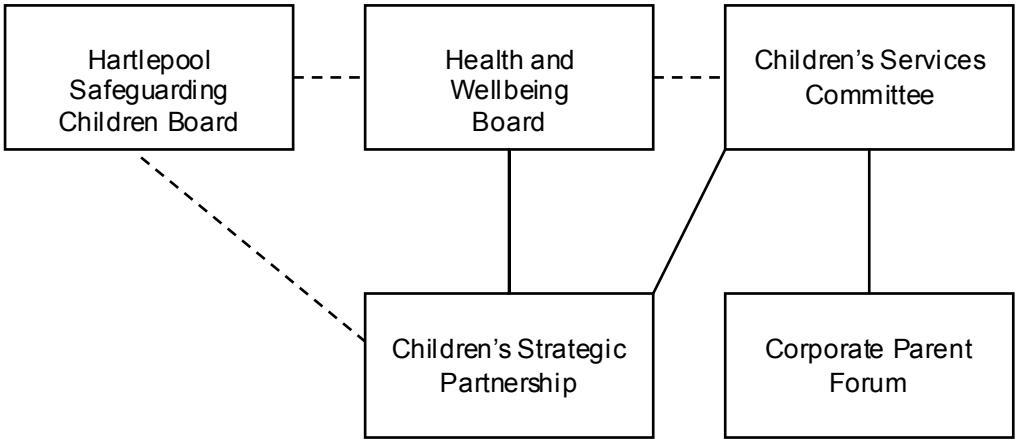
- *There are no guidelines setting out how often the Board should meet and operate;*
- *There is no prescription on the name of the Board or that it should have a clear and separate identity within the wider cooperation arrangements. For example, it would be possible for the Board to be a subset of another board in the local area.*
- *There is no need for a separate representative for each relevant partner. The local authority and the other relevant partners can agree that one person or body can represent others.*

2.2 Following a referendum on 15th November 2012, Hartlepool Borough Council has agreed a new constitution. Under the new arrangements there are 5 Policy Committees, which include a Children's Services Committee and the Chair is the Lead Member for Children's Services. The committee is responsible for all aspects of children's services, including children's social care, early intervention and prevention services, exercising the Council's functions as the Local Education Authority, commissioning and the oversight of the Children's Strategic Partnership for the purposes of the Children Act 2004.

2.3 Under the constitution the Children's Strategic Partnership's function is as follows:

*The Partnership Board brings together partners to inform the Health and Wellbeing Board on the making of arrangements to improve outcomes for local children, young people and their families. This includes supporting the development and refresh of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy. The Partnership is responsible for delivering the Children and Young People's Plan, leading on the Child Poverty Strategy, working in partnership with the Safeguarding Children Board to keep children safe from harm, acting to ensure that all services for children and young people comply with the values set out in the Commissioning Framework and direct joint commissioning arrangements within Hartlepool in line with statutory guidance, taking account of national and local priorities. The Children's Partnership Board is also a sub group of the Hartlepool Health and Wellbeing Board.*

2.4 The table below demonstrates the governance arrangements for the Children's Strategic Partnership.




## 3. PROPOSALS

### 3.1 Terms of Reference

Terms of Reference for the Partnership are attached as **Appendix 1** to this report; Board Members are requested to ratify the terms of reference for the Children's Strategic Partnership.

## 4. RECOMMENDATIONS

4.1 Board members are requested to agree the governance arrangements for the Children's Strategic Partnership.

## 5. CONTACT OFFICER

Ian Merritt
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# HARTLEPOOL CHILDREN'S STRATEGIC PARTNERSHIP

# TERMS OF REFERENCE

## Contents

# HARTLEPOOL CHILDREN'S STRATEGIC PARTNERSHIP

# TERMS OF REFERENCE

## 1.0 Purpose and functions of the Children's Strategic Partnership

The partnership brings together partners to inform the Health and Wellbeing Board on the making of arrangements to improve outcomes for local children, young people and their families. This includes supporting the development and refresh of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy.

The Partnership is responsible for delivering the Children and Young People's Plan, leading on the Child Poverty Strategy, working in partnership with the Safeguarding Children Board to keep children safe from harm, acting to ensure that all services for children and young people comply with the values set out in the Commissioning Framework and direct joint commissioning arrangements within Hartlepool in line with statutory guidance, taking account of national and local priorities

## 2.0 Roles and Responsibilities of Children's Strategic Partnership members

The main role of the Children's Partnership will be to take a Borough wide perspective and develop consensus in the best interests of children and young people of Hartlepool. Members will bring their own perspectives and also represent their organisation, interest group or area. They will be recognised for their valuable contribution bringing ideas, knowledge and expertise to the process.

Where practicable members should have the Authority to take decisions and make commitments. Individual partners will remain responsible and accountable for decisions on their services and use their resources. The Partnership recognises that each partner has different mechanisms for their own decision making. In some cases decisions may be endorsed by the bodies or organisations from which members are drawn.

The Children's Strategic Partnership will provide a forum where partners cooperate in informing the Health and Wellbeing Board on the making of arrangements to improve outcomes for local children, young people and their families.

To achieve this, the partnership will lead the development and implementation of the Child Poverty Strategy and focus on providing coordinated support around the policy objectives outlined in the Health and Wellbeing Strategy.

In particular the Partnership will work to:

**Give every child the best start in life by;**

- Reducing child poverty
- Delivering the early intervention strategy

**Enable all children and young people to maximise their capabilities and have control over their lives by;**

- Empowering children and young people to make positive choices about their lives
- Developing and delivering new approaches to children and young people with special educational needs and disabilities.

## 2.1 Standards of Behaviour

As a member of the Children's Partnership whether in Partnership meetings or working on behalf of the Children's Partnership, the following guidelines outline what the Partnership expects of its members:

**Accountability:** to work openly and honestly and to report back their work on the Board to their organisation or sector.

**Commitment:** to attend Partnership meetings, participate in occasional task group meetings and one-off events. To be properly prepared for meetings by reading the paperwork beforehand. To be prepared to learn from others and from good practice elsewhere and to further develop the breadth of their knowledge of their organisation or sector's role within the town.

**High Quality Debate:** to remain focussed and strategic. To contribute positively to discussions and work with other members to achieve consensus and take important decisions regarding children and young people in Hartlepool.

**Honesty and Integrity:** to act with honesty, objectivity and integrity in achieving consensus through debate. To respect the confidentiality of the information provided.

**Objectivity:** to consider what is in the best interests for the common good of children, young people and Hartlepool and to weigh this along with the interests of their organisation, their sector and themselves when making decisions.

**Representative:** to effectively reflect the interests of their organisation or sector, to raise areas of concern and contribute their experience and expertise to Partnership discussions and decisions to achieve good workable solutions.

**Respect for others:** to respect and to take into account the views of other members regardless of their gender, race, age, ethnicity, disability, religion, sexual orientation or any other status.

**Trust:** as 'trust' is at the heart of partnership relationships, it can be used as the overall barometer of partnership working.

## 3.0 Membership

Membership of the **Children's Strategic Partnership** will be drawn from Hartlepool Borough Council and key local partners. Membership will be as follows:

| **Members** |
| --- |
| • Chair of Children's Services Committee and Lead Member for Children's Services;<br>• Chair of North Neighbourhood Forum;<br>• Chair of South Neighbourhood Forum;<br>• Director of Child and Adult Services, Hartlepool Borough Council;<br>• Assistant Director, Children's Services Hartlepool Borough Council;<br>• Assistant Director, Education, Hartlepool Borough Council;<br>• Director of Public Health, Hartlepool Borough Council;<br>• Assistant Director, Regeneration, Hartlepool Borough Council;<br>• District Commander, Cleveland Police;<br>• Director of Offender Services, Durham Tees Valley Probation Trust;<br>• Chief Officer, ; NHS Hartlepool & Stockton-on-Tees Clinical Commissioning Group;<br>• Chair, NHS Hartlepool & Stockton-on-Tees Clinical Commissioning Group;<br>• Director of Clinical Community Services, Hartlepool & North Tees NHS Foundation Trust;<br>• Head of Service, CAMHS, Tees, Esk and Wear Valleys NHS Trust;<br>• Representative from Housing Hartlepool;<br>• Strategic Commissioner – Children's Services, Hartlepool Borough Council;<br>• Head of Access and Strategic Planning, Hartlepool Borough Council;<br>• Participation Manager, Hartlepool Borough Council;<br>• Representative, Voluntary and Community Sector;<br>• Representative, Cleveland Police Authority;<br>• Representative, Hartlepool Primary Schools;<br>• Representative, Hartlepool Secondary Schools;<br>• Representative, Hartlepool Special Schools;<br>• Representative, Hartlepool Post 16 Colleges;<br>• Partnership Manager, Job Centre Plus;<br>• Representative, HealthWatch;<br>• Representatives, Children and Young People<br>• Parent Representatives |

The Partnership can invite Co-opted Members to attend particular meetings where the agenda is relevant to their work.

## 3.1 Chairing the Children's Partnership

The Chair of the Partnership will be the Chair of the Children's Services Committee and Lead Member for Children's Services. The Vice Chair will be elected from the membership of the Children's Strategic Partnership on a biennial basis and should be from a partner organisation

The Chair will:

- Lead the work of the Partnership, ensuring that the views of the Partnership are communicated to a wide audience;
- Meet with the Chair of the Health and Wellbeing Board to review the performance framework as required and ensure the business of the Partnership is conducted in an efficient and effective manner;
- Promote effective partnership working between members of the Children's Partnership and if necessary resolve conflict and help foster an environment of mutual interest;
- Approve the formation of Task and Finish Groups to deliver specific items of work on behalf of the Children's Strategic Partnership
- Agree the agenda, associated papers and minutes of previous meetings.

The Vice Chair will:

- Deputise for the Chair as required;
- Support the Chair to ensure that the work of the Children's Strategic Partnership is undertaken effectively.

## 4.0 Principles

All members of the Children's Partnership will strive to apply the following nine principles as established in the Community Strategy:

- Effective decision making and communication;
- Effective partnership working;
- Efficient partnership working;
- Acting with integrity
- Ensure widest possible involvement and inclusion;
- Demonstrating leadership and influence;
- Effective performance management;
- Developing skills and knowledge.

## 5.0 Performance Management

The Partnership is responsible for the delivery of the Children and Young People's Plan and has the lead for the Child Poverty Strategy. Each year the Partnership will set out how each Strategy will be delivered. Respective Action Plans will include a number of performance indicators which will be used to asses the progress being made. The Partnership will monitor progress through quarterly performance reports.

The Children's Partnership is also responsible for delivering the Children's theme of the Health and Wellbeing Strategy of which the Board's Plan is the action plan. In particular the Partnership is responsible for:

- Giving every child the best start in life;
- Enable all children and young people to maximise their capabilities and have control over their lives

The Children's Strategic Partnership will establish a robust performance management system to support the planning and review process for the

Health and Wellbeing Strategy which includes children and young people. The Partnership will be sent regular updates on progress towards achieving targets. Where performance is not on track they will take action to address this.

Hartlepool Safeguarding Children Board will provide performance reports to the Partnership every 6 months.

## 5.1 Information, advice and support

All information, advice and support will be fit for purpose and tailored to the functions of the Board. The Board will ensure that all information is directly relevant to the decisions being taken and is:

- Relevant;
- Accurate;
- Timely;
- Objective;
- Clear and concise;
- Reliable.

The Partnership will call on professional advice and support when deemed necessary, particularly when the outcome of the item under discussion has a significant legal or financial implication.

# 6.0 Developing capacity and capability

The Partnership is aware of the importance of ensuring members have the right skills, knowledge and experience to play an effective part in delivering the strategic aims of the Partnership. It aims to involve individuals who reflect the community they represent. It will balance the need for stability which comes from continuity of knowledge and relationships with the need for new ideas and new thinking.

Through a Partnership development process, all members will be given the opportunity to further develop their skills and update their knowledge throughout their period of membership. This will aim to maximise the skills, capacity and resources of all members.

## 7.0 Engaging with Stakeholders

The Partnership, a sub-group of the Health and Wellbeing Board, will endeavor to represent a wide range of stakeholders and will ensure there is extensive consultation in the development of the Health and Wellbeing Strategy and Joint Strategic Needs Assessment and any other issues that the Children's Partnership considers appropriate.

The Partnership will ensure the involvement of children, young people and their families/carers in planning, policy development and service delivery.

The Partnership will strive to meet the codes of practice and terms of engagement as set out in the Hartlepool Voluntary and Community Sector Strategy.

# 8.0 Operation of the Children's Strategic Partnership

## 8.1 Attendance at meetings

Members will endeavour to attend all meetings however if they are unable to attend any meeting then they should submit their apologies in advance of the meeting.

As flexibility and continuity is essential to partnership working, each Member should identify a named substitute who may attend on their behalf when necessary. Substitutes should be suitable senior representatives who are able to speak on behalf of their organisation.

## 8.2 Declaration of Interests

Each member of the Partnership is required to declare any personal or pecuniary interest (direct or indirect) in any agenda items and shall take no part in the discussion or decision making about that item. All such declarations must be included in the minutes of the meeting.

## 8.3 Meeting Procedures

The Board will meet on a six weekly basis. There will be an annual review meeting to reflect on the performance of the Board and proactively plan for the forthcoming year.

## 8.4 Freedom of Information Act

The Freedom of Information Act gives everyone the right to access information that is held by public authorities. Hartlepool Borough Council has developed guidance to help staff comply with the Act. The Children's Strategic Partnership will work within this policy when giving out information to partners and the public.

## 8.5 Public access to the Children's Strategic Partnership

Meetings of the Children's Strategic Partnership will be open to the public and press however, on occasion closed sessions will be required in accordance with the Access to Information Rules in Part 4 of the Hartlepool Borough Council Constitution;

*The public must be excluded from meetings whenever it is likely in view of the nature of the business to be transacted or the nature of the proceedings that confidential information would be disclosed.*
Members of the Public may also be excluded in accordance with Rule 22 of the constitution (Disturbance by the Public)
*If a member of the public interrupts proceedings, the Chair will warn the person concerned. If that person continues to interrupt, the Chair will order his/her removal from the meeting room.*

## 8.6 Secretarial Support arrangements

The Partnership will receive secretarial support through Hartlepool Borough Council's Democratic Services Team.

## 8.7 Sub Groups

Occasionally a Sub Group of the Children's Strategic Partnership may need to be established to expedite a particular matter, which requires focussed activity or where a more specialist membership is required. The membership of these sub groups would be decided by the Partnership the group would normally have a specific remit and period of operation to oversee or undertake a specific task, reporting directly to the Children's Strategic Partnership

## 8.8 Working with other theme groups

The Children's Strategic Partnership will work alongside the other theme groups to improve outcomes for Hartlepool residents. Joint meetings may be arranged on matters of shared interest.

## 8.9 Updating the Terms of Reference

This Terms of Reference can be amended or updated by obtaining a two thirds majority agreement by the Partnership. The proposed change should be set out in a report as a published agenda item.

## 8.10 Making a Complaint

The Children's Strategic Partnership is keen to ensure that all children and young people, Members, partners and residents are satisfied with the procedures and arrangements in place. If an individual is dissatisfied with the work of the Partnership they should first raise their concern with the Chair of the Partnership who will endeavour to resolve the problem quickly and amicably.

# 9.0 Engaging with other Bodies

## 9.1 Clinical Commissioning Group

The Children's Strategic Partnership will work with the Clinical Commissioning Group for North of Tees and Hartlepool to inform the development and/or renewal of the Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy ensuring that the needs of children and young people are at the heart of developments.

The Partnership will also work with the Clinical Commissioning Group to identify, prioritise and commission appropriate services from a range of high quality providers in order to meet identified need, maintain high standards and ensure value for money.

## 9.2 Hartlepool Safeguarding Children Board

The Children's Strategic Partnership will work with Hartlepool Safeguarding Children Board to ensure that children and young people are kept safe from harm at all times.

## 9.3 Health and Wellbeing Board

The Children's Strategic Partnership will provide leadership in relation to the overall vision and strategic direction for children and young people in services within the Health and Wellbeing Board

# HEALTH AND WELLBEING BOARD

**5 August 2013**

HARTLEPOOL BOROUGH COUNCIL

**Report of:** Assistant Director, Adult Services

**Subject:** TEES AUTISM STRATEGY

## 1. PURPOSE OF REPORT

1.1 To approve the proposals outlined in the Tees Autism Strategy 2013-2018.

## 2. BACKGROUND

2.1 The Tees Valley Autism Strategy Delivery Group (ASDG) formed in 2005 following a Strategic Health Authority review of mental health and learning disability services that highlighted shortfalls in the provision of services for people with autism

2.2 In November 2009 The Autism Act was introduced and made two key provisions that: -

1. The Government produce an Adult Autism Strategy by 1 April 2010; and

2. The Secretary of State for Health issues statutory guidance for local authorities and local health bodies on supporting the needs of adults with autism by 31 December 2010.

2.3 On 17 December 2010, the Government published statutory guidance for local councils and local NHS bodies setting out what they have to do to ensure they meet the needs of adults with autism in England.

2.4 The guidance sends a clear message that local councils and local NHS bodies in England must:

- Provide autism awareness training for all staff;
- Provide specialist autism training for key staff, such as GPs and community care assessors;
- Not refuse a community care assessment for adults with autism based solely on IQ;
- Appoint an autism lead in their area;

- Develop a clear pathway to diagnosis and assessment for adults with autism; and
- Commission services based on adequate population data.

## 3. PROPOSALS

3.1 The Tees Autism Strategy was developed over a period of two years using detailed information from statutory agencies, providers, adults with autism and families / carers.

3.2 The strategy pulls together information gathered from three key sources, World Autism Day, a co-produced 'working together for change' report and feedback from key members of the Tees Valley ASDG.

3.3 The strategy outcomes and key target areas will be monitored through the existing Tees Valley ASDG and reported to the North East Autism Consortium (NEAC) through an action plan published on their website: http://www.northeastautismconsortium.co.uk/

3.4 NEAC provides a regional overview of progress on the Autism Act to the Department of Health and supports the completion of an Annual Autism Self Assessment.

3.5 The Tees Autism Strategy supports the Autism Act, the Department of Health's Guidance 'Rewarding and Fulfilling Lives' and provides the information required to support the development of Hartlepool's Joint Strategic Needs assessment.

## 4. RISK IMPLICATIONS

4.1 Local authorities and local health bodies have a legal obligation to follow statutory guidance

## 5. FINANCIAL CONSIDERATIONS

5.1 An ongoing commitment to train the existing workforce in Autism Awareness is required; not just within Child & Adult Services but all key contact points and public facing services. This work is underway but funding needs to be identified to ensure that the wider workforce are able to access appropriate training.

5.2 From April 2013 Tees Esk & Wear Valley NHS Foundation Trust's Adult Diagnostic and Assessment Service will be required to refer all newly diagnosed people to adult social care departments in order to meet their obligation under existing contractual arrangements. Additional resource implications are not known at this point.

## 6. EQUALITY AND DIVERSITY CONSIDERATIONS

6.1 The strategy supports the ethos of Equality Act, the positive attributes of effective compliance with the Equality Act and best practice in workplace diversity.

## 7. RECOMMENDATIONS

7.1 The Health & Wellbeing Board is asked to approve the Autism Strategy, attached as **Appendix 1** and the associated action plan (**Appendix 2**).

## 8. REASONS FOR RECOMMENDATIONS

8.1 The Autism Strategy demonstrates joint working between strategic partners across the Tees Valley and provides evidence of local involvement, engagement and consultation in developing and shaping future service provision. The delivery of the action plan depends on an ongoing commitment from partners across health and social care.

## 9. CONTACT OFFICER

Neil Harrison
Head of Service
Hartlepool Borough Council
Neil.harrison_1@hartlepool.gov.uk

# Tees Autism Strategy

Redcar & Cleveland Borough Council

Stockton-on-Tees Borough Council

Middlesbrough moving forward

Hartlepool Borough Council

Tees, Esk and Wear Valleys NHS Trust

NHS

MAIN

"Working Together for Change"

**Contents**



## Foreword

The Tees Valley Autism Strategy Delivery Group formed in September 2005 following the Strategic Health Authority Review of Mental Health & Learning Disability Services. The Review indicated serious shortfalls in provision of services for Adults with Autism.

A series of consultation (visioning) events have taken place to ensure people with Autism and their families were an integral part of developing service provision in the Tees area.

## Message from Joint Tees Commissioning Group

The Tees Autism Strategy Delivery Group is pleased to participate and present the very first Tees Strategy document. This document not only provides essential feedback and information from people with Autism and their families about the difficulties and barriers they have faced but also makes Commissioners aware of what people want to ensure they have a ***Rewarding and Fulfilled Life.***

This Strategy is an active document that presents an opportunity for local people and Commissioners to work together in meeting all of the challenges we face as well as ensuring people with Autism are seen, heard and valued.

We would like to extend our thanks to all the hard work and contributions made by Tees citizens. We recognise the importance of ensuring that through the continued involvement and participation of people who use services, their families and carers in developing strategies, we can deliver improvement to the care and support that people with Autism receive.

We are proud to be part of this work for people with Autism living in Teesside and are committed to working together to reduce health inequalities and improve well-being.

## Introduction

Autism is a lifelong development disability also referred to as Autism Spectrum Condition or Autism Spectrum Disorder.

There are over half a million people with Autism in the UK, which equates to one person in every 100.

A report from the NHS Information Centre 'Autism Spectrum Disorders in relation to Adults living in households throughout England' (2009) indicated that 1% of the adult population in England has Autism Spectrum Disorders, with the prevalence higher in men (1.8%) than women (0.2%).

Despite significant progress in Mental Health and Learning Disability Services over the last decade, adults with Autism remain socially and economically excluded. Many are dependent on Welfare Benefits for income as well as relying on care and support provided by their families. This care and support is not only for housing but to cope with everyday activities. For those without such support, the risk of severe physical and mental health problems, homelessness, addiction and descent into crime is greatly increased

The Government's vision is:
***"All adults with Autism are able to live fulfilling and rewarding lives within a society that accepts and understands them. They can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents".***

The Autism Act 2009 was the first piece of disability specific legislation and placed a duty on the Secretary of State for Health to introduce a Strategy and Statutory Guidance for improving outcomes for adults with Autism underlining the Government's commitment to achieving this vision.

The Act required the development of a "Strategy" that would meet the needs of Adults with Autism by improving the provision of relevant services. Areas covered by the guidance include:

- Providing services for diagnosing Autism in adults;
- Identifying adults with Autism;
- Carrying out needs assessment for people with Autism;
- Planning appropriate services for young people with Autism as they move from children's to adult services;
- Local planning to provide appropriate services to adults with Autism;
- Training of staff who provide services to adults with Autism;
- Local leadership with regard to providing services to adults with Autism.

The main 5 objectives in the Autism Strategy are:

1. **Increasing Awareness and understanding of Autism amongst front line professionals**
2. **Developing a clear consistent pathway for diagnosis and assessment**
3. **Improving access to services and support so that people with Autism Spectrum Conditions are able to live independently within local communities**
4. **Helping Adults with Autism Spectrum Conditions into employment**
5. **Enable local partners to plan and develop appropriate local services to meet identified needs and priorities.**

**1) Increase awareness and understanding of Autism among frontline professionals** – recommendations include:

- Improve Autism Awareness Training to frontline Public Sectors and Central Government Departments
- Statutory Guidance to provide examples of best practice
- Autism Awareness Training to be provided to all Disability Employment Advisers (DEAs)
- Training to be available to staff in the Criminal Justice System
- Develop Specialist Training for staff in Health and Social Care
- Department of Health (DH) to work with Partners to develop effective local training modules which can be used by Local Authorities (LA) and Primary Care Trust's (PCT) and identify priority groups for training
- Department of Health (DH) to commission the development of new online resources
- Autism Awareness to be part of core training for Doctors, Nurses and other Clinicians
- Autism Awareness training for staff carrying out Community Care Assessments
- Raise Autism Awareness among and through employers using existing campaigns

**2) Develop a clear, consistent pathway for diagnosis in every area -**

National Institute of Clinical Excellence (NICE) guidelines sets out a model care pathway(s), which will form the foundation for Local Commissioners to develop in their local areas:

- Local areas are recommended to appoint a Lead Professional to develop Diagnostic and Assessment services
- Diagnosis should lead to a community care person-centred assessment of need
- Diagnosis should be a catalyst for a Carer's assessment
- Relevant information should be provided to adults with Autism and their carers/families at the point of diagnosis

Diagnosis is not seen as an end in itself **but the beginning of improved support**.

**3) Improving access for adults with Autism to services and support**

There is a requirement for services to make reasonable adjustments for adults with Autism and to demonstrate how reasonable adjustments are made.

- Adults with Autism should have access to Personal Budgets and Direct Payments
- Local Authorities will explore how to support Voluntary and Third Sector groups in Planning and Commissioning services locally.
- Travel training should be made available for adults with Autism who would benefit from it (i.e. use of public transport)
- Improve Transition planning for young people with Autism

**4) Helping adults with Autism into work**

- Ensure adults with Autism benefit from wider employment initiatives
- Improve existing provision
- Developing new approaches to better support adults with Autism

A Review to identify how people with Mental Health problems could be helped back into employment (Work, Recovery and Inclusion) was published in December 2009. The recommendations made from this review should also be used to support Adults with Autism into employment.

**5) Enabling local partners to plan and develop appropriate services**

- Estimates of the number of adults with Autism will be included in the Joint Strategic Needs Assessment (JSNA) core data sets
- Each Local Authority area is expected to develop a Commissioning Plan in relation to services for Adults with Autism using existing resources and budgets
- Director of Adult Social Services should ensure there is a Joint Commissioner/Senior Manager who has in his/her portfolio clear Commissioning responsibility for adults with Autism
- A local Autism Board should be established.
- Department of Health will support the development of a Regional Delivery Plan in each Government region
- Views of adults with Autism and their Carers must be taken into account in the development and delivery of local services
- Department of Health will lead the development of an agreed protocol for recorded information and how this is shared
- Department of Health will continue to identify best practice and promote effective service models

In summary this Strategy is for Adults with Autism Spectrum Conditions to **live fulfilling and rewarding lives**.

The Tees Valley Autism Strategy Delivery Group agreed to develop an understanding of the key areas people with Autism and their families felt should be addressed as well as developing and implementing a local Strategy.

**The five strategic areas the Tees Valley Autism Strategy Delivery Group are focusing on are:**

1. Working with individual users of services and their carers to provide excellent services
2. To continuously improve the quality and value of our work
3. To recruit, develop and retain a skilled and motivated workforce
4. To have effective partnerships with local, national and international organisations for the benefit of our communities
5. To make the best use of resources for the benefit of our communities

The National Autistic Society report "I Exist" highlights the current situation for adults with Autism:

- Only 15% of people with Autism in England are in full time employment.
- 63% of adults with Autism say that they do not have enough support.
- 33% of adults with Autism say that they have experienced severe Mental Health difficulties because of a lack of support.
- Over 60% of adults with Asperger Syndrome or high-functioning Autism have struggled to receive support from Local Authorities and/or Health Services.
- Of the 60% over half were told they do not fit easily into Mental Health or Learning Disability Services.

**National Institute for Clinical Excellence**

In 2012 NICE developed a Clinical Guideline to help improve the care of adults with Autism. The Guideline supports the development of a clear, consistent pathway, which forms the foundation for local Commissioners to develop referral and care pathways in their areas.

The Department of Health is committed to improving access to diagnosis and developing a consistent care pathway for adults with Autism making diagnosis more accessible and consistent.
There should be a clear pathway to diagnosis in every area by 2013.

## The National Picture

The first ever Autism Strategy for improving the lives of adults with Autism in England was published on 3rd March 2010.

The Act required the development of a "Strategy" that would meet the needs of Adults with Autism by improving the provision of relevant local services.

The strategy sets out a number of key actions and recommendations for central Government, Local Authorities, the NHS and Jobcentre Plus as well as focusing on five key areas.

The key areas are:

1. Increasing Awareness and understanding of Autism amongst front line professionals
2. Developing a clear consistent pathway for diagnosis and assessment
3. Improving access to services and support so that people with Autism are able to live independently within local communities
4. Helping Adults with Autism into employment
5. Enable local partners to plan and develop appropriate local services to meet identified needs and priorities.

On 2nd April 2010 the Government produced the First Year Delivery Plan, entitled ***Towards 'Fulfilling and Rewarding Lives': The first year delivery plan for adults with autism in England***.

The Delivery Plan sets out the governance structure along with actions, timescales and responsibilities, for supporting the implementation of ***'Fulfilling and Rewarding Lives': The Strategy for Adults with Autism in England*** **(2010).**
Under the Autism Act 2009, the Secretary of State is required to review the Autism Strategy.
The Strategy sets a framework for 3 years, which is due for review in 2013.


**Albert is 53 years of age and lives on the 14th floor of a high-rise building with his elderly mother. His only support comes from a nephew. He attended a "special needs" school in the 70's and on leaving school was employed by a local removal firm. After a year in employment he was made redundant and has never worked since. He is unable to handle any sort of change. In order to deal with his anxieties he drinks heavily and self harms. His GP diagnosed him with mental health and learning difficulties but doesn't think a diagnosis of Autism would be beneficial especially at the age of 53.**

## The Picture on Tees

Our understanding of Autism has increased since initial diagnosis in the 1940's.
The symptoms and characteristics of Autism present in a wide variety of combinations and affects different people in different ways.
It is estimated there are over 415,000 people in England who have Autism. Together with their families they make up over a million people whose lives are touched by Autism.

The Joint Strategic Needs Analysis (2012) provided Tees Commissioners with the following information:

- There is a need to stimulate local markets to ensure the availability of choice and cost effective provision, which is able to meet local need
- There is a requirement for a specific or tailored representational Advocacy Service, which can meet the needs of people with Autism
- There are a number of people with Autism currently living in care placements outside of their local area. Work should be undertaken to bring people back home and prevent others from being placed out of area through remodelling local services
- There is a requirement to promote personalised systems, which place the person at the heart of any process
- There is a requirement to promote health and well-being including early intervention to prevent/reduce reliance on service provision
- Ensure that the principles of quality, equality and value for money are embedded within processes and service provision

**http://www.teesjsna.org.uk/**

There has been a significant reliance on "Out of Area" Educational and Residenital placements for people with Autism living in the Tees area. Tees Commissioners continue to explore and develop access to local services, which will enable people with Autism to remain in their local area.
Engagement has taken place with Providers to ensure new models of support are developed to meet the diverse needs of people with Autism.

Autism Awareness Training is bringing a greater understanding to universal services and will ensure reasonable adjustments are made, which in turn will support people with Autism in achieving maximum independence.

The development of Personal Health Budgets will enable more person centred accommodation and support for people with more profound Autism Spectrum Conditions.

In 2007 over 60% of people with Aspergers Syndrome or higher functioning Autism who took part in a NAS survey said that they had experienced difficulties in accessing services.

The number of people with a diagnosis of Autism in England is predicted to rise over the next 20 years.

The Tees Autism Strategy Delivery Group meets bi-monthly and its membership includes representation form Health, Education and Social Care but more importantly Carer / family representatives. Information from the group is distributed to a wider group of 55+ people from a variety of Organisations and Carers Groups.
Its aim is to ensure the main priorities for young people and adults with Autism are captured and the information supports improvement in the way services are designed and provided against the Department of Health's National Strategy - ***Rewarding and Fulfilling Lives.***


The North East Autism Consortium (NEAC) was established to support the function of the Local Autism Strategy Delivery Groups (ASDG) in the North East area.

http://www.northeastautismconsortium.co.uk/tasdg.html

Groundswell Partnership was commissioned to facilitate the Working Together for Change process, which provided information for the first Tees sub-regional Autism Strategy.

A number of sessions were held which provided Commissioners with valuable analysis from people with Autism and their families about:

- What's working well
- What's not working
- What's important for the future

Information from sessions was grouped and put together in cluster "themes" using "I Statements".
The themes from this work were:
**I want to be understood**
**I want a job**
**I want to choose where I live**
**I need more local support and provision**

**I don't know how to react or what to say in social situations. I often say the wrong thing, which gets me in to trouble**

It was recognised that meaningful consultation and engagement is key to ensuring services are fit for purpose. Consultation and engagements events have been taking

place across Tees for a number of years to establish need and more importantly gaps in provision for people with Autism.

MAIN agreed to continue to undertake the consultation and engagement process along with providing research from people with Autism and their families so that Commissioners truly understand the barriers people with Autistic face.

Approximately 450+ people are known to Adult Social Care services across the Tees area. It is estimated there will be a projected 63% increase of people diagnosed with Autism by 2030.

All 4 Local Authorities within the Tees area produced information to support a Tees Strategy in 2012 (Local Self Assessment for Adults with Autism). The key themes, which required improvement included:

- **Diagnostic Pathway**
- **Advocacy Provision**
- **Training for staff who provide services to Adults with Autism**
- **Better links to the Criminal Justice System**
- **Improved employment options for people with Autism**


Tees Esk & Wear Valley NHS Foundation Trust developed a pilot Adult Autism Assessment Service in 2008.
In 2012 the Adult Autism Service was commissioned within the Teesside area for Assessment, Diagnosis and Intervention as a specialist tertiary service.

Work is currently taking place across Tees to develop Specialist Advocacy Provision. This gap was highlighted both in the Local Self Assessment for Adults with Autism Framework documents and Working Together for Change consultation process. The development of a Tees Specialist Advocacy Framework will also support the recommendations with the Department of Health Report "Transforming Care: A National response to Winterbourne View Hospital"

**I could clearly see the filing system, which was being used in the office, was not effective so I changed it. Because my Supervisor hadn't asked me to make the changes I was disciplined and eventually lost my job. The Organisation is still using the improved filing system I implemented as it has made the Team more efficient in their daily working.**

The National Autistic Society (NAS) Autism Alert card was launched in 2009 and a re-launch of the card is expected to take place in 2013 funded by non-reoccurring monies from the Teeswide Safeguarding Board.

The card will only be available to people with Autism who have a diagnosis.

An Autism Framework Contract was produced in 2011 and has 8 Independent Providers on the Preferred Provider list. The Framework Contract is due to be reviewed in 2013.

A Residential Care Home for people with Autism, providing support towards future tenancy has recently been developed with 2 people having successfully moved in. Day provision is available for Adults with Autism at a specific Resource in Middlesbrough and Short Breaks (Respite Services) are available at a new purpose built development (Levick Court).

An Animation Group has been formed for young people aged 17 years to 25 years with Autism. Group meetings take place on Friday evenings at a local resource centre supported by staff from Adult Social Care.

A vibrant and active Aspergers Family / Carer Group meets monthly in Middlesbrough supported by Redcar based Carers for Change.

Two parent “self help” groups have been established that enable parents and Carers to be informed of and influence commissioning priorities. Parents have found this to be a valuable forum in the past as they are able to meet other parents on a regular basis, sharing experiences and information.

The Hartlepool Employment Link Team and the Sunflower Suite (Day opportunities resource centre) received National Autism Society (NAS) accreditation for its delivery of services. This involves an annual appraisal and peer review process by an external body to ensure compliance is set and monitored by the NAS.

Redcar & Cleveland have developed Outreach Advisory Teams who have the necessary expertise to support school staff working with pupils with Autism.

Roseberry Park opened in 2010 and at that time was the creation of a Low Secure Autism Specific Service within the Forensic Directorate of the Trust. Further development in 2012 resulted in the opening of a Medium Secure Autism Specific Service.
The state of the art facility provides a highly specific structured environment managed by staff with Autism expertise, where Autism Awareness underpins their treatment and care pathway. The development of this service means people with Autism can be discharged back into their local community and local services.

Tees Esk & Wear Valley NHS Foundation Trust developed and delivered a rolling programme of Clinical Autism Awareness Training. Strategic Health Authority funding allowed further development of this package. This funding has since ceased but the training continues to take place.

Training currently available includes:

- NVQ Basic Autism Awareness
- 1 day introduction to Autism
- Training in Autism Assessment Tools
- Level 7 Masters Course at Teesside University

Training has been adapted and provided to Criminal Justice System Organisations such as the Police and Probation Service.

## Developments on Tees

A number of developments are currently taking place on Tees including:

- The redevelopment of a 5-bed property is taking place, which will provide 3-bed specific accommodation for 3 people with Autism. There is ½ acre of land with the property, which is to be developed by Home Group (previously Stonham) to provide a combination of 2 & 3 bed bungalows and apartments. It is envisaged the development should be complete January 2014.

- A Residential Care Home and Supported Living Scheme for young people aged 16-25. This will enable young people to remain supported in their local area as well as having access to local education, health and leisure facilities. The scheme will also have self-contained accommodation so that young people are able to develop skills to live a more independent life.

- Work is ongoing to develop an Advocacy Framework, a key element will be access to Specialist Advocacy Provision.

- 2013/14 Re-renewal of Framework Contract for Specialist Enablement and Support/

Middlesbrough is currently looking at improving and providing information with the use of the newly developed Middlesbrough Council web site. In the very near future there will be the facility to undertake “Self Referrals” making it a much more accessible process. A “Market Place” of services will be accessible to all citizens of Middlesbrough allowing people to access community services without having to go through Social Workers or other Professionals.

Work has begun to develop relationships with a number of agencies within the Criminal Justice Service including:

- Probation
- Crown Prosecution Service
- Local Triage Team (Police & TEWV)

The Triage Team has been created as part of the “Big Diversion Project” following the Bradley Report.

The Big Diversion Project has received funding to help prevent vulnerable people including people with Autism wrongfully coming in to contact with the Criminal Justice System. The roll of the new Triage Team is to assist with keeping people who fit into the “vulnerable” category and who may be repeat offenders out of the criminal justice system. The Triage Teams new way of working began in August 2012 with a 2 year funding grant.

In Hartlepool, the Parent led Autism Rights Group Hartlepool (ARGH) has received funding supported by HVDA to enable parent Carers and their children to attend regular pamper and networking session at Springs Leisure Centre.

Catcote School retained their NAS accreditation and is looking to extend their provision linked to their 'Catcote Futures' vision.

A new Centre for Independent Living and accommodation strategy is being proposed for the Headland and Harbour area of Hartlepool.

Over 600 people have attended Autism Awareness Training across Tees through the new Autism Workforce Program.

## Diagnosis

### Autism and Autism Spectrum Disorder/ Conditions

Currently the agreed internationally diagnostic criteria (the International Classification of Diseases – version 10 1992) defines Autism as a developmental disorder with difficulties in 3 key developmental domains:

1) Qualitative difficulties in communication;
2) Qualitative impairments in reciprocal social interactions
3) A range of restricted, repetitive and stereotyped behaviours and interests

Classification is developing into two major groups of difficulties:

**Qualitative difficulties in communication and qualitative impairments in reciprocal social interactions**

and;

**A range of restricted, repetitive and stereotyped behaviours and interests with associated sensory difficulties**

Autism is the prototypical disorder within a broader group of disorders known as the Pervasive Developmental Disorders (PDDs). However there is an increased awareness amongst Professionals and affected families of a broader spectrum of Autism disorders that includes the categories within the classification of diseases (ICD-10)-Childhood Autism, Atypical Autism, Asperger Syndrome, and the broader grouping Pervasive Developmental Disorder Unspecified.

Many Clinicians and Authors use the broader term Autism Spectrum Disorders (ASD) when referring to developmental disorders.

The National Autism Plan for Children (NAP-C) produced by NIASA (National Initiative: Autism Screening and Assessment) was published in March 2003. Although this report was developed to examine services and assessments of children, it remains relevant in considering any person with an Autism Spectrum Disorder.

The report stated '***It is now generally recognised that there is a Spectrum of Autism Disorders that includes individuals across the range of severity and intellectual ability – from severely impaired to 'high functioning'***.
Autism Spectrum Disorders are unique in their pattern of deficits and areas of relative strengths.' It is further stated that ASD ***'is not a category within the ICD-10 or DSM-IV classification systems but will be used as a pragmatic 'umbrella term' to reflect the current level of knowledge and degree of certainty of the different syndromes.'***

The concept of a spectrum of Autistic Disorders highlights the range in terms of number or severity of symptoms that people may experience. There must be individual assessment and intervention planning to avoid making assumptions or generalisations about the behaviours, skills, and prognoses of people with Autism. People with Autism and Autism Spectrum Disorders are unique in their pattern of deficits and areas of relative strengths.

The symptomatology in a person with Autism Spectrum Disorders changes over time varying from day to day as well as altering with age. Changes occur unevenly and are particularly prominent in early childhood, adolescence and as the person moves into adulthood.

Social understanding can be limited resulting in poor social judgement and social difficulties. There are usually difficulties in developing relationships with peers. Many behaviour patterns that are characteristic of Autism may reflect a problem with 'theory of mind'. The concept of 'theory of mind' describes the way a person with Autism struggles to understand feelings or beliefs of other people. This contributes to the difficulty people with Autism experience with social relationships.

Problems with 'central coherence' mean that a person with autism or Autism Spectrum Disorders has difficulties using 'context' to understand a situation or to 'generalise' from one task or setting to another. This means for some people with Autism a skill can be learnt in one specific situation, but cannot be transferred easily to another situation, even if it is very similar.

There is no 'cure' for Autism. Understanding the behaviour of a person with Autism Spectrum Disorders can help in managing behaviour. Structured, predictable environments and support can help a person by reducing anxiety, stress, and promote learning.

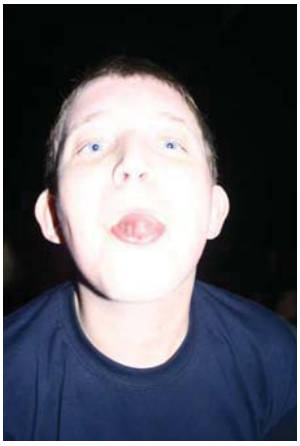
Some important features to manage problems Autism Spectrum Disorders include:

- Lack of incidental learning (everything needs to be directly taught)
- Lack of generalisation of learning so that skills must be taught for each situation
- Literalness of understanding
- Possible reactions to over-stimulation and the fact that this can easily occur in situations that other people cope well with
- Understanding the impact of sensory seeking behaviour or sensory sensitivities
- Predictability and routine have been effective in promoting learning and managing behaviour problems.

The National Centre for Research (2012) estimated there are 1,210 people in the area with a Spectrum Condition.

The number of people known to services with a Spectrum Condition has recently increased possibly due to wider awareness amongst health professionals as well as improved diagnostic techniques.

Best practice states diagnosis of Autism, Asperger Syndrome and Autism Spectrum Disorders (ASDs) should be made by Teams comprised of a group of Professionals from a mixture of disciplines who have training and expertise in Autism Spectrum Disorders.



Tees Esk & Wear Valley NHS Foundation Trust Specialist Tertiary Adult Autism Service was commissioned in Teesside in 2012.

There is some recognition that Nationally a large number of Teams within Mental Health Services, and also some within Learning Disability Services, did not have access to a range of Clinicians with training and expertise in the Diagnosis and Assessment of Autism. Whilst some Community Teams were able to complete assessments and then make a diagnosis where appropriate, there were many who were not able to do this.

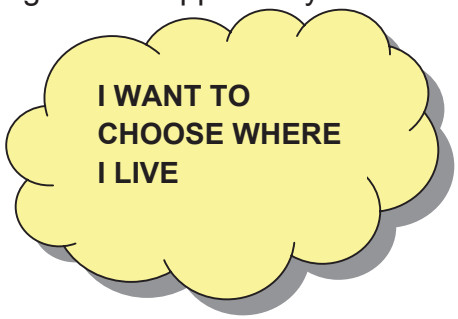
In the Teesside area Mental Health and Learning Disability Teams have access to the Adult Autism Service to make referrals for assessment. Assessments are carried out following National Guidelines.
The skill of Clinicians is developing supported by the Trust Training Programme.


## Every Voice Matters –

## Consultation and Engagement

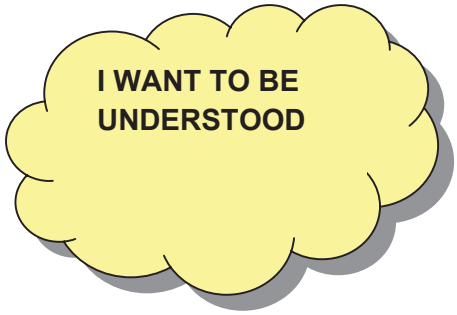
MAIN are the engagement link between the Tees Autism Strategy Development Group and people with Autism and their families, facilitating events as well as ensuring information is fed in and out of the Tees Autism Strategy Development Group.

Prior to World Autism Day in March 2013, events were held in all 4 Local Authorities to ensure people living in each of the areas across Tees were given the opportunity to attend and provide their views. Other methods of engagement used to capture information from the wider Autism community included the use of Social Networking Online Forums and 1 to 1 consultation with people with Autism Spectrum Conditions and their families within their own homes. People's Real Life experiences and stories were gathered, some of which are included in this report.




The most recent World Autism Day event (March 2013) identified 3 reoccurring themes:

- ⇒ **Specific Advocacy Service (I want to be understood)**
- ⇒ **Better Employment Opportunities (I want a job)**
- ⇒ **Access to Independent Living (I want to choose where I live)**



Below is an overview of people's experiences clustered into themes:

## "I want to choose where I live"

**I wanted to live independently but was unable to cope with finances and managing money**

**Accommodation**

Information gathered from an accommodation survey in 2012 did not provided a difference in the settings people said they would choose to live in the future. This may be due to people with Autism being unable to envisage what living outside their current normal setting would be like. A number of Supported Living Schemes have been set up in local areas for people with Autism. Some people classed as living independently still relied on family members help and support, especially with finances.

***Recommendation:***

**Try before you buy trial scheme in various living options for people with Autism**

**A choice of where to live with good quality support**

## "I want a job"

**Employment**

**"I have had work placements which I enjoyed but there is never a job at the end of them."**

The majority of comments made in relation to employment said placements were or are temporary and many are unpaid. Lots of people with Autism that were employed or had a placement told us support with employment could have been improved.

Lots of people with Autism who had been or were in employment said they had chose not to inform their employer about their condition. There had been some incidents of bullying, which had taken place and in 1 case an employee had been disciplined for altering a filing system.

Suggestions made included:

- Greater awareness of Autism for employers
- More support for people with Autism Spectrum Conditions in the workplace
- Autism Breaks – time to deal with anxieties, etc
- Support materials such as "communication passports"
- Buddy system – personal link with someone in the workplace
- Regular reviews and supervision

***Recommendation*:**

**Longer-term placements are needed, along with ongoing support for employers.**

**Autism Awareness Training for employers designed to demonstrate the benefits of employing a person with Autism**

## " I want to be understood"

**Education**

**"Teachers think they can treat everyone with an Autism the same, but we are individuals."**

A suggestion was made for education in secondary and college placements to mirror what happens in children's education services. Most Carers felt Autism training in schools should be mandatory.
Transition support should be given from primary to secondary, from secondary to college, from college to University.
Some people with Autism who had attended university told us they struggled with the lack of structure, socialising and adjusting to new surroundings. It was felt a "buddying" system would have greatly assisted.
Experiences about education support differed greatly with people stating they had received good support and assistance via agencies like Connexions or from Social Workers. A lack of Autism awareness from education professionals was described as being the main problem.
Carers and families felt there should be more local specialist Autism Education services, as this would reduce the need for out of area provision.

Suggestions for improved education services included:
Social skills and practical life skills should feature more in education
Staff should be trained more efficiently to work with people who have autism

***Recommendation:***

**Suitable training on Autism should be available for all staff within Education Services.**

## " I want to be understood"

**Relationships**

**"I get anxious meeting new people, I don't think I will ever be in a proper relationship"**

People with Autism not in a relationship have said they feel "left behind". Due to their age they felt they should be in a relationship and peer pressure causes more anxieties. Lots of young people with Autism said they wanted to try "on line dating sites".
Some Adults have said they are looking for a partner "to take care of them".

***Recommendation:***

**Relationships Training for people with Autism that can help them keep safe**

## " I want to be understood"

### Support Services

It is clear people with Autism are not getting the help or advice they really needed or are being signposted to appropriate services who could help. Carers told us people with a secondary disability (mental health, learning disability) often have this disability looked at first with Autism being classed as the secondary condition.

**"We don't get asked what services we want and what would make our lives better."**

Parents and Carers of people with Autism and a Learning Disability felt their relative's needs were better met than those with a single diagnosis or those with a diagnosis of Autism and Mental Health.

Some people with a single diagnosis of Autism had been told they were "too able to receive support".

***Recommendation*:**

**People with Autism need to be included when support planning takes place.**
**Better signposting to appropriate services for people with Autism**

## " I want to be understood"

### Health

Information gathered in relation to when people received diagnosis of their condition varied and took place at different stages of their life.

**"None of the doctors at my surgery know anything about Autism."**

The majority of people with Autism said they needed support when attending Health appointments as they found this experience to be extremely stressful. Support was often provided by members of the person's family at Health appointments.

There is a great deal of information about people's GP's or Practice Nurses not having any understanding about Autism or Autism Spectrum Conditions. People with Autism and their Carers had not heard of or had access to Health Action Plans or Hospital Passports.

Changes in the Diagnostic & Statistical Manual (DSM) has created anxiety for some parents as they have been told their child is unlikely to meet the criteria so there is little point to the diagnosis.
Most who are referred into the Diagnostic system are often in "crisis". Families see this as reactive rather than proactive and feel GP's should have a greater understanding.

**If you give me an appointment for 9:00am why do I have to wait until 9:10am before I can see the GP -Give me a 9:10am appointment!!!**

***Recommendation:***

**Training and support should be available for GP practices around Autism.**

## "I need more local support and provision"

### Travel

Most people with Autism are able to travel independently, but many felt uncomfortable to do this. Most people with Autism preferred to travel with a companion.

**"I hate getting the bus alone, the drivers look at me like I am weird."**

Support or travel training for young people travelling to new school/ college placements had not been thought of or implemented. It was felt travel training could also help young people and Adults with Autism access local community facilities, which could prevent them from feeling isolated.

Suggestions to help with travelling on local transport included:

- Autism Awareness training for bus drivers
- Free concessionary bus passes
- Electric signs at all bus stops

***Recommendation*:**

**Better training for bus drivers**

**Travel training for people with an Autism**

### Leisure

There are a lot of people with Autism that go out independently and spend time with friends. Some people with Autism require support so they can have a social life.

**"I like going out but want to be able to choose what I do, when I want to."**

However there is evidence to suggest a great deal of people with Autism do not go out and prefer to use Social Media sites to socialise. This leaves them isolated and potentially vulnerable to abuse.

***Recommendation:***

**Services need to be more flexible for people with Autism.**

### Personalisation

Personal Budgets allow people to take control and get the support the way they want it. Direct Payments and Personal Budgets have helped to change some people's lives allowing them to be in control of the services they want and employ staff that provides support to them.

**It seems to have taken forever to get a Personal Budget. My Social Worker wasn't really sure what services are out there for me to buy**

However there were people with Autism and Carers who say there is still not enough Autism Specific Services and the more rural the area you lived in the more excluded people feel.

A number of people with Autism stated there was a lack of knowledge and support from their Social Worker when they asked about Personal Budgets. Carers and families have said Personal Budgets was "hit and miss" and really depended upon the Social Worker.

Lots of people with Autism still received a lot of support from their parents or other family members.

***Recommendation:***

**Give people information about where they can get good quality services to support them and let them be part of their local community**

**Carers**

Carers also need support and most do not recognise themselves as a Carer.

Some Carers and families have been under a great amount of pressure, as they have not recognised their relative has Autism or have had very little any understanding about the condition. Carers often reach crisis point before making a referral or asking for help. Some Carers feel they are an unrecognised workforce and are not properly represented. Some Carers feel there should be more Autism Specific Support groups for Carers.

**I struggle to help and support my Uncle. He relies on me for most things.**

Carers and families have stated there was no real consideration given to them and the affect having someone in the family with Autism has on family life.

***Recommendation:***

**Autism Awareness and additional training (managing behaviours etc) for all family members**

## Things that aren't working

## Things that aren't working

People don't appreciate the value and diversity I can bring

Not enough information on job sites for people with ASC

A life long approach is needed especially for very complex people

Individual Service Design for people with ASC

I am misunderstood

Predatory People – I am at risk because I can't recognise when people are taking advantage

Professionals who think they know about Aspergers but make basic mistakes

I want friends but don't know how to find or make friends

I have difficulty Interacting Socially

I can't adapt to rapid change – I need to be able to adjust to change at my own pace

Not enough Teachers know about Autism Spectrum Condition in mainstream schools

Need to know more about how to keep safe – in public, on the internet

Unable to recognise anxieties and what makes people with ASC anxious

Autism doesn't mean you can't do things!

Bullying still happens to adults – work place / places of worship / in the street

It takes too long to get funding from Local Authorities

I want to live independently but can't afford it

It is very difficult for me to understand myself – I think about harming myself all the time

I don't get supported to do things that are considered to be "out of the normal"

Professionals don't make reasonable adjustments – like keeping to my appointment time

## Things that are working well

I have a range of services and support that is right for me

I have control over my money and how to use it

I get the information I need

I am able to be part of my community

I am getting my life back and am growing in confidence

I have a job

I am able to be independent

My son's smile

Aspergers is CLASS!

Being employed

Accredited Day Centre

Some staff have had Autism Training

Having accommodation for people with ASC

Unique people with personal goals

Good ways of sharing information – like World Autism Day

Micro Enterprises and Self Employment

Good eye for detail – Good memory

More empathy for people who are disabled

The BIG HUGS I get from my son

Purpose built buildings for people with ASC

## What is still needed?

**My Consultant has told me children with Autism don't have emotions**

Concern continues to be raised by Parents, families and Carers in relation to local opportunities for school leavers with Autism along with Further Education and employment options.
There is a need to develop the range of local Further Education provision for young people with Autism, which will also take into account students levels of intellectual ability, support needs and individual interests.

The availability of Speech and Language Therapy is recognised as a key factor as to why young people with disabilities attending out of area education placements are able to achieve much more.

Training remains a priority for all 4 Local Authorities, especially during this time of austerity, as no additional resources have been provided by Central Government to assist with this huge task. Each of the Tees Local Authorities and Health Services continue to explore various options for rolling out training ensuring that those members of the workforce who are working with people with Autism on a daily basis receive the correct level of training.
Training for GP's is seen as essential so as to increase awareness and understanding of Autism in GP Practices / Surgeries.

Additional funding in relation to training is needed for:

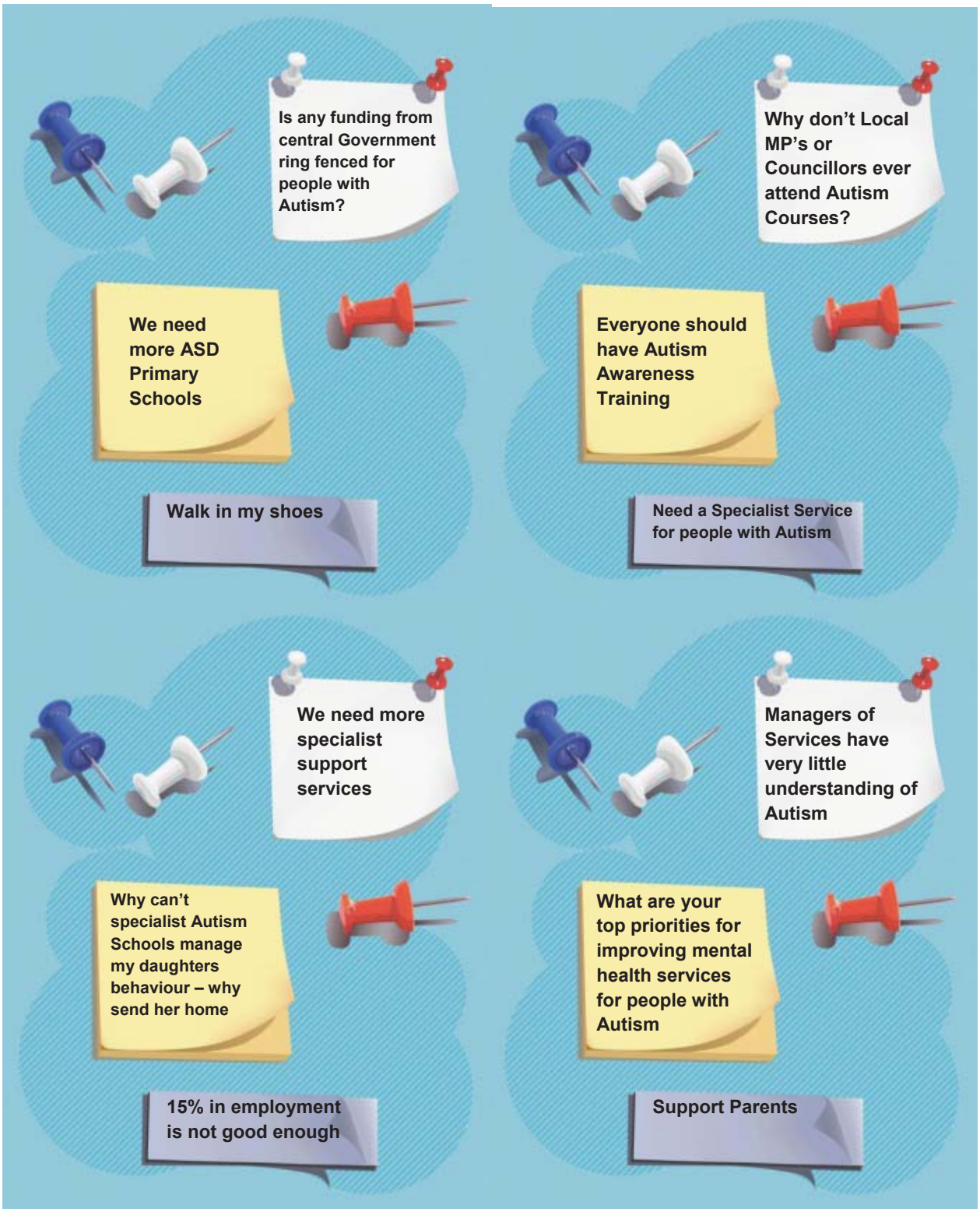
- Clinical and Specialist Training - numbers confirm referrals for Assessment and Diagnosis continue to grow rapidly
- Advocates
- Criminal Justice System Professionals

"Reasonable Adjustments" should be implemented within all service settings for people with Autism as well as ensuring appropriate information and signposting to relevant services.

Awareness of universal services and in particular communication support for deaf people with Autism is problematic especially being able to access appropriately trained interpreters.

Engagement with people with Autism and Carers and families needs to improve. Hidden Carers only become known to services in times of crisis. Improved methods of communication including Social Media and "Apps" must be explored.

## People's Questions About the Future



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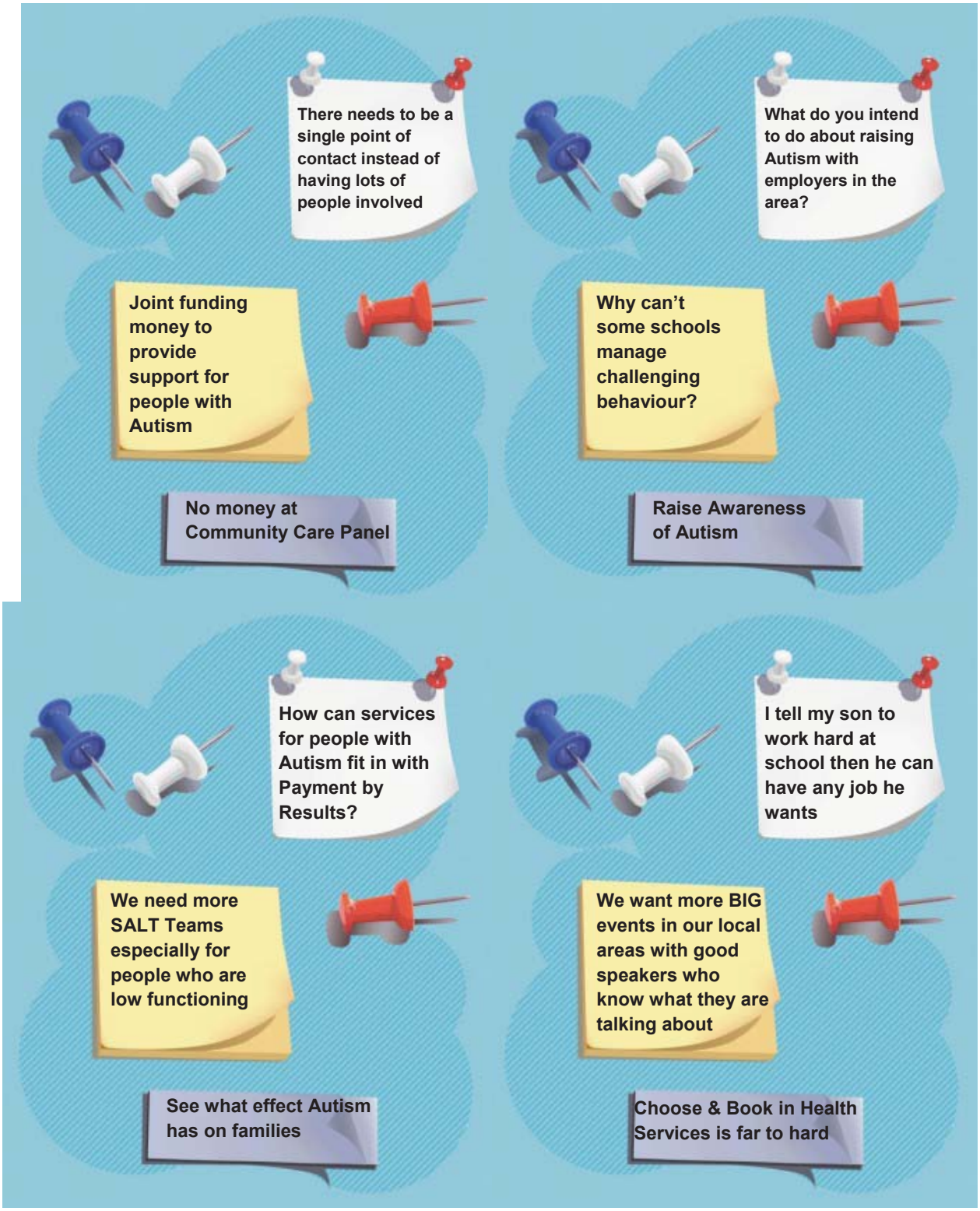

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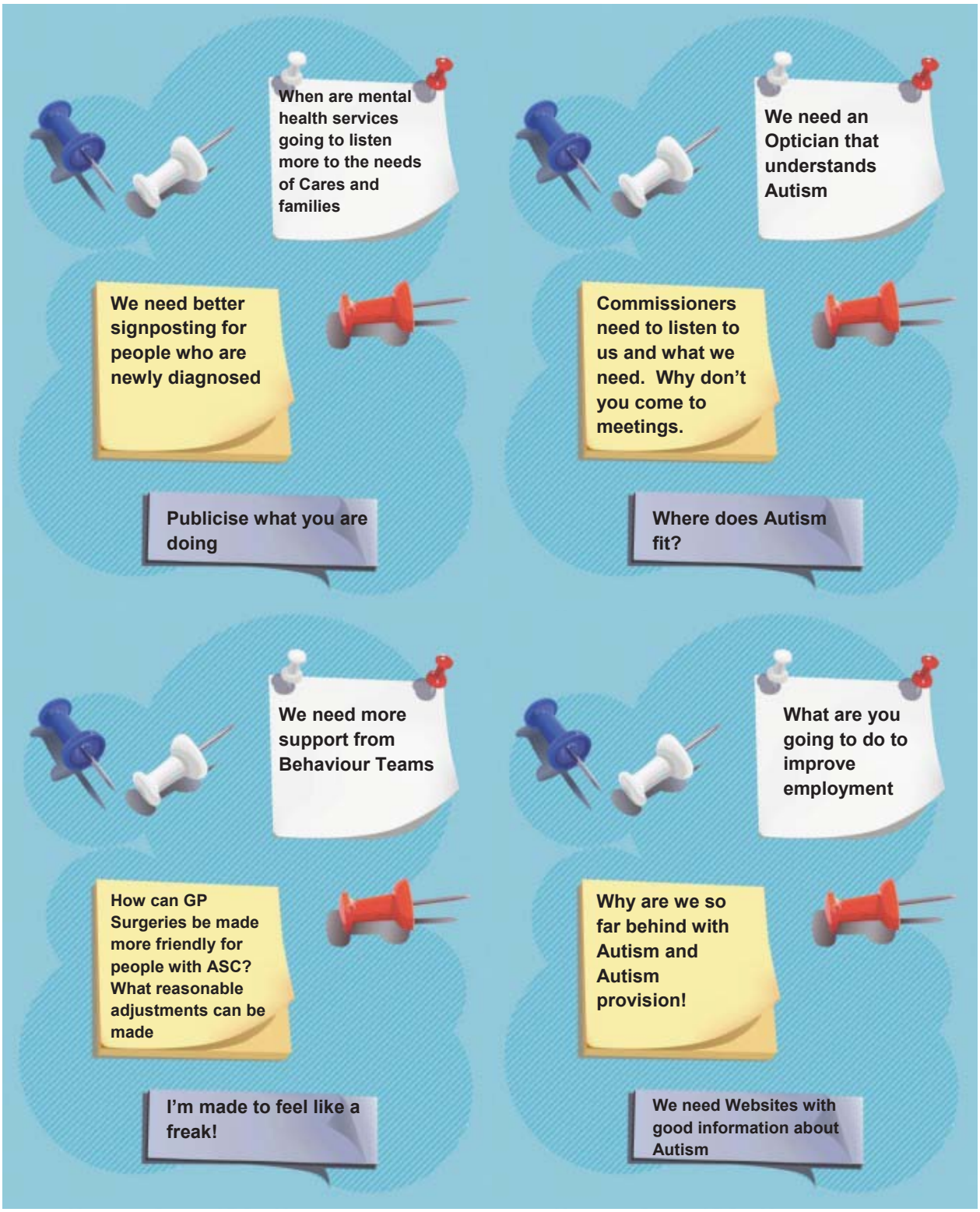

## Themes for the Future

| Theme – I Want To Be Understood |
|---|
| Commission modern learning environments for children and young people with Autism in order to improve learning opportunities. |
| Establish outreach teams to support and provide advice to parents, staff of educational, care and other agencies about managing the needs of children, young people and Adults with Autism. |
| Promote Autism Awareness by improving knowledge and understanding through training and easy to understand information across all areas in Tees. |
| Recruit “specialist Teachers” and specialist Social Workers that are suitably qualified and experienced in Autism. |
| Develop a greater understanding of Autism in Mental Health services to ensure services are in place to meet the Mental Health needs of children, young people and Adults with Autism. |
| Provide the mechanism to enable active support groups (parents and Carers) to be formed where information and advice is shared as well as groups actively promoting changes in policy and practice. |
| Ensure the views of children, young people and Adults with Autism along with Parents, families and Carers are listened to and acted upon by embedding the Engagement Strategy across all organisations. |
| Proactively engage with people with Autism to look at addressing Health inequalities along with promoting reasonable adjustments in Health settings across the Tees area. |
| **Theme – I Want A Job** |
| Local Authority and Health Trust Professionals to liase with post 16 Provider’s and identify ways in which more ‘Autism friendly’ environments can be created in local Colleges. |
| Provide mechanisms for people with Autism to engage with local employers. |
| **Theme – I Need More Local Support and Provision** |
| Develop an “Online Market Place” of Services that provides good information including signposting to Autism Specific Agencies, which is easy to access and understand. |
| Increase the number of people directing their own support with a personal budget to enable people with Autism to have greater control over their care and support. |
| Ensure more children and young people are offered support to plan and manage their own support needs through an individual / personal budget. |
| Direct Commissioning of Speech, Language and Communication Services, Occupational Therapy Services and Physiotherapy Services to meet the needs of people with Autism. |
| Work with Partners to develop the market, increasing local capability and capacity for provision of local Autism services. |

## Themes for the Future continued…

| Theme – I Want To Choose Where I Live |
|---|
| Joint Commissioning of local placements for young people with Autism so that all children in the area can remain at home or within the local area for their care and education. |
| Re-commission short break care provision after Aiming High funding has ceased. |
| Develop a wide range of Carer support services. |
| Develop specialist support services for people with Autistic Spectrum Disorder. |

| |
|---|
| Develop a Tees Action Plan, which will be updated regularly by the Tees Autism Strategy Delivery Group |
| Update the NEAC website to include The Tees Autism Strategy and the Tees Action Plan. The NEAC website will be monitored regularly to ensure information is accurate and up to date. |

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**Acknowledgements**

Sincere thanks to the following who contributed to the production of this report:

- MAIN
- Tees Valley Autism Strategy Delivery Group
- Tees Esk & Wear Valley NHS Foundation Trust
- Adults with Autistic Spectrum Conditions from across the 4 Local Authority areas.
- Parents, Carers, Partners and families of people with Autism from across the 4 Local Authority areas.

# Hartlepool Local Autism Action plan

Local Authorities: **Hartlepool**
Lead Professional: **Neil Harrison**

| Tees Ref | What are the main tasks involved in these priorities? | Who will lead? | Progress | Links |
|---|---|---|---|---|
| 1 | a. basic awareness training across:-<br>• Child & Adult social care<br>• health<br>• community services | Neil Harrison | April 2013<br><br>A tees model has been developed which includes both Foundation, intermediate and advanced training. Approximately 600 people have attended the training TEWV have provided training to its staff and provided additional training to the CJS (Probation service) | NEAC milestone 9 |
| | b. Create a map of existing awareness training for autism to show in-house provision and the types of external training available | Neil Harrison | April 2013<br><br>Autism awareness training is included within the HBC workforce plan, in addition external training is circulated via the TVASDG. | NEAC milestone 2 |
| | c. Arrange awareness training for the following priority groups:<br>• Assessment and care planning staff in mental health<br>• learning disability<br>• Adult community mental and learning disability teams | Ellen Spence<br>Mark Gwilt | April 2013<br><br>Both LD & MH teams have identified training with Care managers in the teams completing the advanced training. | NEAC milestone 9 |
| | d. Professional qualifications and workforce development to involve in-house HR/Training | Neil Harrison | April 2013<br><br>ESPA – accredited training via University of Northumbria<br>TEWV – accredited training via university of Teesside | NEAC milestone 9 |
| | e. Consider extending NAS Accreditation for contracted providers in the independent and voluntary sectors. | Neil Harrison<br>Brian Ayre | April 2013<br>NAS accreditation for both Employment Link, Sunflower lounge (HBC – day opps) and Catcote School | NEAC milestone 4 |

| Tees Ref | What are the main tasks involved in these priorities? | Who will lead? | Progress | Links |
|---|---|---|---|---|
| 1 | f. Identify people on the spectrum and family members who could deliver real-life training to professionals | Neil Harrison | April 2013<br><br>MAIN – Mini World Autism Day events held locally as well as World Autism Event across Tees, utilised the views of local people, to feed into commissioning intentions | NEAC milestone 9 |
| | g. Prepare a sub-regional training plan which all the local authorities are committed to which can be co-ordinated by the ASDG | Neil Harrison | April 2013<br><br>Completed and agreed, initially led by Hartlepool, delivered by Educational Psychologist. Other areas adapting | NEAC milestone 1 |
| | h. Council-wide awareness training is needed for elected members and front desk staff | Democratic Services | April 2013<br>Refresh training required for elected members following changes in local elections. | NEAC Milestone 3 & 10 |
| | i. Review DH guidance on making "reasonable adjustments" for employers to use and incorporate into awareness training | All | April 2013<br><br>Local NAS accredited employment service now co-located with econ and regeneration team, creating more opportunities for people not in education employment or training | NEAC milestone 4 |
| | j. Address the need to provide training before support services are delivered to individuals | Sarah Ward | April 2013<br><br>Addressed within Individuals Service Design. | NEAC milestone 9 |

| Tees Ref | What are the main tasks involved in these priorities? | Who will lead? | Progress | Links |
|---|---|---|---|---|
| 2 | k. Local authorities need to work alongside providers of services so that bespoke training and support is in place for the individual with complex needs and autism<br><br>a. Update the autism data in the JSNA and plan for future needs with stakeholders. | Neil Harrison | April 2013 Tees ASC framework agreement developed with 8 providers identified with the skills, knowledge and competence to work with people with ASC | NEAC milestone 5,7,8 |
| | | | April 2013 JSNA completed with Autism as specific key theme information on the needs of young people, children and Adults outlined. | NEAC milestone 2 |
| | b. Add the co-priorities from this action plan into the JSNA in each local authority. | Neil Harrison | JSNA priorities<br>• Increase uptake of SDS<br>• Develop the workforce<br>• IAG parents cares and staff.<br>• Meeting local education and care needs. | NEAC milestone 2 |
| | c. A RIEP funded project to create a Teeswide plan has recently begun | Main | April 2013<br><br>Main completed draft, commissioners have fed into the process. | NEAC milestone 2 |
| | d. The MAIN Project will provide a written update on the development of the Teeswide plan at each ASDG meeting | | April 2013<br><br>Completed. | NEAC Milestone 2 |
| | | | | |

| Tees Ref | What are the main tasks involved in these priorities? | Who will lead? | Progress | Links |
|---|---|---|---|---|
| 3 | a. Involve TEWV in local meetings so that developments around diagnosis and care pathways are discussed. | TVASDG | April 2013<br><br>TEWV key stakeholder within TVASDG meetings | NEAC milestone 2,5 |
| | b. provide feedback from NEAC on the ASC diagnostic services | Neil Harrison ASDG Chair | April 2013<br><br>Multi Agency Childrens diagnostic service has increased its capacity<br><br>Adult Diagnostic service, provided by TEWV | NEAC milestone 2,5 |
| | c. To follow statutory guidance on the development of diagnostic assessment and follow up services. | Neil Harrison | April 2013<br><br>NEAC discussed potential evaluation of two proposed models for Diagnostic services. MDT approach or specialist TEWV provision. | NEAC milestone 2 |
| | | | | |

| Tees Ref | What are the main tasks involved in these priorities? | Who will lead? | Progress | Links |
|---|---|---|---|---|
| 4 | a. Produce a joint commissioning plan for autism services based on the data in the JSNA | Neil Harrison | April 2013<br><br>JSNA updated | NEAC milestone 4 |
| | b. Involve partners involved in transition planning of young people with autism to identify where improvements can be made | Neil Harrison<br>TOG<br>Sarah Ward | April 2013<br><br>Transitions Operational Group will identify people with ASC and discuss improvements to planning. | NEAC milestone 2 |
| | c. Planning needs to improve around developing further education opportunities for people with ASC' | Neil Harrison<br>Stephen Wright<br>SENCO's | April 2013<br><br>TOG meetings discuss educational opportunities and link to IB's (Personal budgets) | NEAC milestone 3 |
| | d. To work more closely with colleagues in mental health | Neil Harrison<br>Geraldine Martin | April 2013<br><br>Meeting with Ben Smith (Joint Commissioner MH) potential to develop joint Market position statement | NEAC milestone 5 |
| | e. Consult Hartlepool's new transition protocol and feedback experiences to the ASDG | Neil Harrison | April 2013<br><br>Completed – need to include changes to single plan (O-25) | NEAC milestone 2 |
| | f. Explore new types of support in the wider community for people who are assessed as not being eligible for care services | Geraldine Martin | April 2013<br><br>Who Cares North East - Connected Care (LAC) to expand across the Borough, to include people with ASC (non FACS eligible) | NEAC milestone 3,8 |
| | g. Identify the most appropriate place to provide information for families about services and supports, especially following diagnosis. | All | April 2013<br><br>New First Contact and support Hub for Children and Adult (HBC0 | NEAC milestone 2 |

| Tees Ref | What are the main tasks involved in these priorities? | Who will lead? | Progress | Links |
|---|---|---|---|---|
| 4 | h. Support the roll-out of Personal Budgets and Direct Payments for people with autism<br><br>i. Invite a speaker to talk about personal health budgets at the ASDG meeting | Sarah Ward<br>Emma Whitworth<br><br>Emma Whitworth | April 2013<br><br>Completed – PHB ongoing. | NEAC milestone 3,10,13<br><br>NEAC milestone 3 |
| | j. Map existing children's and transition groups to avoid duplication. ASDG to merge or link with them | ASDG Chair<br>Neil Harrison | April 2013<br><br>Joint meeting with Childrens / Adult and Education commissioners to map commissioning priorities | NEAC milestone 2 |
| | k. Engage the Director of Children's services with planning around autism | Neil Harrison | April 2013<br>Childrens Scrutiny report completed for ASC and LD Child and Adult provision linked to Outcomes with the JSNA. | NEAC milestone 4 |
| 5 | a. Out of area placements. Evaluate the outcomes for this group of people to ensure their lives are improved despite the reduction in costs | Neil Harrison<br>Ellen Spence<br>Sarah Ward<br>Donna Owens | April 2013<br><br>Forms the basis of the winterbourne view action plan, ongoing work to review and challenge inappropriate placements | NEAC milestone 8 |
| 6 | a. Explore the need to create an autism partnership board on Teesside | ASDG | April 2013<br>Continue with existing arrangements | NEAC milestone 11 |
| | b. As new Health & Wellbeing partnerships are being created, ensure autism fits properly in the new structures (including GP Consortia) | ASDG<br>Neil Harrison | April 2013<br><br>Early discussion with CCG's include link for autism in the Stockton and Hartlepool CCG Clear and Credible plan 2012-2017 | NEAC milestone 11 |

| Tees Ref | What are the main tasks involved in these priorities? | Who will lead? | Progress | Links |
|---|---|---|---|---|
| 7 | a. NEAC and The MAIN Project to explore how local authorities can meaningful engage with parents and carers | Neil Harrison<br>The MAIN Project | April 2013<br><br>Hartlepool Autism Self Help Group (HASH) information / advice / guidance network<br><br>Autism Rights Group Hartlepool (ARGH) active peer support group. | NEAC milestone 5 |
| 8 | a. Find out about the variety of ways young people and adults with ASCs are able to engage with the work of the ASDG | Neil Harrison<br>Tracey Liveras<br>MAIN Project | April 2013<br>Parent participation Forum and LDPB exploring ways to further engage with young people and adults with ASC. | NEAC milestone 2,3,5,13 |

**Not Covered**
NEAC milestone 6: Supporting initiatives with ASC into Work
NEAC milestone 7: Social care provider supporting employment
NEAC milestone 12: Support to Lead Officers in their role

# HEALTH AND WELLBEING BOARD

**5th August 2013**

HARTLEPOOL BOROUGH COUNCIL

**Report of:** Assistant Director, Adult Services

**Subject:** THE CHALLENGING BEHAVIOUR CHARTER

## 1. PURPOSE OF REPORT

1.1 To seek approval to sign up to the principles of the Challenging Behaviour Foundation (CBF) Charter

## 2. BACKGROUND

2.1 The Challenging Behaviour Charter was developed by the Challenging Behavior National Strategy Group and has endorsement from the Association of Directors of Adult Social Services and several NHS organisations.

2.2 Behaviour can be described as challenging when it is of such an intensity, frequency, or duration as to threaten the quality of life and/or the physical safety of the individual or others and it is likely to lead to responses that are restrictive, aversive or result in exclusion.

2.3 In brief the Charter asks Child and Adult Services and the NHS to collaborate and develop plans across education, social care and health to meet the individual needs of children, young people and adults with a behaviour described as challenging to ensure people have a good quality of life.

## 3. PROPOSALS

3.1 Hartlepool will continue to develop and review its Joint Strategic Needs Assessment (JSNA) in collaboration with NHS partners and can show good joint working which complements the CBF Charter.

3.2 In March 2011, the Government published its consultation Green Paper on special educational needs and disability (SEND). Hartlepool was chosen as a early implementer (pathfinder) and has been supported to design new arrangements to pilot and improve life outcomes for children and young

people; to give parents confidence by giving them more control; and to transfer power to professionals on the front line and to local communities.

3.3 The (SEND) 0-25 pathway provides further evidence of joint working with the development of the single plan and the ability to deploy a personal budget for Health, Education and Care.

3.4 The Charter attached at **Appendix 1** will further support the development of the JSNA for Children and Adults and the rights and values expressed within the Charter will act as a checklist for commissioners.

3.5 **Appendix 2** provides information on a range of key organisations already signed up to the CBF Charter.

## 4. RISK IMPLICATIONS

4.1 There are no risks identified in signing up to the CBF Charter.

## 5. FINANCIAL CONSIDERATIONS

5.1 There are no financial constraints or considerations.

## 6. EQUALITY AND DIVERSITY CONSIDERATIONS

6.1 The charter supports the ethos of the Equality Act, the positive attributes of effective compliance with the Equality Act and best practice in workplace diversity.

## 7. RECOMMENDATIONS

7.1 It is recommended that

- the Health & Wellbeing Board endorse the principles of the CBF Charter and reflect these principles in the JSNA and in any future commissioning decisions.
- organisations that are members of the Health & Wellbeing Board sign up to the principles of the CBF Charter and promote best practice for prople with challenging behaviour.

## 8. REASONS FOR RECOMMENDATIONS

8.1 The charter reinforces the human rights of some of the most socially isolated and excluded groups within society.

## 9. BACKGROUND PAPERS

**Appendix 1 -** The Challenging Behaviour Charter.

**Appendix 2 -** Extract of member organisations signed up to the CBF Charter.

## 10. CONTACT OFFICER

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Child & Adult Services
Hartlepool Borough Council
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CHALLENGING BEHAVIOUR NATIONAL STRATEGY GROUP

# The Challenging Behaviour Charter

"I was at an assessment and treatment unit for about 12 years. It was not nice being there. Now I'm in my own home and I am much happier"

Michael, Out of Sight

## Introduction

This charter, concerning the needs of individuals with learning disabilities who are perceived as challenging to services and others, was compiled in 2008 and published in 2009. Since then many individuals and organisations have signed up to the charter. You can find out who they are on the Challenging Behaviour Foundation website www.challengingbehaviour.org.uk . Following the Panorama programmes on the Winterbourne View abuses and reports flowing from that, we are republishing this charter in 2013. There is still so much to be done.

Challenging behaviour is often perceived as a 'problem' or 'illness' to be 'treated', 'cured' or 'stopped'. The problem is seen as being part of the person rather than focussing on what needs to change around the person, such as their environment or how people support them. This is unhelpful and potentially damaging for these individuals. We need to look beyond the behaviour, understand what the behaviour is communicating and then provide appropriate person centred, holistic support to enable individuals to achieve their full potential.

We know that much better support and services could be provided for children and adults who are perceived as challenging. This charter sets out the rights of these individuals and the action that needs to be taken.

**By signing up to this charter you endorse the rights of these individuals and commit to working in partnership with the National Strategy Group to influence real change.**

## In this charter we are adopting the following definition:


"Behaviour can be described as challenging when it is of such an intensity, frequency, or duration as to threaten the quality of life and/or the physical safety of the individual or others and it is likely to lead to responses that are restrictive, aversive or result in exclusion".

(Challenging behaviour – a unified approach; RCPsych, BPS, RCSLT, 2007)

The charter is a living document and we are happy to receive comments and views.

# Rights and Values:

1) People will be supported to exercise their human rights (which are the same as everyone else's) to be healthy, full and valued members of their community with respect for their culture, ethnic origin, religion, age, gender, sexuality and disability.

2) All children who are at risk of presenting behavioural challenges have the right to have their needs identified at an early stage, leading to co-ordinated early intervention and support.

3) All families have the right to be supported to maintain the physical and emotional wellbeing of the family unit.

4) All individuals have the right to receive person centred support and services that are developed on the basis of a detailed understanding of their support needs including their communication needs. This will be individually-tailored, flexible, responsive to changes in individual circumstances and delivered in the most appropriate local situation.

5) People have the right to a healthy life, and be given the appropriate support to achieve this.

6) People have the same rights as everyone else to a family and social life, relationships, housing, education, employment and leisure.

7) People have the right to supports and services that create capable environments. These should be developed on the principles of positive behavioural support and other evidence based approaches. They should also draw from additional specialist input as needed and respond to all the needs of the individual.

8) People have the right not to be hurt or damaged or humiliated in any way by interventions. Support and services must strive to achieve this.

9) People have the right to receive support and care based on good and up to date evidence.

# Action to be taken:

1) Children's and adults' services will construct long term collaborative plans across education, social and health services and jointly develop and commission support and services to meet the needs of children and adults with learning disabilities, their families and carers.

2) Local Authorities and the NHS will develop and co-ordinate plans to:
   - Reduce the exposure of young children with learning disabilities to environmental conditions that may lead to behavioural challenges.
   - Promote the resilience of young children with learning disabilities who face such environmental conditions.
   - Provide early intervention, support and services that will meet the individual needs (including communication needs) of young children who are showing early signs of developing behavioural challenges.

3) Active listening to the needs of the family will lead to the provision of appropriate and timely support, information and training.

4) People will be supported to have a good quality of life by individuals with the right values, attitudes, training and experience.

5) The NHS and services will proactively plan to ensure that people receive the same range, quality and standard of healthcare as everyone else, making reasonable adjustments when required. People will have an individualised health action plan and be supported to have access to annual health checks to ensure all health needs are met.

6) People and their family carers will receive support and services that are timely, safe, of good quality, co-ordinated and seamless. They will be proactively involved in the planning, commissioning and monitoring of support and services including both specialist and general services.

7) A person-centred approach that enables and manages the taking of risk will be used to ensure that people have access to family and social life, relationships, housing, education, employment and leisure.

8) Local authorities and the NHS will know how many children and adults live in their area and how many they have placed out of area. On the basis of information from person-centred plans all agencies will plan and deliver local support and services.

9) Services will seek to reduce the use of physical intervention, seclusion, mechanical restraint and the inappropriate or harmful use of medication with the clear aim of eliminating them for each individual.

10) All services and agencies will strive to improve continually, using up to date evidence to provide the best support, care and treatment to deliver positive outcomes for individuals.

## Challenging Behaviour National Strategy Group (CB-NSG) Charter

**Sign-up:**

I/We.....(name of individual/ organisation(s)) endorse the rights of individuals as set out within this charter and commit to working with the National Strategy Group to influence change.

All individuals/organisations who sign up to the charter may be listed on the Challenging Behaviour Foundation website/other publications (contact details will not be listed). I/We give my/our permission to be added to this list.

Signed.....

Print name .....

.....
(and name of organisation and job title if appropriate)

Date.....

**Contact Details:**

E-mail address .....

Tel number .....

.....

Address .....

.....

.....

☐ Anyone who signs up to the charter will automatically be added to the CBF database, to receive "Challenge" the newsletter of the Challenging Behaviour Foundation, free of charge, three times a year. Please tick here if you do not wish to be added to the mailing list.

**Please return to:**
CB-NSG Charter, Challenging Behaviour Foundation, The Old Courthouse, New Road Avenue, Chatham, Kent, ME4 6BE

Challenging BEHAVIOUR foundation

making a difference to the lives of people with severe learning disabilities

Published 2009, Re-published 2013

Affix
Stamp
Here

CB-NSG Charter

**Challenging Behaviour Foundation**

The Old Courthouse

New Road Avenue

Chatham, Kent

ME4 6BE

**Appendix 2**

Member Organisations signed up to the Challenging Behaviour Foundation Charter

- ADASS - Association of Directors of Adult Social Services
- ARC (Association for Real Change)
- BILD (British Institute of Learning Disabilities)
- British Psychological Society - Faculty for Learning Disabilities
- Challenging Behaviour Foundation
- College of Occupational Therapists
- Foundation for People with Learning Disabilities
- Humber Mental Health Teaching NHS Trust
- Mencap
- Mersey Care NHS Trust
- National Autistic Society
- NDTi (National Development Team for inclusion)
- Nottinghamshire Healthcare NHS Trust
- Nottinghamshire County Council
- NVFF (National Valuing Families Forum)
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Psychiatrists
- Royal College of Speech and Language Therapists
- Royal Society of Medicine
- Social Care Institute for Excellence (SCIE)
- Sussex Partnership NHS Foundation Trust - Learning Disabilities
- The National Forum of People with Learning Disabilities
- The Richmond Fellowship Scotland
- Tizard Centre - University of Kent
- United Response

# HEALTH AND WELLBEING BOARD

## 5 August 2013

**Report of:** Scrutiny Manager

**Subject:** **SCRUTINY INVESTIGATION INTO SELECTED JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) TOPICS – FINAL REPORT AND AGREED ACTIONS**

---

## 1. PURPOSE OF REPORT

1.1 To present to the Health and Wellbeing Board the findings of the scrutiny investigation into the selected Joint Strategic Needs Assessment (JSNA) Topics.

## 2. BACKGROUND

2.1 As part of the Overview and Scrutiny Work Programme for 2012/13, it was agreed that the Scrutiny Co-ordinating Committee, and each of the individual Scrutiny Forums, would consider selected JSNA topics and formulate views and comments for consideration where appropriate. The aim of the investigations being to 'strategically evaluate and contribute towards the development of Hartlepool's Joint Strategic Needs Assessment'.

2.2 Selected JSNA topics were looked at in detail during the course of 2012/13, culminating in the production of the report attached at **Appendix 1**. Appended to this report are the detailed outcomes of investigations into the selected JSNA topic areas:-

**Appendix A** - **Poverty JSNA Topic** (Scrutiny Co-ordinating Committee)

**Appendix B** - **Transport JSNA Topic** (Scrutiny Co-ordinating Committee via the Transport Working Group)

**Appendix C** - **Older People JSNA Topic** (Adult and Community Services Scrutiny Forum)

**Appendix D** - **Emotional and Mental Wellbeing JSNA Topic** (Children's Services Scrutiny Forum)

**Appendix E** - **Environment JSNA Topic** (Neighbourhood Services Scrutiny Forum)

**Appendix F** - **Employment JSNA Topic** (Regeneration and Planning Services Scrutiny Forum)

**Appendix G** - **Sexual Health JSNA Topic** (Health Scrutiny Forum)

2.3 The report and its appendices were considered and accepted by the Finance and Policy Committee on the 28 June 2013, alongside detailed action plans, formulated to respond to the recommendations made. Copies of these Action Plans are attached at **Appendix 2**.

2.4 In addition to the recommendations made by each Forum, the Board's attention is drawn to a number of overarching comments in relation to the overall JSNA process and content. These are outlined below and action against them are detailed in Appendix 1 (pages 1 to 3):-

i) The scrutiny process highlighted weaknesses in the quality and content of some of the web based JSNA topic areas, with concerns expressed regarding a level of co-ordination between Council and the NHS in the development of entries;

ii) In instances where JSNA entries were incomplete at the time of scrutiny consideration, Members were concerned that the Scrutiny process had been utilised to inform, rather than comment on, the content of the entries;

iii) Entries were in some instances based upon high level statistics / evidence and concern was expressed that the level of local information available could impact on the effectiveness of the JSNA as a tool in the commissioning of services to fit local need in the future;

iv) To ensure the JSNA is a 'living' document that accurately reflects the situation within the town, and can effectively influence the commissioning of future services by the authority and its partners, the various JSNA topics should be updated on a quarterly basis alongside the Councils Covalent database;

v) The impact of welfare reform must be reflected fully across all aspects of JSNA topics; and

vi) The eradication of child poverty must continue to be priority within the Councils new decision making process, particularly through the future work of the Health and Wellbeing Board.

2.5 The Board is asked to note the content of the report(s) at Appendix 1 and the Action Plans at Appendix 2. Progress against the actions identified will be monitored by the appropriate Policy Committees as part of the six

monthly monitoring of outstanding scrutiny actions. The exception to this will be recommendations / actions in relation to the Sexual Health JSNA Topic, which will be monitored by the Audit and Governance Committee as part of the statutory scrutiny process.

## 3. RECOMMENDATIONS

3.1 That the Health and Wellbeing Board notes the content of the report(s) at Appendix 1 and the Action Plans at Appendix 2.

## 4. REASONS FOR RECOMMENDATIONS

4.1 The aim of Scrutiny Co-ordinating Committee and the Scrutiny Forums investigations into JSNA topics was 'to strategically evaluate and contribute towards the development of Hartlepool's Joint Strategic Needs Assessment'.

## 5. BACKGROUND PAPERS

Background paper(s) used in the preparation of this report:-

Report of the Chairs of Overview and Scrutiny entitled 'Joint Strategic Needs Assessment Overview and Scrutiny Investigation' – presented to Scrutiny Co-ordinating Committee on 3 May 2013.

Report of Overview and Scrutiny Chairs entitled 'Scrutiny Investigation into Selected Joint Strategic Needs Assessment (JSNA) Topics – Final report – presented to the Finance and Policy Committee on 28 June 2013.

Report of Directors of Child and Adult Services, Regeneration and Neighbourhoods and Public Health entitled 'Scrutiny Investigation into Joint Strategic Needs Assessment Topics – Action Plans' – presented to the Finance and Policy Committee on 28 June 2013.

## 6. CONTACT OFFICER

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Hartlepool Borough Council
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# SCRUTINY CO-ORDINATING COMMITTEE

**3 May 2013**

HARTLEPOOL BOROUGH COUNCIL

**Report of:** CHAIRS OF OVERVIEW AND SCRUTINY

**Subject:** JOINT STRATEGIC NEEDS ASSESSMENT – OVERVIEW AND SCRUTINY INVESTIGATION

---

## 1. PURPOSE OF REPORT

1.1 To present the findings of Overview and Scrutiny following its investigation into selected Joint Strategic Needs Assessment (JSNA) topics.

## 2. BACKGROUND

2.1 The Scrutiny Co-ordinating Committee met on the 15 June 2012 agreed that the Overview and Scrutiny Work Programme for 2012/13 would focus on consideration of the Joint Strategic Needs Assessment. Given the wide breadth of the areas covered by the assessment, the Committee agreed that a number of specific topic areas would be selected for detail consideration. On this basis, it was agreed that over the course of 2012/13, individual Forums would look in detail at the following JSNA topic areas:

- Poverty;
- Transport;
- Older People;
- Emotional and Mental Wellbeing;
- Environment;
- Employment; and
- Sexual Health.

2.2 The production of a Joint Strategic Needs Assessment has been a statutory responsibility for the Council and NHS since 2007. This year represents the transfer of the document in to a web based 'living' form which has led to some of the issues identified during the course of the Overview and Scrutiny investigation in relation to the uploading and updating / content of some entries. Full details of Overview and Scrutiny comments and recommendations are outlined in each of the attached appendices and section 4.2 below

## 3. OVERALL AIM OF THE SCRUTINY INVESTIGATION

3.1 To strategically evaluate and contribute towards the development of Hartlepool's Joint Strategic Needs Assessment, whilst reflecting (where possible / appropriate) on the Marmot principles.'

## 4. FINDINGS

4.1 The terms of reference for each of the Forum investigations were based on the ten key questions contained within each JSNA topic entry. In considering each topic entry, Members received evidence from a wide range of sources relating to these key questions and the findings of each Forum are outlined in the attached appendices.

**Appendix A** - **Poverty JSNA Topic** (Scrutiny Co-ordinating Committee)

**Appendix B** - **Transport JSNA Topic** (Scrutiny Co-ordinating Committee via the Transport Working Group)

**Appendix C** - **Older People JSNA Topic** (Adult and Community Services Scrutiny Forum)

**Appendix D** - **Emotional and Mental Wellbeing JSNA Topic** (Children's Services Scrutiny Forum)

**Appendix E** - **Environment JSNA Topic** (Neighbourhood Services Scrutiny Forum)

**Appendix F** - **Employment JSNA Topic** (Regeneration and Planning Services Scrutiny Forum)

**Appendix G** - **Sexual Health JSNA Topic** (Health Scrutiny Forum)

4.2 In addition to the recommendations made by each Forum, a number of further comments were made in relation to the overall JSNA process and content. These are outlined below:-

i) The scrutiny process highlighted weaknesses in the quality and content of some of the web based JSNA topic areas, with concerns expressed regarding a level of co-ordination between Council and the NHS in the development of entries;

ii) In instances where JSNA entries were incomplete at the time of scrutiny consideration, Members were concerned that the Scrutiny process had been utilised to inform, rather than comment on, the content of the entries;

iii) Entries were in some instances based upon high level statistics / evidence and concern was expressed that the level of local information available could impact on the effectiveness of the JSNA as a tool in the commissioning of services to fit local need in the future;

iv) To ensure the JSNA is a 'living' document that accurately reflects the situation within the town, and can effectively influence the commissioning of future services by the authority and its partners, the various JSNA topics should be updated on a quarterly basis alongside the Councils Covalent database;

v) The impact of welfare reform must be reflected fully across all aspects of JSNA topics; and

vi) The eradication of child poverty must continue to be priority within the Councils new decision making process, particularly through the future work of the Health and Wellbeing Board.

## 5. RECOMMENDATIONS

5.1 That the comments contained within Section 5 above, and the content, outcomes and recommendations contained within the reports attached at Appendices A to G, be approved for presentation to the Finance and Policy Committee.

**ALL CHAIRS OF OVERVIEW AND SCRUTINY**

**Report of:** SCRUTINY CO-ORDINATING COMMITTEE

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

---

## 1. PURPOSE OF REPORT

1.1 To present the findings of the Scrutiny Co-ordinating Committee following its investigation into the Joint Strategic Needs Assessment (JSNA) topic of Poverty.

## 2. BACKGROUND

2.1 The Scrutiny Co-ordinating Committee met on the 15 June 2012 to consider its Work Programme and agreed that the Committee would in 2012/13 focus on the following JSNA topic:-

Poverty - Support people in Hartlepool to maximise their income and increase the number of people who are economically active, given that over 30% of children in Hartlepool live in poverty; ensure that information about the range of benefits available to vulnerable young people and families is consistent and of high quality.

## 3. MEMBERSHIP OF THE SCRUTINY CO-ORDINATING COMMITTEE

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

Councillors Ainslie, C Akers-Belcher, S Akers-Belcher, Beck, Cook, Fisher, Gibbon, Hall, James, Loynes, Payne, Richardson, Shields, Tempest, Wells and Wilcox.

## 4. OVERALL AIM OF THE SCRUTINY INVESTIGATION

4.1 To strategically evaluate and contribute towards the development of the 'Poverty' topic within Hartlepool's Joint Strategic Needs Assessment, whilst reflecting (where possible / appropriate) on the Marmot principles.'

## 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 5.6 onwards of this report. Details of evidence presented to the Committee are attached at **Appendix A.**

5.2 The Scrutiny Co-ordinating Committee has as part of its work programme in previous years focused its attention on poverty as a key issue, resulting in the formulation of conclusions and recommendations in relation to 'Child Poverty and Financial Inclusion' and 'The Provision of Face to Face Advice and Information Services in Hartlepool'. In considering the content of the Poverty JSNA entry, the Committee utilised the evidence and experienced obtained through its previous investigations.

5.3 As part of the first stage of the process, the Scrutiny Co-ordinating Committee at its meeting on the 30 November 2012 received baseline evidence in relation to the current government definition of poverty and expressed concerns that rather than eradication child poverty by 2020, levels were expected to increase by 2015 (relative child poverty by 400,000 and absolute child poverty by 500,000). Members also noted that seven out of eleven wards in Hartlepool fall within the top 5% most deprived nationally.

5.4 The Committee noted with interest the following snapshot of the consequences of poverty in relation to health in Hartlepool, gaining an understanding of how factors including environment, housing, employment and education relate to poverty and its resulting health implications.

| **Diseases** |
|---|
| Burn Valley Ward – You would be at an increased risk of CVD and cancer compared to the rest of England |

| **Best Start** | **Long Life** |
|---|---|
| Manor House Ward – You have an 80% chance of not being breast fed | Hart Ward – You can expect to live to over 80 years |

| **Income** | **Inequality** |
|---|---|
| Fens and Rossmere Ward – You are more likely to be claiming incapacity benefit than people in Elwick | Victoria Ward – You would live about 10 years less than those in Hart |

| **Risky Behaviour** |
|---|
| Headland and Harbour Ward – You would have at least a 25% chance of experiencing nicotine before you are born |

5.5 Given the wide reaching nature of the poverty issue, in order to facilitate effective discussions the Committee considered the questions contained within the JSNA entry over the course of two separate meetings. The meeting on the 8 February 2013 focused on adult and older person poverty, whilst the meeting on the 22 March 2013 focused on family, child and

welfare reform poverty. Details of the Committees views and recommendations are outlined below.

**What are the key issues?**

5.6 The Committee established that housing, education, environment and employment are all key factors in relation to poverty and its associated health implications. The Committee was of the view that of these factors, perhaps the most fundamental is the provision of employment opportunities as a means of enabling people of all ages to work their way out of poverty and raise aspirations. The importance of the provision of jobs and opportunities is also key to the eradication of family poverty, as a fundamental factor in addressing child poverty.

5.7 It was, however, noted that nationally 60% of children living in poverty live in a household where at least one parent works and as such, the level and type of jobs available is an equally important factor. In the case of Hartlepool, it was noted that there were only 345 live vacancies within Job Centre Plus, which equated to approximately 11 unemployed people per job (as of 30 November 2012) and that the jobs were mainly low level or part time on minimum wage. In addition, the North East region has one of the lowest rates of minimum wage across the country at £7 per hour which would have a financial impact on local residents and families. There is, however, a section of Hartlepool residents that are highly skilled (as a result of being relatively highly paid) which has the effect of raising the average full time equivalent wage in the town to £506.00 per week. Whilst this compared favourably to the national average full time equivalent wage of £508.00 per week, it also demonstrated to the Committee the complexity of the current labour market and the widening wage gap across Hartlepool between the lower and higher skilled workers.

5.8 Attention was drawn to previous work programmes operated by the Council and the voluntary and private sectors, funding for which had been removed. Members were of the view that these programmes had been delivered extremely successfully on a local basis, comparisons being drawn with the far less effective replacement schemes. Particular attention had been drawn to the Future Jobs Fund (FJF) which in Hartlepool had created and helped 720 18-24 year olds into employment over an 18 month period. Members felt strongly that this had been achieved through real efforts and partnership working by the Council, voluntary and private sectors and that the removal of these schemes had been a truly retrograde step.

5.9 In looking at how to reduce poverty in the town, Members emphasised the importance of future investment in the town's infrastructure, and encouragement for the manufacturing industry, as key factors in the generation of local jobs and increasing the local economy. Emphasis was also placed upon the importance of providing jobs and experience for the towns' young people and the Committee was supportive of the promotion of apprenticeship schemes (including those without academic qualifications) as

part of any package of measures to increase employment and reduce the levels of poverty in Hartlepool.

5.10 Key to achieving this was going to be the work undertaken by the Council in liaising with local colleges and local employers and other organisations to look at the skills required for the development of future industry. The Committee was pleased to discover that this work was already ongoing and one example of this was the local authority working closely with Job Centre Plus and National Apprenticeship Service to promote the apprenticeship programme to local employers.

5.11 In considering other factors, Members were exceptionally concerned regarding the effects of future welfare reform changes to benefits and social housing rules (including the bedroom tax) on local people and the local economy. The Committee was reassured that a number of interventions were already in place and commended the activities of services such as First Contact Support Hub and the West View Advice and Resource Centre.

**What commissioning priorities are recommended?**

5.12 Members supported the commissioning priorities identified within the JSNA Poverty entry.

**Who is at risk and why?**

5.13 Members were supportive of the content of this element of the Poverty JSNA entry and explored the potential of refining the information provided even further. The Committee suggested that the provision of statistical information in relation to the number of those seeking advice through council or voluntary services as a result of the welfare reforms would be beneficial on ward by ward basis. The benefits of the use of this information alongside the existing demographic profiling of wards, being that it would assist in the future focus and commissioning of services through the clear identification of:-

i) The location of those affected; and
ii) Patterns in terms of levels and types of advice sought.

5.14 The Committee was of the view that this information should be compiled and utilised to update the JSNA on a regular basis, to maintain its accuracy as a 'living' document. It should also be utilised to inform any future contract arrangements let by the authority. In relation to the future availability of statistical information, concern was however expressed that budgetary cuts could impact on the availability of information to enable the evaluation and monitoring of issues such as poverty and employment levels.

5.15 Members discussed further practical arrangements for the identification of those in need and emphasis was placed upon the importance of partnership working. The Committee noted that arrangements are already in place with the Fire Brigade to ensure that concerns are relayed following home visits

and it was felt that, if not already in place, similar arrangements should be put in place with all JSNA partners. This would ensure that information is relayed to relevant bodies that are in a position to provide help and assistance and reduce the number of people / families that fall between the gaps.

**What is the level of need in the population?**

5.16 Members observed that the information on child poverty in Hartlepool was based on 2010 statistical information across the old ward boundary areas and expressed concern that it was therefore out of date. Whilst the Head of Access and Strategic Planning explained to the Committee that national statistical information was always two/three years out of date, and emphasised the '3 year minimum view' nature of the JSNA, Members remained keen to see the information updated as soon as possible and fed into the JSNA entry.

5.17 Members appreciated the pressure placed on officers as a result of reducing resources and discussed in detail the appropriate frequency for the update of the JSNA. The viability of various options was discussed, alongside the need for the JSNA to be a 'living' document and discussions culminated in support for the updating of the various JSNA topics quarterly. The intention being that this would be in line with the Councils Covalent (performance management) database. Members felt that this would achieve the required outcomes, whilst keeping the impact on officers to an acceptable level.

5.18 The Committee also highlighted the need to ensure that information provided is updated to reflect the new ward boundaries, whilst it was noted that this information would provide a picture of wards on an overall basis. It was suggested that it would be beneficial to also provide information on a super output basis.

5.19 Other issues raised in relation to the level of need in Hartlepool related to:-

i) School Meals - Members discussed in detail the links between school meals, poverty and health and felt that the number of children receiving free school meals should be reflected in the entry; and

ii) Internet Access - Members highlighted potential health and wellbeing issues, in terms of education disadvantage and future life chances, which some children experience as a result of restricted (or non existent) internet access.

5.20 In considering the information provided, the Committee recognised the stigma that was often associated with being in poverty, resulting in some families / individuals being reluctant to access services or benefits that could help. An example of this being the take up of free schools meals. Members concerns in relation to this were shared by the Adult and Public Health Services Portfolio Holder who participated in discussions at the meeting on the 22 March 2013.

5.21 Concern was also expressed that people could often be very judgemental about what people in poverty should or should not have, i.e. internet and children having the latest clothes or trainers. The Committee felt strongly that the isolation experienced by children / young people who are unable to fit into their peer groups for whatever reason could be exceptionally damaging, both now in terms of social exclusion and mental health and in terms of future development and aspirations.

5.22 Members discussed further the issue of unclaimed benefits and were advised that through the work of the Council's partners and the First Contact Support Hub, every effort was made to try and ensure that families are claiming all the benefits they are entitled to. It was, however, recognised that this is still a challenge.

5.23 As part of the information provided by the First Contact Support Hub team, the Committee noted with concern growing demand for food banks in the town. Evidence showed that between January and March 2013 1,031 food parcels had been given out in addition to an average of 20 food vouchers being given out through First Contact Support Hub each week and 5 through West View Advice & Resource Centre (WVARC). Concern was expressed that this service could become a regular source of support rather than an emergency provision, as was intended. Members also expressed concern regarding those children who during the holidays would miss out on their school meals and it was suggested that the potential introduction of school holiday clubs to ensure that children received lunch should be explored.

5.24 Members felt strongly that in 2013 it was a disgrace that food banks are needed and that usage of these services should be reflected in the JSNA, with regular updates to reflect any fluctuations / increases that might occur.

**What services are currently provided?**

5.25 The Committee noted the absence of various activities undertaken in addressing poverty issues across Hartlepool, and in particular the absence of reference to the First Contact Support Hub Team, Connected Care or the West View Advice and Resource Centre. Members suggested that the entry should be updated to more accurately reflect the breadth of activities being undertaken in Hartlepool, with particular attention drawn to the work being undertaken and advice being provided in relation to welfare reform changes.

5.26 The Public Health Intelligence Specialist commented that with the JSNA now being a 'live' document on the internet it was much easier to adapt and update the document to reflect changes in the background information.

**What is the projected level of need / service use?**

5.27 Members noted the content of this section of the JSNA entry and reiterated concerns regarding the impact of loan sharks on those in financial difficulty and the contributing role they play in pushing people and families further into poverty. In light of these concerns, it was suggested that the effect / impact of loan sharks should be reflected in the JSNA entry.

5.28 Taking into consideration the evidence provided through a selection of case studies in relation to all aspects of poverty, Members were concerned that given the aim of the JSNA entry in informing the commissioning of services to reflect local need, the information provided in this section of the entry was heavily focused at a national level. Members were of the view that the information contained within this section of the entry should be more representative of the position on a local basis and suggested that an assessment of local needs / impacts should be included in the entry to build upon the national information provided.

5.29 In addition to this, one key issue which Members felt was not fully represented in the entry was the imminent changes to Housing Benefit (commonly referred to as the 'bedroom tax'), with a particular impact on those who are on the borders of poverty. Particular attention was drawn to the need to address the shortfall in two bedroom homes that exists in the town and Members suggested that the issues and implications of the Housing Benefit reforms need to be fully reflected in the JSNA entry.

5.30 In looking at possible way of addressing the Housing Benefit reform issue, the Committee highlighted the short supply of properties with two or less bedrooms and suggested that ways of either adapting or re-designating properties should be explored with Housing Hartlepool and other social landlords. This being a means of reducing the impact of the new legislation and reducing the potential impact / cost of evictions.

5.31 It was recognised that this would impact on the value of landlord's housing stock, and that a full cost analysis had already been undertaken by Housing Hartlepool. The Committee, however, felt that this should be looked in to further.

5.32 During the course of discussions, Members highlighted the potential for an increase in the number of people who have never in the past needed to access benefits and due to job losses find them selves in debt. This in turn would be a section of the community who will probably have the least amount of knowledge and experience in navigating the benefit system and as such will require significant assistance. Members were concerned that the deteriorating economic climate could see a significant increase in these types of cases.

5.33 In addition to this, taking into consideration all of the factors discussed around current and potential need in the town, Members had real concerns regarding the potential for an increase in mental health issues, that may lead

to an increase in suicide rates and felt strongly that this potential should be planned for.

**What needs might be unmet?**

5.34 Continuing to look at the impact of welfare reform changes, Members drew attention to the potential impact on people as they move over to the Employment and Support Allowance (ESA). This was a source of severe stress for many in this situation, with the potential for some single people to be left with only £71 per week to live on.

5.35 Evidence provided from the First Contact Support Hub team, and representatives from West View Advice and Resource Centre, indicated that requests for advice in relation to the migration over to the ESA was a daily issue. Whilst many seemed to be coping initially, many were still appealing decisions and as such the true impact of the change was not yet known. On this basis, the Committee was of the view that the impact of the migration needed to be fully reflected in terms of future potential unmet needs.

5.36 Members discussed in detail the need for holistic support around the family and expressed concern regarding potential 'out of hours' emergencies for families in need. Whilst the Committee was aware of the existence of an emergency duty team to deal with safeguarding and other issues out of hours, concern was expressed that although Section 17 funding is available for children in need, there is no out of hours mechanism in place to deal with instances of hardship. Members suggested that in recognition of this, emergency numbers needed to be re-circulated to Members and publicised to residents, to ensure that all know what options are available to them in the event of an emergency.

**What evidence is there for effective intervention?**

5.37 Members noted that this section of the JSNA reflected only high level academic indicators of effective intervention. Members were of the view that there was clear need for the JSNA to be responsive to the local situation and include a reflection of the significant amount of work being undertaken locally in tackling poverty issues. This included the successes of the voluntary and community sector as well as the services provided by the local authority.

5.38 Whilst the Committee was advised that the requirement for this element of the entry to focus on high level national indicators had been agreed as a template for all JSNA's, Members were of the view that this should not be the case. Members suggested that in order to have a document that effectively influences the town's Health and Wellbeing Strategy, and subsequently the services commissioned; the JSNA must be reflective of the position in Hartlepool and not simply a national perspective.

**What do people say?**

5.39 Members were concerned that the content of this section was primarily based on the views of children and young people. The Committee suggested that the content of this section should be expanded to include the views of other sections of the community i.e. older people and families and that evidence from other sources such as the older people's strategy could potentially be utilised.

**What additional needs assessment is required?**

5.40 The Committee was happy with the content of this section of the Poverty JSNA entry.

**What are the recommendations for commissioning?**

5.41 Members noted and welcomed the advice being given by the West View Advice and Resource Centre in relation to people opening accounts with the Credit Union (in order to ensure continued access to benefit payments). Members discussed practical barriers to the provision of services as quickly as possible to help alleviate, or remove people and families from, poverty. In doing so, emphasis was placed upon the importance of debt advice and the challenges facing providers in the provision of appointments and the speed at which benefits are processed and payments initiated.

5.42 Members suggested that the importance and effectiveness of debt advice services in helping families and individuals in poverty should be clearly referenced in the JSNA entry in terms of the commissioning of future services.

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

6.1 The Scrutiny Co-ordinating Committee has taken evidence from a wide range of sources to assist in the formulation of a balanced range of recommendations. The Committee noted the JSNA Poverty entry and recommended the following:-

1) In relation to the section of the entry relating to **'What are the key issues'**, Members were generally supportive of the information included, however, recommended the following:-

   i) That the entry be amended to reflect the importance of employment (including the provision of apprenticeships for young people, with or without academic qualifications) and the economic regeneration of the town as key factors in enabling people to work their way out of poverty.

2) In relation to the section of the entry relating to **'What commissioning priorities are recommended'**, Members supported the commissioning priorities identified within the entry.

3) In relation to the section of the entry relating to **'Who is at risk and why'**, Members were generally supportive of the information included, however, recommended the following:-

   i) That statistical information in relation to the number of those seeking advice through the Council, or other services as a result of the welfare reforms, should be compiled on a ward by ward basis and utilised to update the JSNA.

   ii) That arrangements be put in place with partners who visit homes of residents to ensure that information in relation to families / individuals who are experiencing poverty is relayed, and that they are signposted to relevant bodies that are able to provide help / assistance.

4) In relation to the section of the entry relating to **'What is the level of need in the population'**, Members were generally supportive of the information included, however, recommended the following:-

   i) Whilst it was recognised that national statistical information tended to be two/three years old, where possible information contained within the entry be updated to better inform the commissioning of services to meet demand;

   ii) That the information be updated to reflect the new ward boundaries and that the provision of information on a super output basis be explored; and

   iii) That information in relation to food bank usage be included in the entry, with regular updates to reflect any fluctuations / increases that may occur.

5) In relation to the section of the entry relating to **'What services are currently provided'**, Members recommended that the entry should be updated to more accurately reflect the breadth of activities being undertaken in Hartlepool, including food banks and benefits advice services, and as part of this a link to the Family Services Directory should be provided.

6) In relation to the section of the entry relating to **'What is the projected level of need / service use'**, Members were generally supportive of the information included, however, recommended the following:-

i) That this section of the entry be amended to include and reflect:

- The impact of loan sharks on those in financial difficulty and the contributing role they play in pushing people and families further into poverty;
- Issues relating to, and implications of the Housing Benefit reforms; and
- The need to plan for a potential increase in mental health issues that may lead to an increase in suicide rates.

ii) That given the role of the JSNA in informing the commissioning of services to reflect local need, an assessment of local needs / impacts should be included in the entry to build upon the national information already provided.

7) In relation to the section of the entry relating to **'What needs might be unmet'**, Members recommended that:-

i) In response to concerns regarding the transfer over to the Employment and Support Allowance, the impact of the migration should be reflected within the entry; and

ii) In response to concerns regarding the level of knowledge in relation to the options available to deal with out of hour's emergencies, emergency numbers are re-circulated to Members and publicised to residents.

8) In relation to the section of the entry relating to **'What evidence is there for effective intervention'**, Members were generally supportive of the information included, however, recommended the following:-

i) There is a clear requirement for the JSNA to be responsive to the local situation and include a reflection of the significant amount of work being undertaken locally in tackling poverty issues. On this basis, the entry should be amended to reflect the successful activities of the voluntary and community sector, as well as the services provided by the local authority.

ii) The entry should not follow the template agreed for all JSNA's across the region, whereby the focus is on high level national indicators. On this basis, in order to have a document that effectively influences the town's Health and Wellbeing Strategy, and in turn the services commissioned, the entry should be amended to reflective the local position and not solely a national perspective.

9) In relation to the section of the entry relating to **'What do people say'**, Members were generally supportive of the information included, however, recommended the following:-

i) The content of this section should be expanded to include the views of other sections of the community i.e. older people and families and that evidence from other sources such as the older people's strategy could potentially be utilised.

**COUNCILLOR MARJORIE JAMES**
**CHAIR OF THE SCRUTINY CO-ORDINATING COMMITTEE**

## ACKNOWLEDGEMENTS

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

Hartlepool Borough Council:

- Councillor Cath Hill, Children's and Community Services Portfolio Holder
- Councillor John Lauderdale, Adult and Public Health Services Portfolio Holder
- Denise Ogden, Director of Regeneration and Neighbourhoods
- Danielle Swainston, Head of Access and Strategic Planning
- Penny Thompson, First Contact Support Hub Manager
- Patrick Wilson, Employment Development Officer
- Nigel Johnson, Housing Services Manager
- Louise Wallace, Director of Public Health

External Representatives:

- Leon Green, Public Health Intelligence Specialist
- Graeme Cadas, Job Centre Plus
- Val Evens, Alison Thompson, Rebecca Wise, West View Advice and Resource Centre Ltd
- Kate Hogan and Lisa Steel, Hartlepool Carers
- Age UK Teesside (Age Concern) - Elizabeth Briggs
- Catherine Wohlers, Birmingham City Council

**Appendix A**

**Evidence provided to the Committee**

The following evidence was presented to the Scrutiny Co-ordinating Committee throughout the course of the investigation into 'Poverty':-

| **Date of Meeting** | **Evidence Received** |
|---|---|
| 28 September 2012 | Scoping Report – Scrutiny Manager |
| 30 November 2012 | Setting the Scene Presentation - Director of Public Health, Assistant Director (Neighbourhood Services), First Contact Support Hub Manager and Employment Development Officer<br><br>Evidence from the Portfolio Holder for Children's and Community Services<br><br>Previous Poverty Related Scrutiny Investigations – Scrutiny Manager |
| 8 February 2013 | Poverty JSNA Entry (Adult and Older Person Poverty Areas) Case Study Discussions<br><br>Feedback from the Child Poverty Consultation Event - 4th December and formulation of Scrutiny input into HBC response. |
| 22 March 2013 | Poverty JSNA Investigation (Family, Child and Welfare Reform Poverty Areas):<br><br>- Presentation; and<br>- Case Study Discussions (inc. food bank statistics and welfare reform information).<br><br>Evidence from the Portfolio Holder for Adult & Public Health Services. |

**Report of:** SCRUTINY CO-ORDINATING COMMITTEE

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

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## 1. PURPOSE OF REPORT

1.1 To present the findings of the Scrutiny Co-ordinating Committee (formulated through the Transport Working Group) following consideration of the Joint Strategic Needs Assessment (JSNA) topic of Transport.

## 2. BACKGROUND

2.1 The Scrutiny Co-ordinating Committee met on the 15 June 2012 to consider its Work Programme and agreed that consideration of the Transport JSNA topic would be referred to the Transport Working the Committee.

## 3. MEMBERSHIP OF THE TRANSPORT WORKING GROUP

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

Councillors Ainslie, C Akers-Belcher, Cook, James, Loynes, Tempest and Wells.

## 4. OVERALL AIM OF THE SCRUTINY INVESTIGATION

4.1 To strategically evaluate and contribute towards the development of the 'Transport' topic within Hartlepool's Joint Strategic Needs Assessment.

## 5. FINDINGS

5.43 The Transport Working Group, at its meeting on the 27 March 2013, considered each of the questions (outlined overleaf) contained within the Transport JSNA entry:-

(a) What services are currently provided?
(b) What is the projected level of need / service use?
(c) What evidence is there for effective intervention?
(d) What do people say?
(e) What needs might be unmet?
(f) What additional needs assessment is required?
(g) What are the recommendations for commissioning?

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

6.1 The Transport Working Group supported the content of the Transport JSNA entry, with the inclusion of reference where appropriate to the health benefits of the implementation of 20MPH zones across the town.

6.2 The Transport Working Group agreed that whilst in some individual roads it may not be possible to reduce speeds to 20 mph, that they should forward their recommendations to the Neighbourhoods Policy Committee, expressing their view that the Policy Committee take forward the recommendations and attempt to identify an area of the town where a 20 mph zone can be implemented, prior to rolling the initiative out across Hartlepool.

**COUNCILLOR MARJORIE JAMES**
**CHAIR OF THE TRANSPORT WORKING GROUP**

**ACKNOWLEDGEMENTS**

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

Hartlepool Borough Council:

- Alastair Smith, Assistant Director, Transportation and Engineering
- Paul Robson, Integrated Transport Manager
- Paul Watson, Road Safety Team Leader

**Appendix C**

**Report of:** **ADULT AND COMMUNITY SERVICES SCRUTINY FORUM**

**Subject:** **FINAL REPORT – INVESTIGATION INTO THE JSNA TOPIC OF 'OLDER PEOPLE'**

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## 1. PURPOSE OF REPORT

1.1 To present the findings of the Adult and Community Services Scrutiny Forum following its investigation into the Joint Strategic Needs Assessment (JSNA) topic of 'Older People'.

## 2. BACKGROUND

2.1 The Adult and Community Services Scrutiny Forum met on the 30 July 2012 to consider their work programme and agreed that the Forum would in 2012/13 focus on the following JSNA topic:-

Older People - Ensuring older people have full and active lives, accessing services within the community. If their needs change services across both health and social care need to be available and accessible to meet those needs. The principle of independence, reablement and maintaining control is at the heart of the commissioning and provision of services for older people.

2.2 The Marmot principle, 'Enabling All Children, Young People and Adults to Maximise Their Capabilities and have Control over Their Lives' was the overarching principle which the Forum used to measure the provision of Council Services throughout their investigation into 'Older People'. The priority objectives and policy recommendations in relation to this principle being:-

**Priority Objectives:-**

(a) Reduce the social gradient in skills and qualifications;

(b) Ensure that schools, families and communities work in partnership to reduce the gradient in health, well being and resilience of children and young people; and

(c) Improve the access and use of quality lifelong learning across the social gradient.

**Policy Recommendations**

(b) Ensure that reducing social inequalities in pupils' educational outcomes if a sustained priority;

(c) Prioritise reducing social inequalities in life skills by:

- Extending the role of schools in supporting families and communities and taking a 'whole child' approach to education;

- Consistently implementing 'full service' extended school approaches; and

- Developing the school-based workforce to build their skills in working across school-home boundaries and addressing social and emotional development, physical and mental health and well-being.

(d) Increase access and use of quality lifelong learning opportunities across the social gradient, by:

- Providing easily accessible support and advice for 16-25 year olds on life skills, training and employment opportunities;

- Providing work-based learning, including apprenticeships, for young people and those changing jobs / careers; and

- Increasing availability of non-vocational lifelong learning across the life course.

## 3. MEMBERSHIP OF THE ADULT AND COMMUNITY SERVICES SCRUTINY FORUM

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

Councillors Beck, A Lilley, Loynes, Richardson, Shields, Sirs and Wilcox.

## 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 'Older People' topic within Hartlepool's Joint Strategic Needs Assessment, whilst reflecting (where possible / appropriate) on the Marmot principle to 'Enabling all children, young people and adults to maximise their capabilities and have control over their lives'

## 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 5.29 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 Adult and Community Services Scrutiny Forum on 17 September 2012, Members received a setting the scene presentation from the Assistant Director of Adult Social Care and the Head of Strategic Commissioning. The presentation covered the following JSNA questions:-

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

**What are the key issues?**

5.2 The Forum was supportive of the key issues identified within the JSNA at the meeting of the Forum on 17 September 2012 and at the meeting of the Forum on 11 March 2013, where the JSNA entry was presented as a whole.

**Who is at risk and why?**

5.3 Dementia sufferers were one of the groups identified as being at risk in the 'older people' JSNA entry. Members discussed the difficulty surrounding diagnosis of the condition and the misconceptions that may exist around the condition, such as a view that sufferers cannot be cared for in their own homes, which may prevent people seeking a diagnosis.

5.4 Members suggested more publicity should be carried out to promote the facts around dementia and the care options available, to encourage more people to seek an early diagnosis, and that this was reflected in the 'older people' JSNA entry.

**What is the level of need?**

5.5 Members noted that it is very difficult to fully identify all older people who may have a social care need, as many people with low level needs are supported by family and friends, self fund their care or received no support. It was identified that these people occasionally access health services but do not receive social care.

5.6 The Forum heard that approximately 18% of people classed as 'older' are supported by Hartlepool Borough Council Social Services (the JSNA entry classes those aged 65 and over as an 'older person').

**What services are currently provided?**

5.7 The Adult and Community Services Scrutiny Forum met on 23 October 2012 to consider the evidence from Hartlepool Borough Council's Assistant Director of Social Care and Head of Strategic Commissioning, Tees Esk and Wear Valley NHS Foundation Trust, Housing Hartlepool and Connected Care on services currently provided.

5.8 Following evidence from service providers, Members expressed concern that Hartlepool residents may not be aware of the types of support services available to them and queried what measures were in place to address this issue. Members were advised by a representative from Connected Care, that welfare notices were a means of identifying anyone in need of support.

5.9 Members queried whether Housing Hartlepool's Telecare Team had received dementia awareness training, to enable any concerns to be identified during home visits. Members were advised that the Adult Social Care department of Hartlepool Borough Council has been successful in providing a three day intensive training course to a wide range of providers, including Housing Hartlepool staff. To support this training, it was the aim to carry out regular review meetings with staff to discuss any patient concerns.

5.10 At a further meeting of the Forum on 11 March 2013, Members identified that appropriate training of staff who provide social care services across all organisations, particularly to dementia suffers, was crucial in order to deliver a good standard of care to older people. The Forum recommended that the JSNA entry for older people should be updated to incorporate reference to the importance of training.

5.11 Members went on to stress that continuity of care and a co-ordinated approach from all health and social care agencies was very important to those who use social care services, particularly when there was a diagnosis of dementia. The Head of Strategic Commissioning highlighted examples of the processes for reablement and hospital discharge, but it was recognised that there were areas of health and social care still working in silos. The Forum also recognised that maintaining the continuity of care staff was very difficult and due to the nature of the sector staff regularly moved on to other positions.

5.12 Concerns were raised by the Forum in relation to the issue of isolation in the elderly community, identifying that the only people elderly residents may have contact with are those from social care or housing services. Representatives from the agencies present at the meeting on 23 October 2012 acknowledged that whilst progress had been made there was further work required in this respect.

**What evidence is there for effective intervention?**

5.13 At the meeting of the Adult and Community Services Scrutiny Forum on 11 March 2013, Members received evidence from the Head of Strategic

Commissioning from Hartlepool Borough Council in relation to evidence for effective intervention. Members commented that when the 'level of need' figures contained within the JSNA entry, were updated for the 2011 census results, the level of need was likely to increase significantly and therefore the effectiveness of intervention may fall. It was also recognised that current cuts to funding meant that the provision of social care services were reducing and there was a risk that in the future only statutory services would be provided, which was not a situation service users or providers wished to see.

*Projected and unmet needs*

5.14 At the meeting of the Adult and Community Services Scrutiny Forum on 3 December 2012, Members considered evidence from the Assistant Director of Adult Social Care and the Head of Strategic Commissioning from Hartlepool Borough Council and NHS Tees in relation to the following JSNA questions:-

- What is the projected level of need/service use?
- What needs might be unmet?

**What is the projected level of need / service use?**

5.15 Members requested clarification regarding the levels of reablement services available. The Head of Strategic Commissioning confirmed that there were a range of services available. In terms of short term input from the Council's reablement team, early performance measures indicated that 75% of people receiving this support achieved the outcomes identified at the beginning of the process. The aim was to provide low level support and early intervention.

**What needs might be unmet?**

5.16 The impact of the welfare reforms was identified by Members as an area of concern. The Head of Strategic Commissioning, from Hartlepool Borough Council advised the Forum that it was difficult to determine the full impact of the incremental rise in the number of older people affected by the reforms and work was currently ongoing to identify projections in this regard. However, it was anticipated this would include an increase in homelessness, as well as further pressures on health and social care.

5.17 A Member commented on the importance of addressing the needs of older people and emphasised the importance of ensuring reporting and communication arrangements were in place for information to feed into the Health and Wellbeing Board from its sub-groups. The importance of clear communication links between the Health and Wellbeing Board and Clinical Commissioning Group was also emphasised, as well as the need to avoid duplication of information feeding in to the Health and Wellbeing Board.

5.18 Reference was made to the potential increased dependence on crisis level support and the importance of improving communication methods to alleviate this problem. In response, a representative from NHS Tees advised

Members that there was a close working relationship between the Public Health team, the CCG and the North East Public Health Observatory to facilitate a more strategic planning approach to day to day health care needs.

5.19 A query was raised by the Forum in relation to the potential numbers of patients suffering with dementia who remain undiagnosed. It was highlighted by the Head of Strategic Commissioning that the level of awareness and screening had increased. Members highlighted the benefits of raising dementia awareness and the Forum sought clarification on the impact of ongoing budget cuts on services of this type. Members were advised by the Assistant Director of Adult Social Care, of the arrangements in place to minimise the impact of reductions in funding as well as the aims and priorities of the service.

5.20 The Forum expressed further concern in relation to the impact of budget cuts on the level and types of support available to vulnerable people living at home with early onset dementia, who may be better supported in residential care. The Assistant Director of Social Care advised the Forum of the assessment process including eligibility criteria and emphasised that there were no plans at the present time to review eligibility criteria.

*Views and Comments*

5.21 At the meeting of the Adult and Community Services Scrutiny Forum on 11 February 2013, Members received evidence from the Assistant Director of Adult Social Care and the Head of Strategic Commissioning from Hartlepool Borough Council and representatives from NHS Tees, in relation to the following JSNA questions:-

- What do people say?
- What additional needs assessment is required?

In addition to receiving evidence, Members undertook a consultation to enable members of the public, service users and local organisations that offer support to older people, to share their views.

**What do people say?**

5.22 Members of the Forum raised concerns regarding the lack of information available in leaflet format and it was suggested that Hartbeat be utilised to communicate more accessible information in clear language. Whilst it was acknowledged that there was more information available electronically as opposed to hard copy format, the Head of Strategic Commissioning provided assurances that this issue had been noted and was included as an action in the Older People's Strategy.

5.23 The importance of the need to target the independent older person, who had never accessed the services in place and was potentially a higher risk of isolation, was highlighted.

5.24 Members recommended that the views expressed regarding services for older people be incorporated into the JSNA, where appropriate.

**What additional needs assessment is required?**

5.25 In response to concerns raised regarding the level of enabling services available to dementia patients, such as physiotherapy, the NHS Tees representative stated that this was a recognised issue nationally and various schemes were currently being explored to manage this problem.

**What are the recommendations for commissioning?**

5.26 At the meeting of the Forum on 11 March 2013 following a presentation by the Head of Strategic Commissioning in relation to the JSNA entry as a whole, Members were supportive of the commissioning priorities indentified, but expressed frustration that the JSNA website did not as yet contain the entries submitted to NHS Tees. Members recommended that representations were made by the Forum to the Health and Wellbeing Board regarding timely updating of the JSNA website going forward.

5.27 The Forum recognised that support for older people within Hartlepool was not solely the responsibility of those organisations that provided social care and health services. In order to enable older people to live independently a whole life approach was needed, and this was an area for which the community as a whole needed to accept responsibility.

5.28 In addition to the recommendations contained within the JSNA entry for older people a number of further recommendations were suggested, as detailed 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 Adult and Community Services 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 That greater promotion of the care available to help people retain their independence and remain within their own homes is undertaken in conjunction with partner organisations, particularly in relation to dementia sufferers, where concerns over retaining independence may prevent people from seeking an early diagnosis, and that any information produced is clear and concise.

2 That in order to ensure that awareness of conditions such as dementia is maintained amongst providers of services to older people and their staff, Hartlepool Borough Council undertakes the following:-

i re-delivers dementia awareness training to partner organisations at appropriate intervals; and
ii incorporates reference to the importance of appropriate training for all service providers in the 'older people' JSNA entry.

3 That further work is undertaken, in conjunction with partner organisations, to reduce social isolation amongst older residents in Hartlepool, particularly in relation to those people who are more independent and may never previously have accessed services.

4 That in order to address the needs of older people and avoid the duplication of information feeding into the Health and Wellbeing Board, clear and appropriate reporting and communication arrangements are put in place.

5 That in order to maintain JSNA entries as living documents and reflect the current views and issues faced by service users and their families, the results of the public consultation exercise undertaken by the Adult and Community Services Scrutiny Forum and any further public consultations held in the future by Hartlepool Council and partner organisations, be considered for inclusion in the appropriate JSNA entry and are also incorporated as part of the older peoples strategy review.

6 The Health and Wellbeing Board make representations to the appropriate public health body to ensure that the Hartlepool 'Older People' JSNA entry is uploaded on to the website as soon as possible and that future updates supplied by Hartlepool Borough Council in relation to the 'Older People' entry are carried out with appropriate timescales.

**COUNCILLOR CARL RICHARDSON**
**CHAIR OF THE ADULT AND COMMUNITY SERVICES 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:
Jill Harrison – Assistant Director of Adult Social Care
Phil Hornsby – Head of Strategic Commissioning

External Representatives:
Lorraine Ferrier – Tees, Esk and Wear Valley NHS Foundation Trust
Richard Harrety – NHS Tees
Ray Harriman – Connected Care
Rachael Maughan – Connected Care
Dr Boleslaw Posmyk – CCG
Andy Powell – Hartlepool Housing
Caroline Ryder-Jones – Tees, Esk and Wear Valley NHS Foundation Trust
John Stamp – NHS Tees
Julie Stevens – NHS Tees
Jacqui Straughan – Tees, Esk and Wear Valley NHS Foundation Trust
Pauline Townsend – North Tees and Hartlepool NHS Foundation Trust
Dr Chris Ward – North Tees and Hartlepool NHS Foundation Trust
Jan Weedall – Housing Hartlepool

**Appendix A**

**Evidence provided to the Forum**

The following evidence was presented to the Adult and Community Services Scrutiny Forum throughout the course of the investigation into the JSNA topic of 'Older People':-

| Date of Meeting | Evidence Received |
|---|---|
| 30 July 2012 | Scoping Report – *Scrutiny Support Officer* |
| 17 September 2012 | Setting the Scene Presentation – *Assistant Director Adult Social Care and Head of Strategic Commissioning* |
| 23 October 2012 | Presentation – Service Provision and Effective Intervention – *Representatives from Providers of Older People's Services* |
| 3 December 2012 | Presentation – Projected Level of Need – *Representatives from the Council's Adult Social Care Services and NHS Tees* |
| 11 February 2013 | Presentation – What People Say and Additional Needs Assessment Required - *Representatives from the Council's Adult Social Care Services and NHS Tees* |
| 11 March 2013 | Presentation –Hartlepool JSNA Entry – *Head of Strategic Commissioning*<br><br>Feedback from the 'what people say' group exercises. |

**Appendix D**

**Report of:** CHILDREN'S SERVICES SCRUTINY FORUM

**Subject:** FINAL REPORT – INVESTIGATION INTO THE JSNA TOPIC OF 'EMOTIONAL AND MENTAL WELLBEING'

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## 1. PURPOSE OF REPORT

1.1 To present the findings of the Children's Services Scrutiny Forum following its investigation into the Joint Strategic Needs Assessment (JSNA) topic of 'Emotional and Mental Wellbeing'.

## 2. BACKGROUND

2.1 The Children's Services Scrutiny Forum met on the 31 July 2012 to consider their Work Programme and agreed that the Forum would in 2012/13 focus on the following JSNA topic:-

Emotional and Mental Wellbeing – Some people with mental health problems may need access to services and those services need to be inclusive and person centred.

2.3 The Marmot principle, 'Giving every child the best start in life' was the overarching principle which the Forum used to measure the provision of Council Services throughout their investigation into Emotional and Mental Wellbeing. The priority objectives and policy recommendations in relation to this principle being:-

**Priority Objectives:-**

(a) Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.

(b) Ensure high quality maternity services, parenting programmes, childcare and early year's education to meet need across the social gradient.

(c) Build the resilience and well-being of young children across the social gradient.

**Policy Recommendations**

(a) Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused progressively across the social gradient.

(b) Support families to achieve progressive improvements in early child development, including:

- Giving priority to pre and post-natal interventions that reduce adverse outcomes of pregnancy and infancy.
- Providing paid parental leave in the first year of life with a minimum income for healthy living.
- Providing routine support to families through parenting programmes, children's centres and key workers, delivered to meet social need via outreach to families.
- Developing programmes for the transition to school.

(c) Provide good quality early years education and childcare proportionately across the gradient. This provision should be:

- Combined with outreach to increase the take-up by children from disadvantaged families
- Provided on the basis of evaluated models and to meet quality standards.

## 3. MEMBERSHIP OF THE CHILDREN'S SERVICES SCRUTINY FORUM

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

Councillors C Akers-Belcher, Atkinson, Fleet, Giffin, Loynes, Simmons and Wilcox.

Co-opted Members: Sacha Paul Bedding and Michael Lee.

Young People's Representatives: Ashleigh Bostock, Leonie Chappell, Helen Lamb and Sean Wray.

## 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 'Emotional and Mental Wellbeing' topic within Hartlepool's Joint Strategic Needs Assessment, whilst reflecting (where possible / appropriate) on the Marmot principle to 'Giving every child the best start in life'.

## 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 5.39 of this report. Details of evidence presented to the Forum are attached as **Appendix A.**

5.2 At the meeting of the Children's Services Scrutiny Forum on 4 September 2012 Members received a setting the scene presentation from the Assistant Director, Prevention Safeguarding and Specialist Services, the Principal Education Psychologist and the Strategic Commissioner – Children's Services. The presentation covered the following JSNA questions:-

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

**What are the key issues?**

5.3 A Member questioned the data presented to the Forum in relation to Hartlepool. The Strategic Commissioner – Children's Services confirmed that the statistics used were based on data provided by the Office for National Statistics, along with the published findings from a number of clinical and academic studies. Members were concerned to note that there was a lack of detailed information about the range and types of conditions that young people experience in Hartlepool and no clear picture of the number of young people with mental health problems.

5.4 Members emphasised the importance of joined up working with the Health and Wellbeing Board and the Clinical Commissioning Groups to ensure that a clear picture of the numbers of young people accessing services was obtained as this was needed to influence and support the commissioning of emotional and mental wellbeing services for young people going forward.

5.5 Early intervention was identified as a key issue and Members noted that working together with schools and other settings to improve this was vital.

**Who is at risk and why?**

5.6 Members received details of the 'did not attend' Child and Adolescent Mental Health Service (CAMHS) appointments for the year 2011/12 and suggested that more detailed follow up work on instances where children and young people failed to attend scheduled appointments should be undertaken, to determine the reasons for non-attendance.

5.7 In relation to resilience factors identified by the Principal Educational Psychologist, Members commented that there should be mapping between Early Intervention Strategies to highlight what the local authority should be doing. The importance of making the most of any funding mechanisms available to support young people was emphasised, including support beyond the school years. It was suggested that schools within communities and teachers should prioritise the emotional and mental wellbeing of young people when exploring ways to make school improvements and when setting budgets.

**What is the level of need?**

5.8 Members expressed concern at the ongoing problems with the downturn in the economic climate and how this would affect larger families. The Principal Education Psychologist confirmed that currently the local authority continued to fund support for children and young people with special educational needs and in addition, schools currently bought back the service of education psychologists with a view to providing early intervention support where appropriate.

5.9 The Forum expressed surprise at the national figure of 95% of imprisoned young offenders having mental health problems and heard that this may not apply in Hartlepool, due to the significant role that the youth offending team played in prevention. The importance of ensuring that key questions were being asked of the children and young people when they were brought to the attention of Youth Offending, to help identify mental issues was emphasised. The Assistant Director, Prevention, Safeguarding and Specialist Services confirmed that the Youth Offending Services had the support of a dedicated nurse seconded from the Primary Care Trust and part of her role was to provide a holistic review of the health needs of children and young people known to the service. In addition to this, the nurse works with the prevention team in triage alongside the police in order to prevent children and young people from offending.

5.10 Members felt that the risk and resilience factors presented to the Forum were very important in early intervention strategies as these provided a clear steer to the local authority around how services should be configured to support children and young people.

5.11 Members recognised the importance of risk and resilience factors within the child, the family and the community and highlighted that consideration should be given to these factors when considering the budget setting process, in particular the positive outcomes items such as sport and leisure activities can achieve. Members felt that removing funding for such activities might exacerbate problems and cause more children to move towards an emotional and mental wellbeing assessment of 'at risk'. Members felt that they needed to be fully aware of the wider implications of making such budgetary decisions.

**What services are currently provided?**

5.12 During a meeting of the Children's Services Scrutiny Forum on 9 October 2012 Members received evidence from representatives from Hartlepool Council Child and Adult Services Department, Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) and NHS Tees, in relation to the services currently provided to support the emotional and mental wellbeing of children and young people in Hartlepool.

5.13 Members raised a query as to the processes in place to ensure families were being referred to the relevant agency within a reasonable timescale. The Head of Resource and Locality Teams from Hartlepool Borough Council commented on the aspirations of the Early Intervention Strategy to ensure support workers were active in the localities, and assurances were provided that support was available where necessary.

5.14 The Forum discussed the level of educational support for young people experiencing general, emotional and mental health problems as well as school nurse arrangements, it was noted that a review was currently being undertaken in relation to nursing support in schools.

5.15 Members were pleased to note that, where possible, Tier 2 services would be more locally based as opposed to hospital based and Members were keen for this arrangement to continue (Tier 2 services are those provided where a child or young person has been identified as requiring additional support, but does not have complex needs).

5.16 During evidence presented by TEWV and NHS Tees, Members were pleased to note that waiting times for CAMHS appointments had reduced from six to four weeks, but were keen to see these times reduce even further.

5.17 Members queried the 'self referral' process and questioned the impact increasing numbers of referrals would have on service capacity. The Forum was advised by representatives from TEWV, that a quality improvement event would take place and would include referrers, young people, their families and stakeholders to assist the development and design of the self-referral process.

5.18 Members commented that a successful early intervention strategy, whilst initially increasing the numbers of referrals, should reduce the numbers of young people eventually requiring tier 3 (complex needs) interventions.

5.19 The increasing numbers of referrals were discussed and Members commented that this may be due to a greater understanding of conditions and easier referral routes, as well as an increase in the prevalence of such conditions.

5.20 The importance of signposting to the correct service at an early stage was reiterated as well as the need to examine the success of the strategy, and determine whether early intervention had been successful. The need to consider non-recurring funding issues, assess local demand and explore the implications of a shift in funding was emphasised.

5.21 In response to a request for clarification regarding what improvements would be made to ensure clearer pathways into services, it was reported that a quality improvement system would be developed and utilised to deliver improvements of this type. Arrangements would be made to examine how

various groups/partners, including the third sector, could work together with a view to determining an improvement plan.

5.22 The Portfolio Holder for Children's and Community Services attended a meeting of the Forum on 12 March 2013 to share her views on the current emotional and mental wellbeing services provided for children and young people in Hartlepool.

5.23 The Portfolio Holder expressed the view that emotional and mental wellbeing services for children and young people were vital to the health of children in the town, especially at a time of economic downturn. The range of services delivered through both the voluntary and community and public sector supported a high number of children, but there was a lack of intelligence on which children were receiving services from where. The Portfolio Holder also felt more could be done to map local need to understand what services are required by children and what works so that these services could then be invested in.

5.24 The Portfolio Holder commented that the CAMH service did meet the needs of the children who were referred, in particular when there was a clear mental well being need identified that could be treated. However, the Portfolio Holder felt that how these services were organised and delivered should be reviewed, as she believed that more could be done to support the emotional and mental wellbeing of children if the services provided were more integrated with other services for children and young people.

5.25 Members agreed with the Portfolio Holder's concerns and highlighted that she had raised the same issues the Forum had raised throughout the investigation.

5.26 Representatives from Tees, Esk and Wear Valley NHS Foundation Trust, who were also in attendance at the meeting, agreed that the benefits of information sharing and joint working were great and more should be done in this area, especially given the current economic climate. Members suggested that Hartlepool Borough Council should work in partnership with the Trust to map current services and explore alternative models for service delivery, including a single point of access.

5.27 The representatives from TEWV highlighted the ways the services was changing to be more person centred, including proposals the workforce had suggested to make the service more accessible. The Forum welcomed these proposed changes.

**What do people say?**

5.28 At the meeting of the Children's Services Scrutiny Forum on 12 February 2013, Members undertook a consultation exercise to enable service users, members of the public and local organisations that offer support to young

people experiencing emotional and mental wellbeing issues, to share their views on services currently provided.

5.29 The Forum gathered a large number of views in relation to 'what makes a difference', 'what is not currently effective' and 'what service users would like to see provided going forward'. Overall, the responses were very much in favour of a 'person centred' model of service delivery, involving more outreach work, in less clinical surroundings.

5.30 The majority of respondents felt that there was a stigma attached to mental health issues and many service users said they felt uncomfortable with clinical settings in specific locations, where people would know the reason for their attendance. Another issue raised was the timing of appointments, which sometimes meant missing school lessons, which resulted in the young person having to explain where they had been.

5.31 The Forum considered the responses in detail and recommended that in order to maintain the JSNA as a living document and reflect the current views and issues faced by service users and their families, the results of the public consultation exercise undertaken by the Forum should be reflected in the Mental and Behavioural Disorders JSNA entry, where appropriate.

5.32 Members discussed the responses received regarding the Home and Hospital Education Service and recognised the good work the service does for children unable to access a mainstream education environment. Concerns were raised that the demand for such services would only increase in the future and that given the facilities currently available and the size of the service, Members recommended that a review should be undertaken of the Home and Hospital Education Service provision, taking into consideration the issues raised as part of the Children's Services Scrutiny Forum consultation exercise. Members felt that this should include a review of the learning platform and a reconfiguration of services to improve support to children unable to access mainstream learning.

**Additional needs assessment required, unmet and projected level of need/service use**

5.33 At the meeting of the Forum on 12 March 2013, Members considered the JSNA entry into Mental and Behavioural Disorders (Children) as a whole.

5.34 The Forum felt that some of the responses to the questions outlined in the JSNA entry needed to be strengthened, as they did not contain enough detail. Members felt that without the appropriate level of detail and evidence the value and usefulness of the JSNA entry was reduced. It was suggested that the information and views gathered throughout the course of the investigation by the Children's Services Scrutiny Forum should be included in the JSNA entry.

5.35 Members again raised concerns regarding the use of national statistics extrapolated to reflect the Hartlepool population, as this did not give a true reflection of the actual need for emotional and metal wellbeing support within the town. It was felt that this was particularly relevant given the current economic climate and the fact that Hartlepool has high levels of deprivation and poverty, which would skew the figures.

5.36 Members expressed frustration at the inability to identify specific numbers of young people who needed help, due in part to the difficulties in sharing information across a number of services, all with differing IT systems. It was recommended that organisations that work with children with emotional and metal wellbeing issues ensure that information is shared effectively fostering a culture of collaboration with all partners who make up the team around the child.

**What evidence is there for effective intervention?**

5.37 The Forum was supportive of the evidence for effective intervention identified within the JSNA, at the meeting of the Forum on 12 March 2013, though it was noted that this was based on National Institute of Clinical Excellence (NICE) guidelines, rather than detailing effective intervention in Hartlepool.

**What are the recommendations for commissioning?**

5.38 At the meeting of the Forum on 12 March 2013 Members considered the JSNA entry as a whole. Members were supportive of the commissioning priorities indentified.

5.39 In addition to the recommendations contained within the JSNA entry for Mental and Behavioural Disorders (Children) a number of further recommendations were suggested, as detailed 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 Children's Services 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 that:-

1 In order to ensure that the Hartlepool JSNA entry for Mental and Behavioural Disorders (Children), best reflects the needs and services required by the local population, the Health and Wellbeing Board make representations to the Clinical Commissioning Groups regarding:-

(a) the importance of obtaining actual data in relation to the range and types of conditions that young people experience in Hartlepool, rather than prevalence data; and

(b) as part of future commissioning strategies the provision of actual data sets are included as part of the contract.

2 Work is undertaken, in conjunction with partner organisations and service providers, to investigate the reasons behind young people not attending pre-arranged CAMHS appointments and action taken to address this where non attendance relates to service configuration or delivery. Hartlepool Borough Council will work in partnership with Tees, Esk and Wear Valley NHS Foundation Trust to map current services and explore alternative models for service delivery, including a single point of access.

3 Departmental budget consultation proposals provide Members with information in relation to the potential wider implications of proposals and details of the less visible impact these options may have on children and young people.

4 In order to maintain the JSNA as a living document and reflect the current views and issues faced by service users and their families, the results of the public consultation exercise undertaken by the Children's Services Scrutiny Forum, be reflected in the Mental and Behavioural Disorders JSNA entry, where appropriate. The JSNA entry should be also be updated to reflect the areas of collaborative working identified to be taken forward during the course of the investigation.

5 Hartlepool Borough Council works in conjunction with Tees, Esk & Wear Valleys NHS Foundation Trust; schools, and other partner organisations including the voluntary and community sector to address the issues raised as part of the Children's Services Scrutiny Forums public consultation exercise by:-

(a) increasing awareness of emotional and mental wellbeing issues amongst children, young people, parents, carers and professionals, and promotes the services that are available, providing details of how to access those services, in places frequented by young people;

(b) developing/providing emotional and mental health training accessible to all professionals who work with children and young people, to promote early intervention and the correct referral processes; and

(c) developing ways of increasing community based services, and addressing the issues raised by young people attending Dover House.

6 A review is undertaken of the Home and Hospital Service provision, taking into consideration the issues raised as part of the Children's Services Scrutiny Forum consultation exercise. This should include a review of the access to and use of the learning platform to support wider access to the curriculum and

a reconfiguration of services to improve support to children unable to access mainstream learning.

7 Organisations that work with children with emotional and metal wellbeing issues ensure that information is shared effectively, fostering a culture of collaboration with all partners who make up the team around the child.

**COUNCILLOR CHRISTOPHER AKERS-BELCHER**
**CHAIR OF THE CHILDREN'S SERVICES 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:
Councillor Cath Hill – Portfolio Holder for Children's and Community Services
Jacqui Braithwaite – Principal Educational Psychologist
Deborah Gibbin – Health Improvement Practitioner
Ian Merritt – Strategic Commissioner – Children's Services
Sally Robinson – Assistant Director, Prevention Safeguarding and Specialist Services
John Robinson – Head of Resource and Locality Teams
Officers from Child and Adult Services who assisted in the consultation exercise undertaken by the Forum

External Representatives:
Chris Davis – Tees, Esk and Wear Valley NHS Foundation Trust
Dr Simon Forster – Tees, Esk and Wear Valley NHS Foundation Trust
Chris McEwan – NHS Tees
Dr Mike Smith – NHS Tees

**Appendix A**

**Evidence provided to the Forum**

The following evidence was presented to the Children's Services Scrutiny Forum throughout the course of the investigation into the JSNA topic of 'Emotional and Mental Wellbeing':-

| Date of Meeting | Evidence Received |
|---|---|
| 31 July 2012 | Scoping Report – *Scrutiny Support Officer* |
| 4 September 2012 | Setting the Scene Presentation – *Assistant Director, Prevention Safeguarding and Specialist Services* |
| 9 October 2012 | Report – Emotional and Mental Wellbeing Service Provision – *Assistant Director, Prevention Safeguarding and Specialist Services*<br><br>Presentation –Overview of CAMHS Provision provided by TEWV in Hartlepool – *Representatives from Tees, Esk and Wear Valley NHS Foundation Trust* |
| 11 December 2012 | Presentation – Hartlepool Draft Mental Health JSNA Entry – *Head of Service Adult Mental Health and Representatives from TEWV* |
| 12 March 2013 | Verbal evidence from the Portfolio Holder for Children's and Community Services<br><br>Verbal evidence from Tees, Esk and Wear Valley NHS Foundation Trust<br><br>Presentation – Hartlepool Draft JSNA Entry, Mental and Behavioural Disorders (Children) – *Strategic Commissioner – Children's Services*<br><br>Feedback from the 'what people say' group exercises. |

**Appendix E**

**Report of:** NEIGHBOURHOOD SERVICES SCRUTINY FORUM

**Subject:** FINAL REPORT – INVESTIGATION INTO THE JSNA TOPIC OF 'ENVIRONMENT'

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## 1. PURPOSE OF REPORT

1.1 To present the findings of the Neighbourhood Services Scrutiny Forum following its investigation into the Joint Strategic Needs Assessment (JSNA) topic of 'Environment'.

## 2. BACKGROUND

2.1 The Neighbourhood Services Scrutiny Forum met on the 1 August 2012 to consider their Work Programme and agreed that the Forum would in 2012/13 focus on the following JSNA topic:-

Environment - The environment people live in is critical to a sense of health and wellbeing. The quality of air, water, noise pollution and cleanliness across the town is often of concern to residents. Therefore, services need to be provided and monitored to ensure a clean and healthy environment.

2.4 The Marmot principle, 'Create and develop healthy and sustainable places and communities' was the overarching principle which the Forum used to measure the provision of Council Services throughout their investigation into 'Environment'. The priority objectives and policy recommendations in relation to this principle being:-

**Priority Objectives:-**

(a) Develop common policies to reduce the scale and impact of climate change and health inequalities.

(b) Improve community capital and reduce social isolation across the social gradient.

**Policy Recommendations**

(a) Prioritise policies and interventions that reduce both health inequalities and mitigate climate change, by:

- Improving active travel across the social gradient;
- Improving the availability of good quality open and green spaces across the social gradient;
- Improving the food environment in local areas across the social gradient;

- Improving energy efficiency of housing across the social gradient.

(b) Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.

(c) Support locally developed and evidence based community regeneration programmes that:
- Remove barriers to community participation and action
- Reduce social isolation.

## 3. MEMBERSHIP OF THE NEIGHBOURHOOD SERVICES SCRUTINY FORUM

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

Councillors Beck, Cook, Gibbon, Jackson, Loynes, Payne and Tempest.

## 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 'Environment' topic within Hartlepool's Joint Strategic Needs Assessment, whilst reflecting (where possible / appropriate) on the Marmot principle to 'Create and Develop Healthy and Sustainable Places and Communities'.

## 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 5.34 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 Neighbourhood Services Scrutiny Forum on 19 September 2012 Members received a setting the scene presentation from the Director of Regeneration and Neighbourhoods. The presentation covered the following Environment JSNA questions:-

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

**What are the key issues?**

5.3 The Forum was supportive of the key issues identified within the JSNA at the meeting of the Forum on 19 September 2012 and at the meeting of the Forum on 20 March 2013, where the JSNA entry was presented as a whole.

**Who is at risk and why?**

*Enforcement*

5.4 A Member questioned whether there were particular areas of the town targeted for enforcement activity in relation to dog fouling and litter. The Waste and Environmental Services Manager confirmed that due to the level of resources available, areas known as hot spot areas were targeted including the town centre, Seaton and the Headland promenades. However, when reports of excessive litter in other areas were received they were always responded to.

5.5 Members indicated that they would like to see an increase in enforcement activity and innovative ways of delivering services investigated, though it was recognised that this would need to form part of future budget considerations.

*Bathing Water Quality*

5.6 At the meeting of the Forum on 20 March 2013, members received a presentation regarding bathing water from the Quality and Safety Officer from the Parks and Countryside Team. Members raised concerns regarding the loss of the blue flag status at Seaton Carew. Members were advised that the new bathing water directive, which had been introduced, was twice as stringent as the old testing regime and extremely heavy rainfall experienced last year had also affected the water quality readings for the area.

5.7 Members heard from a representative of Northumbrian Water that a collapsed storm outfall at Mainsforth Terrace had also added to the problems with the bathing water in the area. Work to repair this was ongoing, but had been delayed due to protected birds using the area over winter. The Forum was pleased to note that Northumbrian Water had recognised the poor water quality results at North Seaton and were factoring sewage modelling systems work into their business plan for 2015-2020.

5.8 A representative from the Environment Agency highlighted the effected the extreme weather had on water samples all over the country and advised the forum that during normal weather conditions the infrastructure in Hartlepool coped well with the water levels experienced.

*Drinking Water Quality*

5.9 At the meeting of the Forum on 20 March 2013, during a presentation by the Principal Environmental Health Officer with input from a representative from Hartlepool Water, Members noted that there was one private water supply in

Hartlepool, but several private distribution networks. Members heard that drinking water quality is heavily regulated, tested and was of good quality. The Council was required to carry out a full risk assessment of the private water supplies every 5 years. With regard to private distribution networks the landlord/owners were responsible for maintenance of the pipework and for managing any incidents which may affect water quality or supply.

**What is the level of need?**

5.10 Whilst Members recognised that the town was generally clean and looked after, it was acknowledged that the continuous promotion of the services and facilities available to recycle needed to be undertaken with a view to changing people's behaviour.

**What services are currently provided?**

*Cleanliness and Enforcement*

5.11 At the meeting of the Neighbourhood Services Scrutiny Forum on 19 December 2012, Members received evidence for the Environment Team in relation to cleanliness and enforcement. Following discussions regarding local environmental quality and the responsibilities undertaken by the street cleansing operatives, the importance of reporting any areas of concern in relation to litter problems was emphasised.

5.12 The problem of abandoned vehicles was discussed and the impact these vehicles had on communities, Members queried the definition of an abandoned vehicle and sought clarification regarding the powers available to remove such vehicles from outside peoples' homes. The Senior Environmental Enforcement Officer provided details of the powers available to the Council highlighting the various restrictions applied which prevent removal.

5.13 During evidence regarding enforcement activities reference was made to the higher level of fixed penalty notices issues in Hartlepool in respect of dog fouling in comparison to neighbouring authorities and the reasons for such levels were questioned. It was reported that given that Seaton Carew and the Headland were popular tourist attractions, there was a significant impact on the level of litter and dog fouling. It was noted that a significant number of fixed penalty notices were issued to non-Hartlepool residents.

5.14 The Forum raised a number of queries in relation to the level of patrols and enforcement arrangements to which the Senior Environmental Enforcement Officer provided clarification. Members discussed the potential benefits of extending the hours over which enforcement activities took place, given concerns raised that a number of incidents of dog fouling occurred outside current working hours.

5.15 The Forum was of the view that the option to delegate the power to issue fixed penalty notices to more officers of the Council was something that could be considered.

5.16 Concerns were raised regarding the problem of cigarette butts and various methods of addressing this town wide problem were discussed, which included approaching residents associations to assist with the distribution of ash trays and the need to review current fine levels. The Forum noted that the level of fines are set by the Government.

*Noise*

5.17 At the meeting of the Forum on 13 February 2013 Members received evidence from the Public Protection and the Community Safety Team in relation to the noise elements contained within the Environment JSNA entry.

5.18 The Forum were advised of the national noise action plan which requires the highways authority to implement an action plan to reduce the levels of traffic noise at specific locations in Hartlepool. A Member sought clarification on the timescales for resurfacing roads which were identified as requiring low noise surfaces, particularly if the road surface was relatively new. The Principal Environmental Health Officer confirmed that the next time the road was due to be resurfaced the low noise surfaces would be utilised, there was no requirement to resurface the road immediately.

5.19 Members questioned local authority powers to stop the continuous disturbance of noise in residential areas due to maintenance on properties. The Principal Environmental Health Officer confirmed that, if builders were causing a disturbance out of normal working hours, restrictions could be introduced to restrict their work to day time hours. However, it was recognised that any building works would cause a disturbance in the short term, and if this was at a time deemed acceptable there was little that could be done to stop it.

**What is the projected level of need / service use?**

5.20 At the meeting of the Neighbourhood Services Scrutiny Forum on 17 October 2012, Members received evidence in relation to the Climate Change element of the JSNA topic of environment. The Climate Change Officer outlined the process and benefits of the Collective Energy Switching Scheme in response to a number of queries raised by the Forum. Members commented on the need to publicise the scheme to residents acknowledging the continuing increase in fuel poverty in the town.

5.21 The Forum discussed renewable energy issues, the proposals to introduce wind turbines at Brenda Road and the potential benefits as a result. The Forum suggested that any income received in relation to this should be split between the Community Benefit Fund and the Invest to Save Scheme.

5.22 Members suggested that the use of solar panel water heaters on Council Buildings was investigated. The Forum also suggested that the least energy efficient Council buildings should be considered for disposal first.

**What evidence is there for effective intervention?**

5.23 Throughout the investigation, Members were advised of the service provided and resulting levels of interventions currently being undertaken by Hartlepool Borough Council and partner organisations. Members were satisfied that these were effective, though more could always be done to improve the local environment, as highlighted by the recommendations contained within section 6.

5.24 At the meeting of the Forum on 20 March 2013, Members considered the draft JSNA entry as a whole. Whilst acknowledging that the entry was the latest draft and was not yet live on the Tees JSNA website the Forum felt that there was a substantial amount of editing required to ensure the entry reflected the good work undertaken by the Council, but also contained the needs identified as being important to the health and wellbeing of the residents of Hartlepool. The Climate Change Officer advised Members that a number of suggested inclusions and rewording had already been passed to the site administrators at NHS Tees and this work would continue until the entry was signed off by Hartlepool Council as being ready to go live on the website.

5.25 Members questioned the authorisation process for updating the website once the document was live, and suggested that a system of authorisation was implemented to maintain the quality of the entry.

**What do people say?**

5.26 As part of the investigation in order to seek the views of residents on the JSNA topic of 'Environment' members of the Forum attended the North and Coastal and South and Central Neighbourhood Forum meetings held on 3 October 2012. A number of ward issues were raised in relation to the environment theme which were responded to by the Director of Regeneration and Neighbourhoods. Members were satisfied that the issues raised were covered by the investigation and resulting recommendations.

**What additional needs assessment is required?**

5.27 During the meeting of the Forum on 13 February 2013, Members were presented with evidence by the Community Safety Team in relation to the noise element of the environment topic.

5.28 Members discussed the proposed future anti-social behaviour powers and their impact on the Local Authority and the Police. The Director of Regeneration and Neighbourhoods confirmed that Government policy dictated whether Local Authorities or the Police had specific powers in relation to anti-social behaviour and whilst the new proposals were currently

going through Parliament as a draft bill, they might be amended before becoming becomes an Act of Parliament in April 2014. The Director of Regeneration and Neighbourhoods confirmed that the Police were suffering severe budget cuts similar to Local Government, so the implementation of any new regulations would need to be considered in partnership.

5.29 In relation to Community Protection Notices, a Member questioned how the decision was taken whether the noise being complained about was deemed a nuisance. The Neighbourhood Safety Co-ordinator confirmed that the officer attending the complaint would make a decision whether to issue a warning or a fine based on their opinion, after undergoing appropriate training. A Member highlighted a concern that any new proposals that transferred powers could de-skill Council officers. It was identified that, subject to the contents of the Act, the adoption and implementation of Community Protection Notices would required training for both Cleveland Police and Hartlepool Borough Council officers.

**What needs might be unmet?**

5.30 At the meeting of the Neighbourhood Services Scrutiny Forum on 19 December 2012, Members welcomed evidence from Cleveland Police, Chief Inspector for Neighbourhood Policing. It was recognised that the need for all partner organisations to work together to deliver services that meet the needs of communities in Hartlepool was greater than ever, particularly given the current economic climate.

5.31 Members of the Forum questioned the levels of enforcement activities that were currently undertaken by Neighbourhood Police Officers and Police Community Support Officers (PCSOs) and were advised that these were recorded on a force-wide level and were not broken down further into specific areas. It was agreed that more needed to be done to ensure that the powers available to all partners were linked to the priorities of the community to deliver services that yield the greatest impact. The Chief Inspector for Neighbourhood Policing identified such an area as working with partners to deliver the forces 'Pledge Operations'.

5.32 The Forum was supportive of further collaborative working to address the needs of communities, particularly in relation to enforcement activities, and felt that this should be represented in the JSNA entry for Environment.

**What are the recommendations for commissioning?**

5.33 At the meeting of the Forum on 20 March 2013 Members considered the JSNA entry as a whole. Members were supportive of the commissioning priorities indentified, though concerns were raised regarding the current quality and editing of the entry, as it was in draft form and contained several gaps. Members recognised that work was already underway to ensure the entry was updated prior to being uploaded onto the Tees JSNA website.

5.34 In addition to the recommendations contained within the JSNA entry for the environment topic a number of further recommendations were suggested, as detailed 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 Neighbourhood Services 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 That the following is undertaken in relation to the Environment JSNA entry:-

(i) the entry is updated, edited and authorised by Hartlepool Borough Council prior to being uploaded on the Tees JSNA website, and all future updates to the live document, including those supplied by partner organisations, are appropriately reviewed and authorised;

(ii) the entry reflects the increasing need for collaborative working between Hartlepool Borough Council and partner organisations to deliver services that address the priorities of local communities.

Over and above the Forum's comments in relation to the JSNA entry the following key recommendations were also made in relation to the development and delivery of future services:-

2 That the potential to expand the current enforcement activity undertaken by Hartlepool Borough Council is explored through:-

(i) further developing collaborative working arrangements with Hartlepool neighbourhood police to increase the use of enforcement powers currently available;

(ii) potential flexible working arrangements for Council Officers;

(iii) delegation of the power to issue fixed penalty notices to more Council Officers; and

(iv) working in conjunction with partner organisations, such as residents associations, to help reduce the problem of litter and dog fouling.

3 That consideration is given to splitting income received from the lease of land in relation to renewable energy projects between the Community Benefit Fund and the Invest to Save Scheme.

4 That in order to help reduce fuel poverty, current and future energy saving or cost reducing schemes, such as collective switching, are publicised as widely as possible, and via methods that include residents who do not have access to the internet, by Hartlepool Council and partner organisations.

5 That the energy efficiency of Council buildings is a factor taken into consideration when identifying possible assets for disposal.

6 That the use of solar panel water heaters on Council buildings is investigated.

**COUNCILLOR SYLVIA TEMPEST**
**CHAIR OF THE NEIGHBOURHOOD SERVICES 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:
Helen Beaman – Environment Co-ordinator
Alison Carberry - Senior Environmental Enforcement Officer
Adrian Hurst – Principal Environmental Health Officer
Paul Hurwood – Climate Change Officer
Debbie Kershaw – Quality and Safety Officer
Jane Kett – Principal Environmental Health Officer
Denise Ogden – Director of Regeneration and Neighbourhoods
Sylvia Pinkney – Public Protection Manager
Alastair Smith – Assistant Director Transportation and Engineering
Nicholas Stone – Neighbourhood Safety Co-ordinator
Craig Thelwell – Waste and Environmental Services Manager
Albert Williams – Property Manager
Jon Wright – Neighbourhood Co-ordinating Manager

External Representatives:
Kevin Ensell – Hartlepool Water
Graeme Hull – Environment Agency
Steve Jermy – Cleveland Police
Allan Snape – Northumbrian Water
Gamini Wijesinghe – Middlesbrough Council

Members of the Public
Gordon and Stella Johnson

**Evidence provided to the Forum**

The following evidence was presented to the Neighbourhood Services Scrutiny Forum throughout the course of the investigation into the JSNA topic of 'Environment':-

| Date of Meeting | Evidence Received |
|---|---|
| 1 August 2012 | Scoping Report – *Scrutiny Support Officer* |
| 19 September 2012 | Setting the Scene Presentation – *Assistant Director Neighbourhood Services* |
| 17 October 2012 | Presentation – Climate Change – *Climate Change Officer*<br><br>Information from the Health Protection Agency - Health Effects of Climate Change in the UK 2012 |
| 19 December 2012 | Presentation – One Planet Living – *Middlesbrough Council Community Protection Officer*<br><br>Presentation – Local Environmental Quality (Cleanliness) – *Environment Team*<br><br>Presentation – Hartlepool Neighbourhood Policing - *Chief Inspector of Neighbourhood Policing* |
| 13 February 2013 | Presentation – Noise – *Public Protection Team*<br><br>Presentation – Noise – *Community Safety Team*<br><br>Feedback from the North and Coastal and South and Central Neighbourhood Forums |

| | |
|---|---|
| 20 March 2013 | Presentation – Bathing Water Quality – *Parks and Countryside Team*<br>Presentation – Drinking Water Quality – *Public Protection Team*<br><br>Presentation – Air Quality – *Public Protection Team*<br><br>Hartlepool Draft JSNA Entry |

**Appendix F**

**Report of:** REGENERATION AND PLANNING SERVICES SCRUTINY FORUM

**Subject:** FINAL REPORT – INVESTIGATION INTO THE JSNA TOPIC OF 'EMPLOYMENT'

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## 1. PURPOSE OF REPORT

1.1 To present the findings of the Regeneration and Planning Services Scrutiny Forum following its investigation into the Joint Strategic Needs Assessment (JSNA) topic of Employment.

## 2. BACKGROUND

2.1 The Regeneration and Planning Services Scrutiny Forum met on the 2 August 2012 to consider their Work Programme and agreed that the Forum would in 2012/13 focus on the following JSNA topic:-

Employment - Increasing the number of people who are 'work ready' with the right skills to get local employment; helping people understand that they could have their own business, and help them to develop their entrepreneurial ideas.

2.5 The Marmot principle, 'Create Fair Employment and Good Work for all' was the overarching principle which the Forum used to measure the provision of Council Services throughout their investigation into Employment. The priority objectives and policy recommendations in relation to this principle being:-

**Priority Objectives:-**

(a) Improve access to good jobs and reduce long-term unemployment across the social gradient;

(d) Make it easier for people who are disadvantaged in the labour market to obtain and keep work; and

(e) Improve quality of jobs across the social gradient.

**Policy Recommendations**

(e) Prioritise active labour market programmes to achieve timely interventions to reduce long-term unemployment;

(f) Encourage, incentivise and, where appropriate, enforce the implementation of measures to improve the quality of jobs across the social gradient, by:

- Ensuring public and private sector employers adhere to equality guidance and legislation; and

- Implementing guidance on stress management and the effective promotion of wellbeing and physical and mental health at work.

(g) Develop greater security and flexibility in employment, by:

- Prioritising greater flexibility of retirement age; and

- Encouraging and incentivising employers to create or adapt jobs that are suitable for lone parents, carers and people with mental and physical health problems.

## 3. MEMBERSHIP OF THE REGENERATION AND PLANNING SERVICES SCRUTINY FORUM

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

Councillors Ainslie, Cranney, Dawkins, Hall (Chair), Payne, Sirs and Wells (Vice-Chair)

## 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 'Employment' topic within Hartlepool's Joint Strategic Needs Assessment, whilst reflecting (where possible / appropriate) on the Marmot principle to 'Create Fair Employment and Good Work for all'.

## 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 5.45 of this report. Details of evidence presented to the Forum is attached as **Appendix A.**

*Setting the Scene*

5.2 At the meeting of the Regeneration and Planning Services Scrutiny Forum held on 13 September 2012 and 11 October 2012, Members received a setting the scene presentation from the Economic Regeneration Team;

verbal evidence from the Member of Parliament for Hartlepool; and verbal evidence from the Mayor as Portfolio Holder for Regeneration and Neighbourhoods. The presentation and evidence 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?**

5.3 Members supported the key issues identified in the Employment JSNA entry. However, Members raised concerns about constrained access to business finance and questioned whether banks were lending money. It was confirmed by the Economic Regeneration Manager that banks were lending money but based on standing lending criteria. This was a fundamental issue because it was difficult for start up businesses to access finance based on standard lending criteria. The Assistant Director of Regeneration and Planning was aware of successful businesses being adversely affected by decisions made by banks.

5.4 Members recognised that one of the main key issues was decreasing levels of local pre-start up and start-up business support, particularly following the abolition of the Working Neighbourhoods Fund and Business Support Organisations. However, Hartlepool had made good progress on business start ups and Hartlepool's rate was above the Tees Valley and North East rate. Members were informed that business deaths had decreased and Hartlepool compared well with other localities.

5.5 The MP commented that the size of the Hartlepool economy was significantly smaller than the North East and UK averages which resulted in reduced economic activity. In addition to this, youth unemployment rates were high. The MP felt that this was due to young people not being able to gain employment because of lack of experience but not being able to gain experience because of not being able to get a job.

5.6 A key issue highlighted by the MP was long term unemployment and an over reliance on large employers, such as the Council and the NHS to provide employment. However, Members were very supportive of the fact that the engineering industries had the opportunity to increase employment and training opportunities within Hartlepool. Members emphasised the importance of the Council continuing to work together with the larger employers in the Tees Valley.

**What is the level of need?**

5.7 There are approximately 16 unemployed people for every vacancy in Hartlepool, which is the highest in the Tees Valley. Members welcomed securing investment and jobs through the offshore renewable energy sector, as Hartlepool is well placed geographically to attract this type of

development. The Mayor highlighted that Hartlepool College of Further Education provided key training in the areas of nuclear power, aeronautics, renewables and engineering. These courses provided essential training to the next generation of the workforce to meet the needs of employers in the local area.

5.8 In relation to the Talent Match funding provided by the National Lottery, Members were disappointed that Hartlepool had not qualified to receive any of the funding. However, other Tees Valley Local Authorities had been invited to submit a bid.

5.9 The Forum was very supportive of the key role that economic development played in supporting the health and wellbeing of the town. The Mayor emphasised the importance of the involvement of Hartlepool in the development of the Local Enterprise Partnership across the Tees Valley with the potential to secure further bids to the Regional Growth Fund. It was essential that the Economic Regeneration Strategy and the Health and Wellbeing Strategy ensured that resources were utilised in the best way possible to meet the needs of residents in Hartlepool.

**Who is at risk and why?**

5.10 The Forum acknowledged that skilled workers were critical to the growth and success of a business. Members recognised that the reduction in industrial and manufacturing jobs within Hartlepool had impacted on the workforce which had resulted in a reduced skilled workforce. Members drew attention to recent statistics that highlighted that there was a skills gap in certain trade areas, including engineering. Figures collated by the Local Government Association showed that in construction nationally, approximately 123,000 people trained for approximately 275,000 advertised jobs. Similarly, in hairdressing approximately 94,000 completed hair and beauty courses, but only 18,000 jobs were available. Currently, in Hartlepool there were 420 apprentices aged 16-18 at Hartlepool College of Further Education and 350 over the age of 19. Members were pleased to hear that Hartlepool had the second highest number of 16-18 year olds in learning in the North East, the figure was 84.3%. This compared to a National average of 80.8% and a regional average of 79.1%, with only North Tyneside having a higher number of 16-18 year olds undertaking further education.

5.11 The MP highlighted that more work was needed to encourage the growth of small businesses. It was suggested by the MP that schemes such as entrepreneurs going into primary and secondary schools would be beneficial and / or low cost start up units should be considered by the Council to encourage people to start their own businesses. In relation to women starting their own businesses, the MP indicated that the statistics revealed more women were starting their own businesses than men. However, there was still an expectation that businesses must always succeed first time. Members were of the opinion that a business failure should not be seen as a reason not to try again.

5.12 It was recognised by Members that the majority of start–up businesses were by people aged over 25. Members were very keen to encourage people under the age of 25 to start their own businesses or at least consider it as an option.

5.13 In relation to advice and resources available to new business start-ups. Members suggested the expansion of the One Stop Shop approach and how promotion should be inclusive of the harder to reach groups.

5.14 The MP was disappointed that the JSNA employment entry had not been uploaded onto the website and commented and that there was no statistical evidence to recognise and support the fact that employment reduces health inequalities.

*Service Provision*

5.15 At the meeting of the Regeneration and Planning Service Scrutiny Forum held on 13 December 2012, Members received a presentation from the Council's Economic Regeneration Team; the Council's School Improvement Advisor and representatives from a local school and college. Verbal evidence was received from the young people's representatives. The evidence presented covered the following JSNA questions:-

- What services are currently provided?
- What evidence is there for effective intervention?

**What services are currently provided and what evidence is there for effective intervention?**

5.16 The Economic Regeneration Team provided Members with details of the range of services and projects provided by the Council. These included the Hartlepool Youth Investment Project, Youth Guarantee Scheme, FamilyWise, Flexible Support Fund; Incubator Business Support; Regional Growth Fund, Enterprise Zone and City Deal.

5.17 The Forum was informed by the School Improvement Advisor that statutory entitlement to work experience had been removed by the Government in 2012. The Youth Parliament believed that the removal of statutory work experience from school was disappointing and had a negative impact when trying to prepare young people for the world of work. The young people suggested that work experience or an alternative should be re-introduced into schools.

5.18 Members raised concerns that young people were not encouraged to consider self employment as a career option. It was confirmed by the Economic Regeneration Manager that the Hartlepool Youth Investment Programme linked business enterprises with schools and colleges to ensure self employment was discussed as a career option.

5.19 The Forum questioned the options that were available to young people who did not achieve a GCSE level of education. The 11-19 Framework for

Economic Well-being was used across Hartlepool schools and the wider Tees Valley area to support young people into further education, training or employment. The school representative indicated that secondary schools had the responsibility to ensure that students were encouraged to achieve a GCSE standard of education and a personalised education programme was developed for all students based on whether they would be suited to achieving GCSE or vocational qualifications.

5.20 Members were of the view that age should not be a barrier to self-employment. However, the young people's representatives highlighted to Members that they did not have the option to study 'enterprise' at school. The Assistant Director of Regeneration and Planning confirmed that 'Young Enterprise' programmes were in place in some schools and offered as an extra curricula option to students in Years 10 and 12. These programmes were diverse in nature and focussed on the life span of a business from birth through to wind up. Members were strongly of the view that enterprise programmes should be introduced in all schools and also into youth centres to encourage entrepreneurial activity. It was suggested that programmes could include the option to set up a business within the school / youth centre, for example a tuck shop, which would provide young people with some of the practical skills needed for self employment. The promotion of business ventures should be shared with young people, for example, successes, such as the recent young person who sold his business for millions. It was acknowledged that people aged 50+ were also looking at self employment as an option.

5.21 Members viewed a DVD produced by the Wharton Trust which captured the views of young people on training, employment and education. The majority of young people on the DVD said that they would like to go onto further and higher education after school.

5.22 The Youth Parliament recommended to Members that it would be beneficial for colleges to make substantial links with employers to create work experience programmes. It would be beneficial if colleges and employers could develop a formal recruitment and selection process, the young people believed that this would be very beneficial as the employers could select through a formal and vigorous process and the young people would have an interest in the area as they would be studying it at college.

5.23 The young people believed that self employment opportunities were not very well promoted and suggested that agencies throughout the town needed to make young people more aware of where they can obtain information regarding employment. The young people did express concerns about promoting self employment at a young age as young people may not be equipped with the skills at a young age. However, schools and colleges should be encouraging young people to consider this as an option.

5.24 Members received an update on the progress in Hartlepool of the Department for Work and Pensions' Work programme. Members felt that there should be a more collective approach between the Local Authority and

the providers of the work programme as everyone is seeking the same outcomes. There were a number of concerns expressed by Members about the numbers of people in sustainable employment from the work programme in comparison to previous successful initiatives which secured employment, for example the Future Jobs Fund.

**What do people say?**

5.25 The Forum at their meeting of 21 February 2013 received evidence in relation to the JSNA question 'What People Say'. As part of the investigation, the Forum sought views from the North and Coastal and South and Central Neighbourhood Forum meetings held on 3 October 2012. A presentation regarding the investigation into Employment was delivered to the Neighbourhood Forums and members of the public were asked to answer questions on the subject and were also able to ask questions and raise any matters of concern.

5.26 Members of the Regeneration and Planning Services Scrutiny Forum welcomed the comments and views from the Neighbourhood Forums. A concern was raised at the Neighbourhood Forum meeting regarding the emphasis on qualifications. Members were of the view that schools should offer vocational and enterprise programmes tailored to young peoples' needs, aspirations and skills in order to provide young people with a variety of options, both academic and vocational.

*Level of Need*

5.27 At the meeting of the Regeneration and Planning Service Scrutiny Forum held on 21 February 2013, Members received a presentation from the Skills Funding Agency, National Apprenticeship Service, Hartlepool's Job Centre Plus and the Council's Director of Public Health. The evidence presented covered the following JSNA questions:-

- What is the projected level of need / service use?
- What needs might be unmet
- What additional needs assessment is required

**What is the projected level of need / service use?**

5.28 The representative from the National Apprenticeship Scheme, which supports, funds and co-ordinates the delivery of Apprenticeships throughout England confirmed that anyone aged between 16 and 65 can apply for an apprenticeship and grants were available for employers who were new to offering apprenticeships or had not offered an apprenticeship within the previous 12 months. Members were informed that the target for participation in Hartlepool for apprenticeships was 20% and currently the participation rate in Hartlepool was 15%.

5.29 In relation to apprenticeships, Members questioned whether people who had not achieved the expected academic qualifications could secure an

apprenticeship. Members were reassured that it was possible for people to secure an apprenticeship without the expected academic qualifications as there was additional support in place to help those people to achieve the appropriate academic qualifications. Although, this would be subject to the employers' requirements in relation to the essential qualifications and skills needed to commence employment within their company.

5.30 In relation to awareness of apprenticeships, Members were very interested to hear how people could be encouraged to apply for apprenticeships. Members welcomed the concept of traineeships, which would last up to six months and enable young people aged 16-18 years who were unemployed to gain skills required for work or an apprenticeship.

5.31 Members welcomed the introduction of the Environmental Apprenticeships which had been part funded from Members' Ward budgets. 15 people had been selected to undertake the apprenticeships.

5.32 Members questioned whether the Future Jobs Fund could be replicated by work programme providers. It was confirmed that Providers can offer advice and guidance on opportunities but it was the employers' decision whether to take part in an apprenticeship programme or offer permanent employment.

5.33 Members were mindful of the need to up skill the workforce but also the need to create longer term sustainable jobs. The Forum was supportive of the need for local authorities to be able to target funding for training into areas where there were local skills shortages, rather than targeted from Central Government. Members recognised that the City Deal bid was looking at direct links between trainers and employers to identify local need with the aim to channel funding into areas of need.

5.34 The Forum hoped that future health initiatives could focus on preventative actions to stop the escalation of ill health and mental health. For example, engaging with local people within their communities to promote health and encourage people who were long term unemployed to engage in community activities and develop new skills. Members were very supportive of a holistic approach to health and employment.

**What needs might be unmet?**

5.35 Members acknowledged that there were still high numbers of young people aged 18 – 24 years who were unemployed in Hartlepool and that joint working between schools, colleges, training providers and employers needed to continue.

5.36 In order to help people gain experience the Get Britain Working initiative provided work experience to those in receipt of Job Seekers Allowance. However, Members questioned what measures were in place to stop employers continually seeking people to undertake work experience at no cost. Members were pleased to hear that this initiative was managed very closely and if employers did take advantage of the service then discussions

would take place in order to create a waged vacancy or if this was not successful, the Job Centre would stop sending volunteers to that company. The Job Centre Plus highlighted that work was ongoing to develop work clubs within the community.

5.37 Concerns were raised by Members around the potential problem in the future of a shortage of industry workers due to an ageing workforce and people not being skilled to undertake jobs in industry. One of the ways to help tackle this issue was that many training providers were working with retired workers to provide training and share their skills.

5.38 In relation to funding, it was highlighted by Members that young people were volunteering within the Voluntary and Community Sector (VCS), but the VCS organisations could not access training and obtain funding for qualifications because there was no funding to access. The representative from the Skills Funding Agency confirmed that there would be opportunities for providers to work with VCS organisations.

5.39 Members discussed clawing back of funding and future budget allocations. Members questioned whether provider organisations that had not hit their targets would have more flexibility to offer alternative training. However, it was for the provider organisations to be proactive about marketing and delivering Government priorities.

**What additional needs assessment is required?**

5.40 The Forum was supportive of the additional needs assessment as identified in the JSNA entry for employment.

5.41 The Director of Public Health delivered a presentation to Members which highlighted the Marmot Principles and how employment can improve health and wellbeing but also how employment can sometimes have a negative impact on health and wellbeing, for example stress.

5.42 Members discussed mental health and raised concerns about people who were employed but were reluctant to talk about their health due to fear of loosing their jobs. The Director of Public Health strongly supported the need to talk about mental health and by doing this would in turn remove the stigma associated with mental health. Members highlighted that people who were long term unemployed may also suffer from mental health and often were offered no support when starting a new job. Good mental health was an essential part of improving a person's health and wellbeing. Members commented that it was for the local authority to set an example and lead the way in supporting employees and cascade the message to all staff about good mental health. Members strongly believed that employment was a big determinate of health. It was essential that people were aware of mental health services and Managers raised awareness of 'good mental health' to their staff, this could be done by asking people from mental health charities to talk to staff. Members felt that the Council should be taking the lead on health and wellbeing and promoting good mental health.

5.43 Members supported the need for the Council to generate investment and income. The Forum suggested rewarding staff for successful investment and income ideas and also creating an online suggestion box for staff to submit ideas.

**What are the recommendations for commissioning?**

5.44 The Forum was supportive of the recommendations for commissioning as detailed within the JSNA entry for employment.

5.45 In addition to the to the recommendations for commissioning identified in the JSNA entry, the Forum formulated the recommendations, outlined 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 Regeneration and Planning Services 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) That the Employment JSNA entry is uploaded onto the JSNA website and is updated on a regular basis to reflect the needs of Hartlepool residents, including statistical information to support how employment reduces health inequalities

2) That within the Employment JSNA entry, the need to encourage the growth of businesses in Hartlepool is identified as a key issue and that the Council:-

   (a) introduces schemes that promote entrepreneurial activity with specific focus on people under the age of 25. For example, entrepreneurs visiting primary and secondary schools to offer advice and mentoring and to highlight business successes and failures;

   (b) expands the current 'one stop shop' approach to provide advice and resources to new business start ups and to promote self employment opportunities including to the harder to reach groups; and

   (c) pursues funding and investment opportunities with companies, for example, explores offering investment

packages to new businesses, such as revolving loans, low interest funds and buying shares in growing companies

3) That partnership working is included in the JSNA entry and that the Council works with schools, colleges, training providers and employers to:-

(a) help support the implementation of the Hartlepool Youth Investment programme;

5 explore the option of creating work experience programmes for students at secondary school and college;

(c) introduce vocational and enterprise programmes in schools and use council services, for example, youth centres, to teach young people about self employment and help prepare young people for work by equipping young people with the right skills;

(f) widely communicate and publicise the local need for skills in the engineering, manufacturing and renewable energy sectors to encourage people to train in these areas, as local companies are suffering a shortage of skilled workers; and

(g) support the devolvement of training funds to local authorities to match training to the local need for skills

4) That the Council, through the Health and Wellbeing Board:-

(a) focus future health initiatives on preventative actions to stop the escalation of ill-health and mental health within communities; and

(b) raise awareness to Council employees of the mental health services available to enable employees to access the services if required

5) That the Council encourage staff to put forward ideas for investment and income generation, for example by rewarding staff for successful ideas and / or creating an online suggestion box for staff to submit ideas

**COUNCILLOR GERARD HALL**
**CHAIR OF THE REGENERATION AND PLANNING SERVICES 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:

Elected Mayor, Portfolio Holder for Regeneration and Neighbourhoods – Stuart Drummond

Damien Wilson – Assistant Director (Regeneration and Planning)

Louise Wallace – Director of Public Health

Antony Steinberg – Economic Regeneration Manager

Patrick Wilson – Employment Development Officer

Mark Smith – Head of Integrated Youth Support Services

Tom Argument – School Improvement Adviser

Kimberley Bell – Participation Worker

Hartlepool Youth Parliament

External Representatives:

Iain Wright, Member of Parliament for Hartlepool

Graeme Cadas – Job Centre Plus

Simon Wigington – National Apprenticeship Service

David Jackson – Skills Funding Agency

Lee Brown – Deputy Headteacher, Dyke House School

Jane Steel – Director of Curriculum, Hartlepool College of Further Education

Teresa Driver – Wharton Trust

**Appendix A**

**Evidence provided to the Forum**

The following evidence was presented to the Regeneration and Planning Services Scrutiny Forum throughout the course of the investigation into the JSNA topic of 'Employment':-

| Date of Meeting | Evidence Received |
|---|---|
| 2 August 2012 | Scoping Report – *Scrutiny Support Officer* |
| 13 September 2012 | Setting the Scene Presentation – *Economic Regeneration Manager*<br><br>Verbal Evidence – *Mayor as Portfolio Holder for Regeneration and Neighbourhoods* |
| 11 October 2012 | Verbal Evidence – *Member of Parliament for Hartlepool* |
| 13 December 2012 | Service Provision and Effective Intervention – Presentation – *Economic Regeneration Team, local school / college; Youth Support Service*<br><br>DVD – *Wharton Trust* |
| 17 January 2013 | Written Evidence – Feedback on the JSNA Topic of Employment – *Hartlepool Youth Parliament* |
| 21 February 2013 | Projected Level of Need / Service Use; Unmet Needs; Additional Needs Assessment – Presentation – *Representatives from Job Centre Plus, national Apprenticeship Service and The Skills Funding Agency* |
| 21 March 2013 | Verbal Evidence - Health and Employment – *Director of Public Health*<br>Recommendations for Commissioning – Presentation – *Economic Regeneration Team*<br>Verbal Evidence – *Hartlepool Youth Parliament* |

**Appendix G**

**Report of:** HEALTH SCRUTINY FORUM

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

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## 1. PURPOSE OF REPORT

1.1 To present the 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.

2.6 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 met 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*<br><br>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*<br><br>Presentation – Mystery Shop – *Young Inspectors* |
| 10 January 2013 | Evidence from voluntary and community groups, schools and the youth service<br><br>Written Report – The Teaching and Support of Sexual Health in Hartlepool Secondary Schools – *Headteacher, Manor College*<br><br>Hartlepool JSNA Entry<br><br>Report – You're Welcome Quality Standards – *Health Improvement Practitioner*<br><br>Report - Teenage Pregnancy Performance Report – *Director of Public Health*<br><br>Presentation – Need and Commissioning Priorities – *Director of Public Health* |

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

# ACTION PLANS

**Appendix 2(a)**

## OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN

**NAME OF FORUM:** Scrutiny Co-ordinating Committee

**NAME OF SCRUTINY ENQUIRY:** Overall JSNA and Poverty JSNA Topic

**DECISION MAKING DATE OF FINAL REPORT:** 28 June 2013

| RECOMMENDATION | EXECUTIVE RESPONSE / PROPOSED ACTION | FINANCIAL / OTHER IMPLICATIONS | LEAD OFFICER | COMPLETION DATE* |
|---|---|---|---|---|
| **Overall JSNA** | | | | |
| i) The scrutiny process highlighted weaknesses in the quality and content of some of the web based JSNA topic areas, with concerns expressed regarding a level of co-ordination between Council and the NHS in the development of entries; | The core offer of public health expertise to Clinical Commissioning Groups (CCG) will improve the process of completing JSNA.<br><br>The Health and Well Being Board including the Local Authority and the CCG as statutory partners places a duty to ensure the JSNA is completed and reviewed. | None | Louise Wallace / Health and Well Being Board | Refreshed JSNA March 2014 |
| ii) In instances where JSNA entries were incomplete at the time of scrutiny consideration, Members were concemed that the Scrutiny process had been utilised to inform, rather than comment on, the content of the entries; | The JSNA is an ongoing and iterative process. As sections are refreshed members through involvement in policy committees will be able to comment on content on topics relevant to each policy committee area. | None | Lead Director for each topic area | Refreshed JSNA March 2014 |

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| iii) Entries were in some instances based upon high level statistics / evidence and concern was expressed that the level of local information available could impact on the effectiveness of the JSNA as a tool in the commissioning of services to fit local need in the future; | Local intelligence is continuously being developed through the Tees Valley Public Health Shared Service. As this intellignce becomes available it will be reflected in the JSNA entries. | None | Louise Wallace / Tees Valley Shared Public Health Service | 31 December 2013 |
| iv) To ensure the JSNA is a 'living' document that accurately reflects the situation within the town, and can effectively influence the commissioning of future services by the authority and its partners, the various JSNA topics should be updated on a quarterly basis alongside the Councils Covalent database; | Implementation of this recommendation needs to be explored by the Health and Well Being Board as part of the 2013/14 refresh to see how practicable and meaningful a quarterly update would be. | None | Louise Wallace / Health and Wellbeing Board | 31 October 2013 |
| v) The impact of welfare reform must be reflected fully across all aspects of JSNA topics; and | As part of the ongoing and continued development of the JSNA there will be a range of additional supporting information and requirements in respect of all aspects of the JSNA to make it a document reflective of its importance.<br><br>The head officer for the JSNA (Director of Public Health) will highlight the requirements | None | Louise Wallace / Health and Wellbeing Board | 31 December 2013 |

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| | encompassed under actions (v), with all lead officers as part of its development. | | | |
| vi) The eradication of child poverty must continue to be priority within the Councils new decision making process, particularly through the future work of the Health and Wellbeing Board. | Child Poverty Strategy and action plan refreshed and to be approved by Children's Services Committee July 2013. | None | Danielle Swainston/ Louise Wallace | Strategy approved July 2013<br>Action plan completion Mar 14 |
| | The responsibility for Child Poverty has been included in all policy Committees in the new council constitution | None | Andrew Atkin | May 2013 completed |
| **Poverty JSNA Topic Entry** | | | | |
| i) In relation to the section of the entry relating to **'What are the key issues'**, Members were generally supportive of the information included, however, recommended the following:- | | | | |
| a) That the entry be amended to reflect the importance of employment (including the provision of apprenticeships for young people, with or without academic qualifications) and the economic regeneration of the town as key factors in | The Poverty JSNA entry will be amended by the Economic Regeneration Team to confirm that employment is the best way out of poverty. | No financial implications. Officer time only. | Patrick Wilson | 30th September 2013 |

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| enabling people to work their way out of poverty. | | | | |
| ii) In relation to the section of the entry relating to **'What commissioning priorities are recommended'**, Members supported the commissioning priorities identified within the entry. | No action required | | | |
| iii) In relation to the section of the entry relating to **'Who is at risk and why'**, Members were generally supportive of the information included, however, recommended the following:- | | | | |
| a) That statistical information in relation to the number of those seeking advice through the Council, or other services as a result of the welfare reforms, should be compiled on a ward by ward basis and utilised to update the JSNA. | Data will be collated as part of the ongoing monitoring of the Community Pool Advice & Guidance contract, the West View Advice & Resource Centre welfare reform additional advice sessions contract and data will also be compiled from Civic Centre customer contacts. | None | John Morton Strategic Welfare Reform Group | 31 December 2013 |
| b) That arrangements be put in place with partners who visit homes of residents to ensure that information in relation to families / individuals who are experiencing poverty is | Framework and Arrangements will be co-ordinated via Strategic Welfare Reform Group. | None | John Morton Strategic Welfare Reform Group | 31 October 2013 |

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| relayed, and that they are signposted to relevant bodies that are able to provide help / assistance. | | | | |
| iv) In relation to the section of the entry relating to **'What is the level of need in the population'**, Members were generally supportive of the information included, however, recommended the following:-<br><br>a) Whilst it was recognised that national statistical information tended to be two/three years old, where possible information contained within the entry be updated to better inform the commissioning of services to meet demand;<br><br>b) That the information be updated to reflect the new ward boundaries and that the provision of information on a super output basis be explored; and<br><br>c) That information in relation to food bank usage be included | As part of the ongoing and continued development of the JSNA there will be a range of additional supporting information and requirements in respect of all aspects of the JSNA to make it a document reflective of its importance.<br><br>The head officer for the JSNA (Director of Public Health) will highlight the requirements encompassed under actions (iv), (v), (vi), (viii), (ix) with all lead officers as part of its development. | None | Louise Wallace / Health and Wellbeing Board | 31 December 2013 |

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| in the entry, with regular updates to reflect any fluctuations / increases that may occur. | | | | |
| v) In relation to the section of the entry relating to **'What services are currently provided'**, Members recommended that the entry should be updated to more accurately reflect the breadth of activities being undertaken in Hartlepool, including food banks and benefits advice services, and as part of this a link to the Family Services Directory should be provided. | As part of the ongoing and continued development of the JSNA there will be a range of additional supporting information and requirements in respect of all aspects of the JSNA to make it a document reflective of its importance.<br><br>The head officer for the JSNA (Director of Public Health) will highlight the requirements encompassed under actions (iv), (v), (vi), (viii), (ix) with all lead officers as part of its development. | None | Louise Wallace / Health and Wellbeing Board | 31 December 2013 |
| vi) In relation to the section of the entry relating to **'What is the projected level of need / service use'**, Members were generally supportive of the information included, however, recommended the following:-<br><br>a) That this section of the entry be amended to include and reflect: | As part of the ongoing and continued development of the JSNA there will be a range of additional supporting information and requirements in respect of all aspects of the JSNA to make it a document reflective of its importance.<br><br>The head officer for the JSNA (Director of Public Health) will | None | Louise Wallace / Health and Wellbeing Board | 31 December 2013 |

| | | | | |
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| - The impact of loan sharks on those in financial difficulty and the contributing role they play in pushing people and families further into poverty;<br>- Issues relating to, and implications of the Housing Benefit reforms; and<br>- The need to plan for a potential increase in mental health issues that may lead to an increase in suicide rates.<br><br>b) That given the role of the JSNA in informing the commissioning of services to reflect <u>local</u> need, an assessment of local needs / impacts should be included in the entry to build upon the national information already provided. | highlight the requirements encompassed under actions (iv), (v), (vi), (viii), (ix) with all lead officers as part of its development. | | | |
| vii) In relation to the section of the entry relating to **'What needs might be unmet'**, Members recommended that:-<br><br>a) In response to concerns regarding the transfer over to | The Poverty JSNA entry will be amended by the Economic | No financial implications. | Patrick | 30th September 2013 |

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| the Employment and Support Allowance, the impact of the migration should be reflected within the entry; and | Regeneration Team to reflect this impact. | Officer time only. | Wilson | |
| b) In response to concerns regarding the level of knowledge in relation to the options available to deal with out of hour's emergencies, emergency numbers are re-circulated to Members and publicised to residents. | The Council website will be updated with details of emergency advice and support arrangements covering housing, food and clothing. Emergency contact details will be compiled and circulated for information to Members and Hartlepool Financial Inclusion Partnership members. | Officer time | John Morton | 31st July 2013 |
| viii) In relation to the section of the entry relating to **'What evidence is there for effective intervention'**, Members were generally supportive of the information included, however, recommended the following:- | As part of the ongoing and continued development of the JSNA there will be a range of additional supporting information and requirements in respect of all aspects of the JSNA to make it a document reflective of its importance. | None | Louise Wallace / Health and Wellbeing Board | 31 December 2013 |
| a) There is a clear requirement for the JSNA to be responsive to the local situation and include a reflection of the significant amount of work being undertaken locally in tackling poverty issues. On this | The head officer for the JSNA (Director of Public Health) will highlight the requirements encompassed under actions (iv), (v), (vi), (viii), (ix) with all lead officers as part of its development. | | | |

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| basis, the entry should be amended to reflect the successful activities of the voluntary and community sector, as well as the services provided by the local authority.<br><br>b) The entry should not follow the template agreed for all JSNA's across the region, whereby the focus is on high level national indicators. On this basis, in order to have a document that effectively influences the town's Health and Wellbeing Strategy, and in turn the services commissioned, the entry should be amended to reflective the local position and not solely a national perspective. | | | | |
| ix) In relation to the section of the entry relating to **'What do people say'**, Members were generally supportive of the information included, however, recommended the following:-<br><br>a) The content of this section | As part of the ongoing and continued development of the JSNA there will be a range of additional supporting information and requirements in respect of all aspects of the JSNA to make it a document reflective of its importance. | None | Louise Wallace / Health and Wellbeing Board | 31 December 2013 |

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| should be expanded to include the views of other sections of the community i.e. older people and families and that evidence from other sources such as the older people's strategy could potentially be utilised. | The head officer for the JSNA (Director of Public Health) will highlight the requirements encompassed under actions (iv), (v), (vi), (viii), (ix) with all lead officers as part of its development. | | | |

**Appendix 2(b)**

## OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN

**NAME OF FORUM:** Scrutiny Co-ordinating Committee (Via the Transport Working Group)
**NAME OF SCRUTINY ENQUIRY:** Transport JSNA Topic
**DECISION MAKING DATE OF FINAL REPORT:** 28 June 2013

| RECOMMENDATION | EXECUTIVE RESPONSE / PROPOSED ACTION+ | FINANCIAL / OTHER IMPLICATIONS | LEAD OFFICER | COMPLETION DATE* |
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| i) The Transport Working Group supported the content of the Transport JSNA entry, with the inclusion of reference where appropriate to the health benefits of the implementation of 20MPH zones across the town. | The Transport JSNA is to be amended, to reflect the Working Group's comments regarding health benefits of 20mph zones. | None | Paul Watson | 30 June 2013 |
| ii) The Transport Working Group agreed that whilst in some individual roads it may not be possible to reduce speeds to 20 mph, that they should forward their recommendations to the Neighbourhoods Policy Committee, expressing their view that the Policy Committee take forward the recommendations and attempt to identify an area of the town where a 20 mph zone can be implemented, prior to rolling the initiative out across Hartlepool. | Transport Working Group report included on the agenda for the 3 June 2013 | To be ascertained through the Neighbourhood Services Committee consideration of Transport Working Group report | Joan Stevens | Completed |

**Appendix 2(c)**

## OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN

**NAME OF FORUM:** Adult and Community Services Scrutiny Forum
**NAME OF SCRUTINY ENQUIRY:** JSNA Topic of Older People
**DECISION MAKING DATE OF FINAL REPORT:** 28 June 2013

| RECOMMENDATION | EXECUTIVE RESPONSE / PROPOSED ACTION+ | FINANCIAL / OTHER IMPLICATIONS | LEAD OFFICER | COMPLETION DATE* |
|---|---|---|---|---|
| (a) That greater promotion of the care available to help people retain their independence and remain within their own homes is undertaken in conjunction with partner organisations, particularly in relation to dementia sufferers, where concerns over retaining independence may prevent people from seeking an early diagnosis, and that any information produced is clear and concise. | There is an ongoing commitment to providing clear and concise information to people and to supporting people to retain their independence. A new booklet is being developed which will provide information on a range of services including reablement, extra care and residential care.<br><br>The North of Tees Dementia Collaborative is exploring a range of issues affecting people with dementia (including diagnosis and access to reablement services) and is expected to deliver improvements to processes and better outcomes for people. | Limited capacity to produce, maintain and actively promote information.<br><br>Current NHS funding for the Dementia Collaborative ceases in October 2013. | Jill Harrison<br><br>Jill Harrison | Oct 2013<br><br>Oct 2013 |

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| (b) That in order to ensure that awareness of conditions such as dementia is maintained amongst providers of services to older people and their staff, Hartlepool Borough Council undertakes the following:-<br><br>(i) re-delivers dementia awareness training to partner organisations at appropriate intervals; and<br>(ii) incorporates reference to the importance of appropriate training for all service providers in the 'older people' JSNA entry. | The Council is working with partners to promote Dementia Awareness Week (20-24 May 2013) and will aim to deliver further training to providers via the annual training plan, if funding is available.<br><br>Reference to appropriate training for providers will be included in the JSNA entry for older people. | Limited funding to deliver courses. | Jill Harrison | Oct 2013 |
| (c) That further work is undertaken, in conjunction with partner organisations, to reduce social isolation amongst older residents in Hartlepool, particularly in relation to those people who are more independent and may never previously have accessed services. | An Expression of Interest has been submitted for the Big lottery Fund's Fulfilling Lives: Ageing Better programme which aims to tackle the problem of social isolation in older people. Successful applicants will be informed by late July 2013. | Successful areas will be awarded funding of between £2 and £6m for projects lasting three to six years. | Jill Harrison | August 2013 |

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| (d) That in order to address the needs of older people and avoid the duplication of information feeding into the Health and Wellbeing Board, clear and appropriate reporting and communication arrangements are put in place. | The Health & Wellbeing Board Terms of Reference, which include a Healthy and Independent Adults Delivery Group and outline reporting and communication arrangements, are expected to be ratified by the Board on 24 June 2013. | None identified. | Jill Harrison | July 2013 |
| (e) That in order to maintain JSNA entries as living documents and reflect the current views and issues faced by service users and their families, the results of the public consultation exercise undertaken by the Adult and Community Services Scrutiny Forum and any further public consultations held in the future by Hartlepool Council and partner organisations, be considered for inclusion in the appropriate JSNA entry and are also incorporated as part of the older peoples strategy review. | All relevant public consultation will be considered for inclusion in appropriate JSNA entries and will feed in to relevant strategies and action plans as appropriate. | None identified. | Jill Harrison | Oct 2013 |

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| (f) | The Health and Wellbeing Board make representations to the appropriate public health body to ensure that the Hartlepool 'Older People' JSNA entry is uploaded on to the website as soon as possible and that future updates supplied by Hartlepool Borough Council in relation to the 'Older People' entry are carried out with appropriate timescales. | The JSNA entry for older people will be uploaded onto the website as soon as possible and will be reviewed at least annually and updated as required. | None identified. | Jill Harrison | Oct 2013 |

**Appendix 2(d)**

**OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN**

**NAME OF FORUM:** Children's Services Scrutiny Forum
**NAME OF SCRUTINY ENQUIRY:** JSNA Topic of Emotional and Mental Wellbeing
**DECISION MAKING DATE OF FINAL REPORT:** 28 June 2013

| RECOMMENDATION | EXECUTIVE RESPONSE / PROPOSED ACTION+ | FINANCIAL / OTHER IMPLICATIONS | LEAD OFFICER | COMPLETION DATE* |
|---|---|---|---|---|
| (a) In order to ensure that the Hartlepool JSNA entry for Mental and Behavioural Disorders (Children), best reflects the needs and services required by the local population, the Health and Wellbeing Board make representations to the Clinical Commissioning Groups regarding:- | | The universal CAMH Service is commissioned by the North of England Commissioning Support Team working with the Clinical Commissioning Group. The Council currently commissions a smaller specialist service for children in the care of the local authority. | | |
| (i) the importance of obtaining actual data in relation to the range and types of conditions that young people experience in Hartlepool, rather than prevalence data; and | i) The Tees-wide CAMHS Transformation Group is working with Tees, Esk & Wear Valley's NHS Foundation Trust to provide accurate and up to date data on children and young people's emotional and mental health needs. | | Ian Merritt | 31st December 2013 |
| (ii) as part of future commissioning strategies the | The service is currently developing new pathways | | | |

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| | provision of actual data sets are included as part of the contract. | which will deliver the data that is required. Managers are due to bring an initial report back to the Transformation Group in July 2013. | | | |
| (b) | Work is undertaken, in conjunction with partner organisations and service providers, to investigate the reasons behind young people not attending pre-arranged CAMHS appointments and action taken to address this where non attendance relates to service configuration or delivery. Hartlepool Borough Council will work in partnership with Tees, Esk and Wear Valley NHS Foundation Trust to map current services and explore alternative models for service delivery, including a single point of access. | A local CAMHS Partnership is to be re-established led by the Clinical Commissioning Group bringing together those organisations operating within Hartlepool in the field of emotional and mental wellbeing, to consider and address the issues raised by this recommendation. | To implement a single point of access Tees, Esk and Wear Valley's NHS Foundation Trust will have to find the resources for a qualified CAMHS worker to work within the team. | Ian Merritt | 31st December 2013 |
| (c) | Departmental budget consultation proposals provide Members with information in relation to the potential wider implications of proposals and details of the less visible impact these options may have on children and young people. | Directors and Assistant Directors to be notified of this recommendation and asked to consider the implications of proposals and its impact on the emotional health and wellbeing of children. | None | Sally Robinson | |

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| (d) In order to maintain the JSNA as a living document and reflect the current views and issues faced by service users and their families, the results of the public consultation exercise undertaken by the Children's Services Scrutiny Forum, be reflected in the Mental and Behavioural Disorders JSNA entry, where appropriate. The JSNA entry should be also be updated to reflect the areas of collaborative working identified to be taken forward during the course of the investigation. | The JSNA will be updated to reflect new or updated information. It will be the responsibility of the local CAMHS Partnership to ensure that information on JSNA is up to date, reflects local need and views and this is reviewed regularly in light of new and emerging information | None. | Ian Merritt | 31st July 2013 |
| (e) Hartlepool Borough Council works in conjunction with Tees, Esk & Wear Valleys NHS Foundation Trust; schools, and other partner organisations including the voluntary and community sector to address the issues raised as part of the Children's Services Scrutiny Forums public consultation exercise by:- | | | | |
| (i) increasing awareness of emotional and mental wellbeing issues amongst children, young people, parents, carers and professionals, and promotes the services that are | **i)**;ii)To be addressed through the Children's Workforce Development Plan in conjunction with Tees, Esk and Wear | Within existing resources | Ian Merritt | |

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| available, providing details of how to access those services, in places frequented by young people;<br><br>(ii) developing/providing emotional and mental health training accessible to all professionals who work with children and young people, to promote early intervention and the correct referral processes; and<br><br>(iii) developing ways of increasing community based services, and addressing the issues raised by young people attending Dover House. | Valley's NHS Foundation Trust and coordinated through the CAMHS Partnership.<br><br>iii) Service delivery developments within localities to be progressed through implementation of Early Intervention Strategy and CAMHS Strategy. | | Ian Merritt | 31st December 2013 |
| (f) A review is undertaken of the Home and Hospital Service provision, taking into consideration the issues raised as part of the Children's Services Scrutiny Forum consultation exercise. This should include a review of the access to and use of the learning platform to support wider access to the curriculum and a reconfiguration of services to improve support to children unable to access | A Review will be undertaken to address:<br>• How the provision is delivered and location of service;<br>• Staffing requirements to meet the demand taking into account the number of teaching hours available, the size of teaching groups and the expertise of the teachers. | Within existing resources | Zoe Westley | 31st December 2013 |

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| mainstream learning. | • The learning platform and how this can be maximised to contribute to the achievement outcomes for pupils who attend the provision? | | | |
| (g) Organisations that work with children with emotional and mental wellbeing issues ensure that information is shared effectively, fostering a culture of collaboration with all partners who make up the team around the child. | To be addressed through the local CAMHS Partnership described in Recommendation (b) above. | Need to ensure Information security and governance arrangements are in place. | Ian Merritt | 31st December 2013 |

**Appendix 2(e)**

## OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN

**NAME OF FORUM:** Neighbourhood Services Scrutiny Forum
**NAME OF SCRUTINY ENQUIRY:** JSNA Topic of Environment
**DECISION MAKING DATE OF FINAL REPORT:** 28 June 2013

| RECOMMENDATION | EXECUTIVE RESPONSE / PROPOSED ACTION+ | FINANCIAL / OTHER IMPLICATIONS | LEAD OFFICER | COMPLETION DATE* |
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| (a) That the following is undertaken in relation to the Environment JSNA entry:- | | | | |
| (i) the entry is updated, edited and authorised by Hartlepool Borough Council prior to being uploaded on the Tees JSNA website, and all future updates to the live document, including those supplied by partner organisations, are appropriately reviewed and authorised; | A response will be produced in partnership with other stakeholders, including Hartlepool Water, Housing Hartlepool and the Environment Agency.<br><br>The Director for Regeneration & Neighbourhoods will view and approve the final submission. | Within existing budgets.<br><br>Within existing budgets | Paul Hurwood<br><br>Paul Hurwood | 30/9/2013<br><br>30/9/2013 |
| (ii) the entry reflects the increasing need for collaborative working between Hartlepool Borough Council and partner organisations to deliver services that address the priorities of local communities. | Relevant officers will ensure that, where their work areas overlap with those of partners, they engage with partners and other stakeholders. | Within existing budgets | Paul Hurwood | 30/9/2013 |

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| (b) Over and above the Forum's comments in relation to the JSNA entry the following key recommendations were also made in relation to the development and delivery of future services:-<br><br>That the potential to expand the current enforcement activity undertaken by Hartlepool Borough Council is explored through:- | | | | |
| (i) further developing collaborative working arrangements with Hartlepool neighbourhood police to increase the use of enforcement powers currently available; | (i) Officers will meet with local Police teams to address local environmental issues. | Within existing budgets | Craig Thelwell | 31/12/2013 |
| (ii) potential flexible working arrangements for Council Officers; | (ii) Discussions will take place with staff, unions and partners with regard to joined up initiatives and flexible working arrangements. | Further staffing budgets may be required for extended/out of hours work. | Craig Thelwell | 30/09/2013 |
| (iii) delegation of the power to issue fixed penalty notices to more Council Officers; and | | | | |
| (iv) working in conjunction with partner organisations, such as | Discussions will be held with staff, unions and partners to consider the issuing of | Within existing budgets | Craig Thelwell | 31/12/2013 |

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| residents associations, to help reduce the problem of litter and dog fouling. | powers to issue FPNs to more officers.<br><br>A strategy will be produced to look at options for replacing Operation Clean Sweep, with education and enforcement campaigns targeted at problem areas.<br><br>Work will be undertaken to ensure that local waste carriers adopt good practices regarding their Duty of Care. | Within existing budgets<br><br>Within existing budgets | Craig Thelwell<br><br>Craig Thelwell | 31/12/2013<br><br>31/12/2013 |
| (c) That consideration is given to splitting income received from the lease of land in relation to renewable energy projects between the Community Benefit Fund and the Invest to Save Scheme. | The Council's Carbon Reduction & Energy Efficiency (CREE) Team will discuss opportunities for the splitting of income from renewable energy projects to contribute to further energy efficiency and carbon reduction projects. | No budget required | Denise Ogden | 30/9/2013 |
| (d) That in order to help reduce fuel poverty, current and future energy saving or cost reducing schemes, such as collective switching, are publicised as widely as possible, and via methods that include | New opportunities for energy efficiency and fuel poverty promotion will be sought.<br><br>Current and future energy efficiency and fuel poverty | None<br><br>None | Paul Hurwood<br><br>Paul | 31/12/2013<br><br>31/12/2013 |

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| | residents who do not have access to the internet, by Hartlepool Council and partner organisations. | opportunities will be publicised widely. | | Hurwood | |
| (e) | That the energy efficiency of Council buildings is a factor taken into consideration when identifying possible assets for disposal. | Running costs are a key element of the assessment and this will include energy performance | Potential savings through property rationalisation and energy efficiency | Dale Clark | Part of ongoing rationalisation programme<br><br>31/12/2013 |
| (f) | That the use of solar panel water heaters on Council buildings is investigated. | When systems are being renewed and upgraded the solar panel option will be considered | Potential savings but there may be an initial "invest to save cost". Business cases will be undertaken | Colin Bolton | To be considered on system renewals/ Upgrades<br><br>31/12/2013 |

**Appendix 2(f)**

## OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN

**NAME OF FORUM:** Regeneration and Planning Services Scrutiny Forum
**NAME OF SCRUTINY ENQUIRY:** Investigation into the JSNA Topic of 'Employment'
**DECISION MAKING DATE OF FINAL REPORT:** 28 June 2013

| RECOMMENDATION | EXECUTIVE RESPONSE / PROPOSED ACTION+ | FINANCIAL / OTHER IMPLICATIONS | LEAD OFFICER | COMPLETION DATE* |
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| 1) That the Employment JSNA entry is uploaded onto the JSNA website and is updated on a regular basis to reflect the needs of Hartlepool residents, including statistical information to support how employment reduces health inequalities | Hartlepool Economic Regeneration Team will be responsible for continuously updating the Employment JSNA entry. Further research will be undertaken between the Council and Public Health to analyse the link between employment and improved health. | No financial implications. Officer time only. | Patrick Wilson | 31st December 2013 |
| 2) That within the Employment JSNA entry, the need to encourage the growth of businesses in Hartlepool is identified as a key issue and that the Council:- | The Employment JSNA entry will be revised to include a comprehensive statement on the Council's key issue of increasing the number of new businesses in Hartlepool and how this will be accomplished through the implementation of the Economic Regeneration Strategy. | No financial implications. Officer time only. | Patrick Wilson | 30th September 2013 |
| (a) introduces schemes that promote entrepreneurial activity with specific focus on people under the age of 25. | As part of the Hartlepool Youth Investment Programme, entrepreneurs will be linked to schools to promote setting up a | No financial implications. Officer time and in-kind | Tom Argument | 31st December 2013 |

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| | For example, entrepreneurs visiting primary and secondary schools to offer advice and mentoring and to highlight business successes and failures; | new business. Economic Regeneration Forum members and Federation of Small Businesses have agreed to support working with schools. | contribution from entrepreneurs. | | |
| (b) | expands the current 'one stop shop' approach to provide advice and resources to new business start ups and to promote self employment opportunities including to the harder to reach groups; and | The Council already provides an existing service to residents seeking advice on setting up in business through the Hartlepool Enterprise Team (HET). Alongside this, further partnership working has been developed between HET and local 'self-employment' training providers to increase the number of adults accessing advice and to specifically target hard to reach groups, including the long term unemployed and returners to the labour market. This work will be ongoing throughout the year. | No financial implications. Officer time only. | Mick Emerson | 31st December 2013 |
| (c) | pursues funding and investment opportunities with companies, for example, explores offering investment packages to new businesses, such as revolving loans, low interest funds and buying | The Council's Economic Regeneration Team will continue to provide advice to businesses on funding opportunities to support growth, such as Let's Grow grant scheme and Regional Growth Fund. In | Officer time.<br><br>As part of the best practice review of loan fund schemes, it will be necessary | Antony Steinberg | 31st December 2013 |

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| shares in growing companies | addition, there will be a best practice review of established Council led loan schemes to businesses, such as Portsmouth City Council Revolving Loan Fund (PRLF). | to provide a follow-up report on the financial and legal implications of establishing a similar scheme in Hartlepool. | | |
| 3) That partnership working is included in the JSNA entry and that the Council works with schools, colleges, training providers and employers to:- | The Employment JSNA entry will be revised to outline partnership working, particularly in relation to initiatives such as Hartlepool Youth Investment Programme. | No financial implications. Officer time only. | Patrick Wilson | 30th September 2013 |
| (a) help support the implementation of the Hartlepool Youth Investment programme; | Hartlepool Youth Investment Programme will be officially launched in September 2013 which will help raise awareness and increase the number of partners involved in this initiative. | No financial implications. Officer time only. | Tom Argument | 30th September 2013 |
| (b) explore the option of creating work experience programmes for students at secondary school and college; | It should be noted that from September 2012, Government removed the statutory entitlement to work-related learning, including work experience for Key Stage 4 pupils, which will impact on 14-16 year olds. However, schools are still committed to work experience | Implications as stated. | Tom Argument | 30th September 2013 |

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| | | and in the last academic year have placed 100 pupils into a work placement environment. The 11-19 Partnership will further explore work placements for pre and post-16 learners. | | | |
| (c) | introduce vocational and enterprise programmes in schools and use council services, for example, youth centres, to teach young people about self employment and help prepare young people for work by equipping young people with the right skills; | Currently, all schools offer Enterprise Days for Year 9-11 pupils and this will be expanded by linking entrepreneurs to schools. Also, all Deputy Heads and Curriculum Managers who form the Raising Achievement Group are in the process of reviewing their curriculum offer for September 2013 and to make a decision on whether they include vocational programmes based on the governments move towards the baccalaureate system. | Changes to the 14-16 league tables will reduce the range of vocational qualifications, including specialist diplomas that offered ten-days of work experience in an industrial setting. | Tom Argument | 30th November 2013 |
| | | The Council's Economic Regeneration Team and Integrated Youth Support Service to work in partnership to develop a 'Preparing Young People for the World of Work' session which will be delivered in youth centres. | No financial implications. Officer time only. | Caron Auckland and Beth Storey | 30th November 2013 |

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| (d) | widely communicate and publicise the local need for skills in the engineering, manufacturing and renewable energy sectors to encourage people to train in these areas, as local companies are suffering a shortage of skilled workers; and | In November 2013, there will be a Tees Valley Skills Event based in Hartlepool which is sponsored by the Department for Business, Innovation & Skills. TVU will lead on this event and will be supported by the five local authorities to bring together school, colleges, training providers and employers to raise awareness to young people on career opportunities in growth sectors, such as engineering.<br><br>There will be additional events organised by the Council in the next year to promote opportunities in growth sectors including:<br><br>1. Hartlepool Choices Event which will be attended by all Year 11s who will meet local employers and training providers.<br><br>2. STEM Days for Year 9 and Year 10 pupils in partnership with Hartlepool College of Further Education, Hartlepool Sixth Form | There are no financial implications for the Tees Valley Skills Event as it is funded by BIS.<br><br>No financial implications for the Council with the delivery of these additional events. Officer time only. | Tom Argument<br><br>Tom Argument<br><br>Tom Argument | 30th November 2013<br><br>31st October 2013<br><br>30th September 2013 |

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| | | College, English Martyrs Sixth Form College and Teesside University. | | | |
| | | 3. Four Sixth Form A-Level Taster Events in June and July 2013 with a particular emphasis on STEM related subjects at Hartlepool Sixth Form College. | | Tom Argument | 31st July 2013 |
| | | 4. Four Further Education Experience Days in June and July 2013 with a particular emphasis on STEM related subjects at Hartlepool College of Further Education. | | Tom Argument | 31st July 2013 |
| (e) | support the devolvement of training funds to local authorities to match training to the local need for skills | The Council's Adult Education Service is the accountable body for the ESF Tees Valley Skills for the Workforce programme which will upskill over 2000 employed people across the sub-region and support companies facing skills shortages. | Externally funded programme to be delivered between June 2013 and July 2015 | Maggie Heaps | 31st July 2015 |
| | | Tees Valley Unlimited (TVU) has been shortlisted to bid for City Deal status and is currently in the process of developing a final proposal that will be submitted to | Financial and devolved powers to be confirmed. | Antony Steinberg | 31st December 2013 |

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| | Government in the autumn. This document will outline Tees Valley's plans for economic growth and also the key 'asks' of Government. In return for strong plans, the Government will negotiate with TVU on devolving financial and planning powers to enable the area to grow, such as giving greater autonomy on how to spend training and skills budgets to meet local need. | | | |
| 4) That the Council, through the Health and Wellbeing Board:-<br><br>(a) focus future health initiatives on preventative actions to stop the escalation of ill-health and mental health within communities; and<br><br>(b) raise awareness to Council employees of the mental health services available to enable employees to access the services if required | The Council's Economic Regeneration Team and Public Health to work in partnership to develop joint initiatives, such as pre-employment programmes (which incorporate health and well-being) that are targeted at young unemployed people.<br><br>The Council's Health, Safety and Wellbeing Team delivered mental health awareness raising sessions to Council and School Managers on 30th April and 2nd May 2013. The Council is committed to continuing to raise awareness to staff and will do so through activities including staff newsletters. | No financial implications in delivering the programme. Officer time.<br><br>No financial implication. Officer time. | Louise Wallace and Patrick Wilson<br><br>Stuart Langston | 31st December 2013<br><br>31st December 2013 |

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| 5) | That the Council encourage staff to put forward ideas for investment and income generation, for example by rewarding staff for successful ideas and / or creating an online suggestion box for staff to submit ideas | Council staff have already undertaken The Commercial Skills Programme which included modules on Trading Public Services (For Income Generation) and Financial Planning. Alongside this, further exploratory work will be undertaken on developing an income generation 'staff suggestion' scheme, including reviewing potential rewards. | Officer time. The financial implications will be confirmed as part of the exploratory work. | Andrew Atkin | 30th November 2013 |

**Appendix 2(g)**

**OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN**

**NAME OF FORUM:** Health Scrutiny Forum
**NAME OF SCRUTINY ENQUIRY:** Investigation into the JSNA Topic of 'Sexual Health'
**DECISION MAKING DATE OF FINAL REPORT:** 28 June 2013

| RECOMMENDATION | PROPOSED ACTION | FINANCIAL / OTHER IMPLICATIONS | LEAD OFFICER | COMPLETION DATE |
|---|---|---|---|---|
| 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:-<br><br>(a) Increases awareness and understanding of the types of sexually transmitted infections, prevention and the services available through:-<br><br>(i) social media / internet sites / blue tooth;<br><br>(ii) schools / colleges / literature on school buses; and<br><br>(iii) counselling / advisory services available to those | A comprehensive sexual health communications plan will be developed across all partners to ensure sound evidenced based advice and support is available to the whole population.<br><br>This plan will look at all forms of communication including social media. It will be targeted at different age groups with consistent messages about safe sex. | Officer time / within existing resources | Louise Wallace / Deborah Gibbin | 31 December 2013 |

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| individuals participating in the night time economy<br><br>(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:<br><br>(a) Commissioning services that are accessible to all and have good transport links;<br><br>(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<br><br>(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. | The local authority became the commissioner of sexual health services on 1 April 2013.<br><br>Commissioning sexual health services is a mandatory function and the local authority will seek to maximise all service provision in existing contracts.<br><br>The commissioning of services will ensure that services provide open access comprehensive sexual health services for the whole population. | Officer time / within existing resources | Louise Wallace / Deborah Gibbin | 31 October 2013 |

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| 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 | The Public Health Team will ensure effective partnerships and relationships between all sexual health service providers. This will be done through contract management and pathway development. | Officer time / within existing resources | Louise Wallace / Deborah Gibbin | 31March 2014 |
| (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. | The C-Card scheme will continue to be offered in a wide range of venues as well as training for service providers. | Officer time / within existing resources | Louise Wallace / Deborah Gibbin | 31 July 2013 |
| 4) That Hartlepool Borough Council commissions the APAUSE programme through the allocated budget for sexual health | The Public Health Team will develop a proposal regarding the commissioning of the APAUSE programme through the ring fenced public health grant. | Officer time / within existing resources | Deborah Gibbin | August 2013 |

# HEALTH AND WELLBEING BOARD

**5 August 2013**

HARTLEPOOL BOROUGH COUNCIL

**Report of:** Ali Wilson, Chief Officer, Hartlepool and Stockton on Tees CCG and Rosemary Granger, Project Director, Securing Quality in Health Services

**Subject:** SECURING QUALITY IN HEALTH SERVICES

## 1. PURPOSE OF REPORT

1.1 The purpose of the report is to inform the Health and Wellbeing Board about a piece of work being carried out across County Durham and Tees Valley that is focused on improving the quality of acute hospital services.

## 2. BACKGROUND

The project was initiated in April 2012 and was part of the process for Primary Care Trusts to transfer commissioning responsibility to Clinical Commissioning Groups (CCGs) and it covered the PCT clusters across County Durham and Darlington and Tees Valley.

The overall objective of the project was to enhance the commissioning of acute hospital services by reaching consensus on the key clinical quality standards in acute hospital care that should be commissioned by CCGs. The project aimed to produce a report that would describe the agreed clinical quality standards in the context of the financial and workforce resources that are expected to be available to support implementation of the standards.

The first phase of the work was entitled Acute Services Quality Legacy Project and it has since been renamed as the Securing Quality in Health Services project since it is no longer part of the hand over between PCTs and CCGs. The project report from the first phase of the work was received at the final meetings of the PCT clusters in March 2013. A copy of the final summary report and quality standards are attached to this report.

There were three workstreams within the project covering clinical quality, workforce and finance. The clinical quality workstream had four clinically led groups looking at:

- Acute paediatric, maternity and neonatal services
- Acute Care

- End of Life Care
- Long Term Conditions
- Planned Care

## 3. PROPOSALS

Acute Services Quality Legacy Project - Final Report - Summary of key messages and recommendations

Both commissioners and providers of acute services face a similar set of challenges over the next five to ten years. Our population will be older, with more long term conditions being treated by a state funded NHS that is ultimately tied to the performance of the national economy. These services will also be operating as part of a wider system with social care which itself faces significant challenges related to national financial constraints.

We are fortunate however to start from a strong starting position. Our current main providers consistently deliver high quality services, meet national performance targets related to waiting times and cleanliness and operating efficiently within their means. Having said that, we know that we can do better. In this process we have looked to our clinical community to define what the best possible care should look like in our hospitals and begin to outline the next steps of how we should go about delivering them, given the likely financial future and the workforce that will be available to us.

The findings and recommendations set out in the report have implications that range from potential changes to be made to provider contracts through incorporating the agreed clinical quality standards, to potential service reconfiguration across County Durham and Tees Valley.

Key Messages from the economic and workforce workstreams of the ASQL Project:

- Following years of growth, demand for acute services is currently high for both elective and non-elective care.

- There will be a significant increase in prevalence across the major long term conditions over the next ten years and a greater proportion of the population will be over the age of 65.

- This will have an impact on the utilisation of acute services to a varying degree in the different service areas.

- This growth will put pressure on commissioners' allocations over the next ten years as an older population with more co-morbidity will consume more health resource, unless effective demand and long term condition management are implemented. This analysis does not take into account potential increased spend on high cost drugs and new medical technologies in the acute setting that may require further investment from commissioners.

- Forecasts show that providers can maintain a financially stable position over the next five years as long as cost improvement plans deliver to target. Failure to deliver these targets will have implications for Trusts' operating surplus/deficit position and ultimately the length of time they can rely on cash savings to keep them solvent.

- This means that new funding is unlikely to be available to expand the access to services of the very highest quality as providers look to maintain the current levels of quality within the resources they have access to.

- Even if commissioners were to receive increases to their allocations and providers had efficiency requirements at pre-Comprehensive Spending Review levels, national and regional workforce constraints may have more impact on the ability to deliver higher quality standards.

- These national and regional workforce considerations are further compounded by supply and demand of particular grades and skills of the current and future workforce within the acute sector in County Durham, Darlington and Tees.

**Recommendations from the clinical quality workstream**

The overall recommendations for the ASQL project board from key clinical areas are set out below. These recommendations were identified in the context of the wider financial and workforce contexts, the underlying health data, views of the clinical advisory groups and the specific workforce risks and opportunities

Acute Paediatrics, Maternity and Neonatal Services – the project board agreed to:

Endorse the Royal College of Obstetricians and Gynaecologists (RCOG) standard of 168 hours (24/7) consultant presence as the ultimate goal for maternity services across County Durham Darlington and Tees. This standard was supported by the majority of the Clinical Advisory Group (CAG) but there was a minority view that 98 hours consultant presence should be established as the standard for units with less than 4000 deliveries a year. The Project could not find enough evidence to inform a recommendation that goes against the Royal College standard, therefore the Project supports the RCOG standard and majority view of the CAG. Given the scale of this challenge however, there is a recognition that this needs to be delivered in a staged way, with 98 hours as an interim step for units with less than 4000 deliveries a year as part of a phased approach to implementation.

Endorse the key quality standard of 1:1 Midwife care for women in established labour.

Ask Clinical Commissioning Groups to consider the steps they may take in the next contracting round to address some of the gaps in quality standards

through the use of CQUIN incentives and agreeing small scale service improvement work with individual trusts.

Agree to a further feasibility analysis to understand the implications of implementing the standards across County Durham, Darlington and Tees. This assessment should take into account the role of Midwife Led Units and how best to support an increase in home-births.

Agree to inform the LETB – Local Education and Training Board to adjust commissioning plans to increase the numbers of midwife training places to mitigate against risks in future workforce shortages.

Acute Care - the project board agreed to:

Endorse the key quality standards recommended by the CAG as those that define high quality care, for example: Emergency admissions seen and assessed by a relevant consultant within 4 hours (in hours) and 12 hours (out of hours); Emergencies to have access to key diagnostics 24/7: for critical cases – imaging and reporting within 1hour of request, for non-critical cases – imaging and reporting within 12 hours of request.

Endorse the recommendation for acute trusts to collaborate in establishing an interventional radiology service available 24/7.

End of Life Care – the project board agreed to:

Endorse the key quality standards recommended by the CAG as those that define high quality care, particularly those that relate to the 24/7 availability of an appropriately trained nurse to provide practical support, responding within one hour, with access to necessary medicines and home equipment for End of Life cases. In addition the CAG recommends the appropriate use of the Liverpool Care Pathway in all care settings including the sharing of results

Endorse the recommendation for collaboration across the acute trusts to establish a 7 day per week service providing specialist palliative care advice.

Long Term Conditions - The overall recommendations of the Acute Services Quality Legacy Project in relation to long term conditions are as follows:

Given the scale of the likely challenge ahead due to the ageing population, the rising prevalence of LTCs and the wider membership of organisations involved, a new project focusing on LTC management should be initiated across health and social care. This project should include community services, mental health and primary care providers as well as acute trusts.

The project will add value to the existing work on long term conditions led by CCGs, by establishing a consensus on the scale of intervention needed and the quality standards to be achieved.

Further work in this area would include more detailed work on the financial and workforce challenges to provide a better understanding of the required scale of transformation and the development of concrete plans to achieve this, learning from success locally, regionally and nationally.

Planned Care - The overall recommendations of the Acute Services Quality Legacy Project in relation to planned care are as follows:

CCGs should review the Planned Care Briefing Paper to identify and continue to understand unexplained variations in referrals from Primary Care and clinical practice in secondary care

Where appropriate CCGs should look to use information to inform patient choice and commissioning levers to encourage competition to drive quality in Planned Care. This includes the introduction of new providers into the market to stimulate innovation

CCGs should however consider the financial implications for current providers that any movement of activity away from them may have (either to other current or new providers) when making changes to elective pathways.

**Next steps:**

Following completion of phase one of this project and the project report described above, the five CCGs across County Durham and Tees Valley have agreed to build on this legacy work and will take this work forward in line with the duty placed upon them to commission high quality sustainable services. It has been agreed that this work will continue to be a commissioning led process and as such, Darlington CCG will lead the work on behalf of the five CCGs. Hambleton, Richmondshire and Whitby CCG is working closely with the project due to the scale of their patient flows into the Tees Valley area. The project will also feed into, and be supported by, the work of the Area Team of NHS England.

The objectives for the next phase of work which is expected to be complete by the end of the summer 2013, are to assess the feasibility of, and options for, implementing the standards and progressing implementation.

## 4. RECOMMENDATIONS

4.1 It is recommended that the Health and Wellbeing Board:

a. Accept the report for information
b. Agree that further reports will be submitted to the Health and Wellbeing Board as the project progresses.

## 5. REASONS FOR RECOMMENDATIONS

This work is important for the CCGs as part of their responsibility to commission high quality sustainable services and is likely to be reflected in commissioning intentions for 2014/15. As such, it is important to ensure that

the Health and Wellbeing Board is aware of the work and has an opportunity to comment on it as it progresses.

## 6. BACKGROUND PAPERS

- Acute Services Quality Legacy Project – final report and appendices
- Securing Quality in Health Services – stakeholder briefing

## 7. CONTACT OFFICER

Ali Wilson, Chief Officer, Hartlepool and Stockton on Tees CCG

NHS Tees

NHS County Durham and Darlington

# County Durham and Tees Valley Acute Services Quality Legacy Project

## Final Report

## March 2013

# Foreword

In April 2012, we initiated a project across County Durham, Darlington and Tees that would bring together our main providers of acute services to ask ourselves if we were delivering the best possible service in terms quality and efficiency for our patients.

Both commissioners and providers of acute services face a similar set of challenges over the next five- to ten years. Our population will be older, with more long term conditions being treated by a state funded NHS that is ultimately tied to the performance of the national economy. These services will also be operating as part of a wider system with social care which itself faces significant challenges related to national financial constraint.

We also know that we have historically called upon our acute hospitals too often with our use of hospital beds in the North East being higher than in other parts of the country. They are higher than what they should be based on the levels of illness, deprivation and age profile of our local communities.

We are fortunate however to start from a strong starting position. Our current main providers consistently deliver high quality services, meet national performance targets related to waiting times and cleanliness and operating efficiently within their means. Having said that, we know that we can do better.

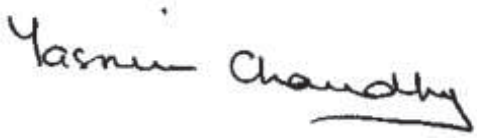
There is important work already underway to improve standards of care for patients such as the proposals to reconfigure paediatric and maternity services at the Friarage Hospital in Northallerton. This report compliments that vital work and the recommendations on quality standards for acute paediatric, maternity and newborn services contained within this document clearly support the proposals put forward by Hambleton, Richmondshire and Whitby Clinical Commissioning Group, and it will be important to maintain that consistency going forward.

However, taking into account the current programmes of improvement work underway across the health economy, there is still even further to go until we can state we have universal coverage of services that can be described as “best in class”. In this process we have looked to our clinical community to define what the best possible care should look like in our hospitals and begin to outline the next steps of how we should go about delivering them, given the likely financial future and the workforce that will be available to us.

This report will act as one of the batons that will be passed to the new generation of commissioners; clinically-led, locality focused but with a will to work together. It will also be an important introductory guide for local Health and Wellbeing Boards and Health Watch groups to discuss the future development of local health economies and the implications for both health and social care. It is only through this common understanding of where we are now and what we should be aspiring to, that will allow us to deliver the improved standards that we all recognise our patients deserve.

Cameron Ward

Chief Executive
NHS Tees



Yasmin Chaudhry

Chief Executive
NHS County Durham and Darlington

# Contents

# Introduction

In 2010, the NHS Constitution was established to define the principles and values of the NHS in England, setting out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve.

This Acute Services Quality Legacy Project was designed to help provide the evidence base that will help ensure the delivery of the NHS Constitution and the principles that underpin it, in particular *Principle 3: "aspiring to the highest standards of excellence and professionalism".*

Following the passing of the Health and Social Care Act 2012 and in time for the start of the 2013/14 financial year, there will be a new commissioning architecture for the NHS in England. Clinically-led commissioning groups (CCGs) will replace Primary Care Trusts (PCTs) as the main commissioner and purchaser of healthcare on behalf of patients, Local Education and Training Boards (LETBs) will replace Strategic Health Authorities (SHAs) as the main commissioner of medical education places for doctors and nurses and new Health and Wellbeing Boards (H&WBs) will be responsible for the alignment of health and social care strategies to improve outcomes for their populations.

The 2012/13 financial year is largely a transitional period between the current and the new worlds and as part of this transition, a series of legacy documents are being produced by PCT Clusters to support the emerging organisations in undertaking their new responsibilities.

The Acute Services Quality Legacy Project contributes to the development of these legacy documents so that CCGs, LETBs and H&WBs understand the opportunities and challenges in achieving best-in-class levels of service within the likely financial environment over the coming years.

This has been achieved by establishing definitions of the highest standards of service quality and the evidence base for these definitions and identifying what factors are most important when considering the sustainability of services that will meet these standards into the future.

The project builds on similar work carried out by the NHS North East Our Vision Our Future Clinical Innovation Teams and looks to ensure continuity of membership relative to local organisations where possible. It also feeds into the development of the new Clinical Senate for the North East and Cumbria and proposed strategic clinical networks.

The outputs of the project will also support commissioners to meet the requirements of the *NHS Outcomes Framework 2011/2012 (*Figure 1*).*

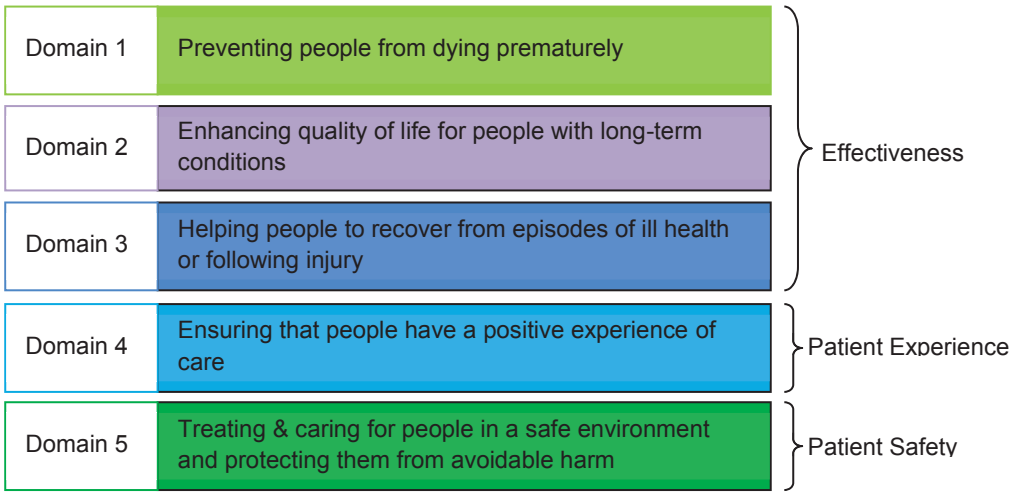



Figure 1: Domains mapped to elements of quality

The County Durham, Darlington and Teesside health economy is fortunate to have three large secondary care organisations within it's boundaries that provide high-quality care to their patients. The current Care Quality Commission quality measures underline this as depicted in figure 2.

| Provider | Accident & Emergency | Waiting list and planned admissions | Waiting to get a bed on a ward | The Hosptial and ward | Doctors | Nurses | Care and Treatment | Operations and Procedures | Leaving hospital | Overall views and experiences |
|---|---|---|---|---|---|---|---|---|---|---|
| CDDFT | 7.5 | 6.6 | 7.7 | 8.1 | 8.5 | 8.2 | 7.3 | 8.2 | 7.1 | 5.7 |
| NTHFT | 8.4 | 6.5 | 8.5 | 8.3 | 8.5 | 8.3 | 7.5 | 8.5 | 7.2 | 6 |
| STHFT | 8.1 | 6.6 | 8.3 | 8.2 | 8.7 | 8.6 | 7.7 | 8.3 | 7.1 | 6.2 |

Worse than other Trusts nationally | Better than other Trusts nationally | In-line with other Trusts nationally

Figure 2: Care Quality Commission Indicators for Inpatients across service providers (out of ten)

Whilst demonstrating current secondary care providers are offering a high level of quality, these measures do not tell us if our patients are receiving now (or can expect to in the future) the highest possible level of quality of care.

This report will support commissioners and providers alike in determining priorities for incentivising changes to current practice, under-taking service improvement work or for re-designing the models of care that deliver them.

## Summary of Project Recommendations

The follow recommendations are based on the work undertaken by the project team, clinical advisory groups and consultancy support and are explained in detail in the later sections of the document and under-pinned by the technical data outlined in Appendix 1.

The main contextual messages on economics and workforce are as follows:

- Following years of growth, demand for acute services is currently high for both elective and non-elective care.
- There will be a significant increase in prevalence across the major long term conditions over the next ten years and a greater proportion of the population will be over the age of 65.
- This will have an impact on the utilisation of acute services to a varying degree in the different service areas.
- This growth will put pressure on commissioners' allocations over the next ten years as an older population with more co-morbidity will consume more health resource, unless effective demand and long term condition management are implemented. This analysis does not take into account potential increased spend on high cost drugs and new medical technologies in the acute setting that may require further investment from commissioners.
- Forecasts show that providers can maintain a financially stable position over the next five years as long as cost improvement plans deliver to target. Failure to deliver these targets will have implications for trusts' operating surplus/deficit position and ultimately the length of time they can rely on cash savings to keep them solvent.
- This means that new funding is unlikely to be available to expand the access to services of the very highest quality as providers look to maintain the current levels of quality within the resources they have access to.
- Even if commissioners were to receive increases to their allocations and providers had efficiency requirements at pre-Comprehensive Spending Review levels, national and regional workforce constraints may have more impact on the ability to deliver higher quality standards.
- These national and regional workforce considerations are further compounded by supply and demand of particular grades and skills of the current and future workforce within the acute sector in County Durham, Darlington and Tees.

**Acute Paediatrics, Maternity and Neonatology**

The overall recommendations of the Acute Services Quality Legacy Project in relation to acute paediatrics, maternity and neonatology services, given the wider financial and workforce contexts, the underlying health data, views of the clinical advisory group and the specific workforce risks and opportunities, are that the Project Board:

- Endorse the Royal College of Obstetricians and Gynaecologists (RCOG) standard of 168 hours (24/7) consultant presence as the ultimate goal for maternity services across County Durham Darlington and Tees. This standard was supported by the majority of the Clinical Advisory Group (CAG) but there was a minority view that 98 hours consultant presence should be established as the standard for units with less than 4000 deliveries a year. The Project could not find enough evidence to inform a recommendation that goes against the Royal College standard, therefore the Project supports the RCOG standard and majority view of the CAG. Given the scale of this challenge however, there is a recognition that this needs to be delivered in a staged way, with 98 hours as an interim step for units with less than 4000 deliveries a year as part of a phased approach to implementation.
- Endorse the key quality standard of 1:1 Midwife care for women in established labour
- Ask Clinical Commissioning Groups to consider the steps they may take in the next contracting round to address some of the gaps in quality standards through the use of CQUIN incentives and agreeing small scale service improvement work with individual trusts.
- Agree to a further feasibility analysis to understand the implications of implementing the standards across County Durham, Darlington and Tees. This assessment should take into account the role of Midwife Led Units and how best to support an increase in home-births.
- Agree to inform the LETB to adjust commissioning plans to increase the numbers of midwife training places to mitigate against risks in future workforce shortages.

**Acute Care**

The overall recommendations of the Acute Services Quality Legacy Project in relation to acute care, given the wider financial and workforce contexts, the underlying health data, views of the clinical advisory group and the specific workforce risks and opportunities, are that the Project Board:

- Endorse the key quality standards recommended by the CAG as those that define high quality care.
- Endorse the recommendation for acute trusts to collaborate in establishing an interventional radiology service available 24/7.
- Agree that the critical care element of the Acute Care CAG continue until final recommendations can be made.

## End of Life Care

The overall recommendations of the Acute Services Quality Legacy Project in relation to end of life care, given the wider financial and workforce contexts, the underlying health data, views of the clinical advisory group and the specific workforce risks and opportunities, are that the Project Board:

- Endorse the key quality standards recommended by the CAG as those that define high quality care, particularly those that relate to the 24/7 availability of an appropriately trained nurse to provide practical support, responding within one hour, with access to necessary medicines and home equipment for End of Life cases. In addition the CAG recommends the appropriate use of the Liverpool Care Pathway in all care settings including the sharing of results
- Project board to endorse the recommendation for collaboration across the acute trusts to establish a 7 day per week service providing specialist palliative care advice.

## Long Term Conditions

The overall recommendations of the Acute Services Quality Legacy Project in relation to long term conditions are as follows:

- Given the scale of the likely challenge ahead due to the ageing population, the rising prevalence of LTCs and the wider membership of organisations involved, a new project focusing on LTC management should be initiated across health and social care. This project should include community services, mental health and primary care providers as well as acute trusts.
- The project will add value to the existing work on long term conditions led by CCGs, by establishing a consensus on the scale of intervention needed and the quality standards to be achieved.
- Further work in this area would include more detailed work on the financial and workforce challenges to provide a better understanding of the required scale of transformation and the development of concrete plans to achieve this, learning from success locally, regionally and nationally.

## Planned Care

The overall recommendations of the Acute Services Quality Legacy Project in relation to planned care are as follows:

- CCGs should review the Planned Care Briefing Paper to identify and continue to understand unexplained variations in referrals from Primary Care and clinical practice in secondary care
- Where appropriate CCGs should look to use information to inform patient choice and commissioning levers to encourage competition to drive quality in Planned Care. This includes the introduction of new providers into the market to stimulate innovation
- CCGs should however consider the financial implications for current providers that any movement of activity away from them may have (either to other current or new providers) when making changes to elective pathways.

## Overview of project methodology

In order to provide this assessment, the project consists of three inter-linked workstreams which contribute to the production of a final set of recommendations and an understanding of the wider context in which they are being made.

1) A clinical quality assessment across four broad clinical areas undertaken by Clinical Advisory Groups (CAGs) that addresses the following questions:

    - What are the current issues facing each service area?
    - What does best practice look like?
    - What are the barriers to achieving best practice?
    - What can be done to overcome those barriers to achieve best practice?

2) An economic assessment that provides an understanding of the local financial environment through a local agreed set of planning assumptions feeding into a fifth clinical area (Planned Care)

3) A workforce assessment that identifies current gaps/over-supply and future constraints of specialist clinical staff in relation to the deliverability of the quality standards agreed by the Clinical Advisory Groups.

The relationships and dependencies of the workstreams are shown in the figure 3.

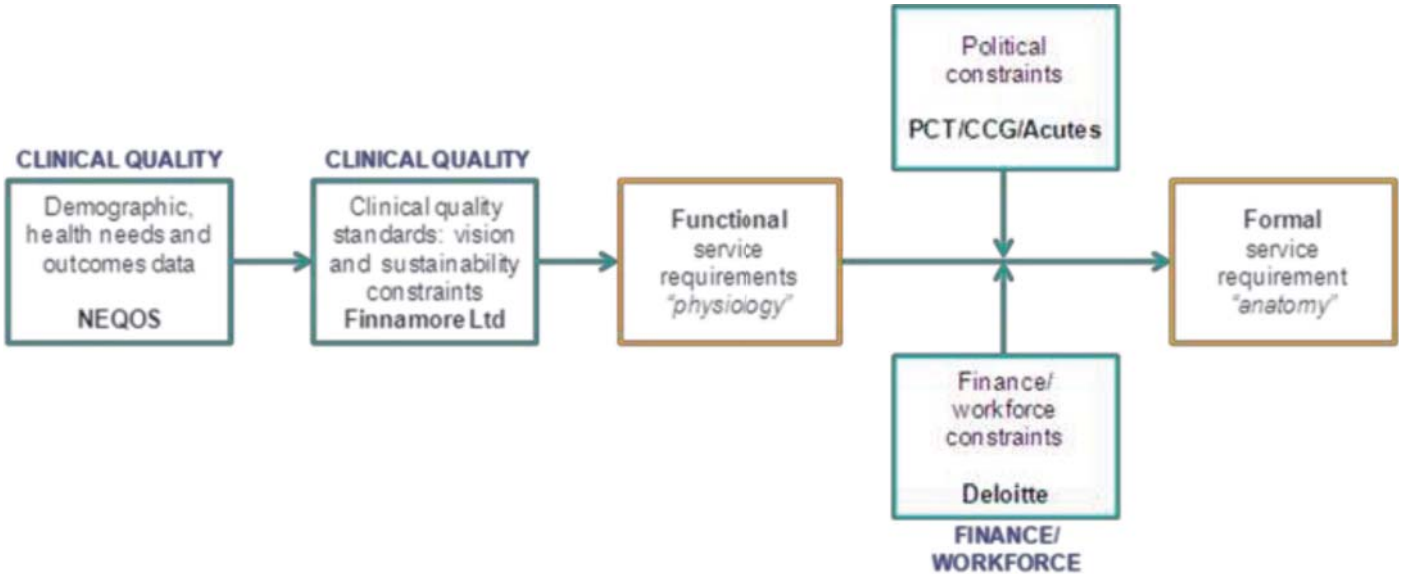



Figure 3: Workstream relationships and dependencies.

The Clinical Advisory Groups of the Clinical Quality work stream focused on secondary and tertiary care services at County Durham and Darlington FT, North Tees and Hartlepool FT and South Tees Hospitals FT, in three clinical areas.

These clinical areas are:

- Acute Paediatrics, Maternity and Neonatology
- Acute medicine, general surgery and ITU
- End of Life

Each of these Clinical Advisory Groups is made up of clinicians from each of the Foundation Trusts and representatives from CCGs. This report outlines the key recommendations from each of these groups, the ways in which the recommendations are most likely to be realised and the environment in which they are being made. A fourth Clinical Advisory Group with a smaller membership of primary care clinicians was also established to support the scoping of the long term conditions work.

**Communications and engagement**

Since May 2012 we have carried out the following work to ensure key stakeholders are informed about the project and are given opportunities to contribute their views:

- Briefings on the project have been made available to OSCs, shadow health and wellbeing boards and local authority leaders, chief executives and senior officers

- A number of meetings have been held with key stakeholders, such as the Tees Valley Health Scrutiny Joint Committee, Durham Adults, Wellbeing and Health Overview and Scrutiny Committee, local authority CEs, and the leaders and mayors group in Tees Valley, to inform them about the project and gather their views on further methods and opportunities to keep them informed of project progress and wider engagement

- Meetings with LINks will take place over the coming weeks

- MPs have been informed about the project and offered an opportunity for in depth briefing, Meetings with two MPs have been held as a result of such requests.

## Context

In order to fully understand the findings and the recommendations from the project, it is important to set out the context for this work. The three main aspects of this context are:

- The changing demands on the acute sector caused by changes in demography, disease prevalence and clinical practice (including advances in medical technologies and drug therapies)
- The national and local financial environment over the coming years
- An understanding of national and local workforce considerations

A wide ranging analysis of nationally available data has been undertaken by the North East Quality Observatory System (NEQOS) to support each Clinical Advisory Group in understanding their own unique challenges caused by potential changes in demography, disease prevalence and clinical practice. As well as this service level analysis, the impact these changes have at macro- health economy level can also be assessed. This should support commissioners in choosing where to prioritise investment and to identify the opportunity cost of this prioritisation across the various health sectors (e.g. community based services and mental health provision).

These economic pressures then need to be seen within the wider financial environment of the NHS and the likely impact this will have on funding settlements for commissioners and efficiency expectations for acute providers. There will also be some “knock-on” to the NHS due to national funding settlements in other governmental department areas that have close ties with healthcare provision (for example social care).

Finally, several national policies will affect the supply or availability of the NHS workforce available to acute providers. These national policy decisions may be compounded by local constraints specific to either the North East as a region, County Durham, Darlington and Teesside as an area or at individual trust level.

## Changing demands on the acute sector

Since the implementation of the Commissioning a Patient-Led NHS policy in 2005 there has been a steady and inexorable increase in secondary care activity. Some of this increase can be attributed to the reduction in elective waiting times across outpatient appointments, diagnostic testing and inpatient procedures, some to increased screening and early identification of conditions and some to the introduction of new services to meet previously unmet demand.

Despite the achievement of delivering the18 Week Wait across all specialties, the demand for services continues to remain high in County Durham, Darlington and Tees. Figure 4 shows the current activity levels for elective and non-elective admissions.

This high starting point is at risk of increasing further in the future due to the rise in the prevalence of long term conditions (figures 5 and 6) due mainly to a change in the age profile of the population (figure 7).

Increased activity in the secondary care sector has two main impacts. Firstly the increase in activity draws commissioners' resources into the acute sector (through the Payment By Results mechanism) at the opportunity cost of investing in more "up-stream", preventative services that would help manage demand in future years.

This creates a cycle of missed opportunities that over time becomes less and less affordable due to the rate at which the population ages. It can be argued that in the past, the impact of this cycle was masked by increases in commissioners' allocations at above inflation levels. The financial future of the NHS is tied to that of the wider UK economy however, so when forecast demand for services is mapped against a range of scenarios for income and efficiency, the effect of increased acute activity becomes more stark.

Secondly, depending on the type of activity, it makes it harder for providers to make the cost improvements necessary to make them financially stable on an ongoing basis as financial rules (such as the marginal tariff for non-elective care over 2008/09 levels) remove the income but without removing cost of caring for patients.

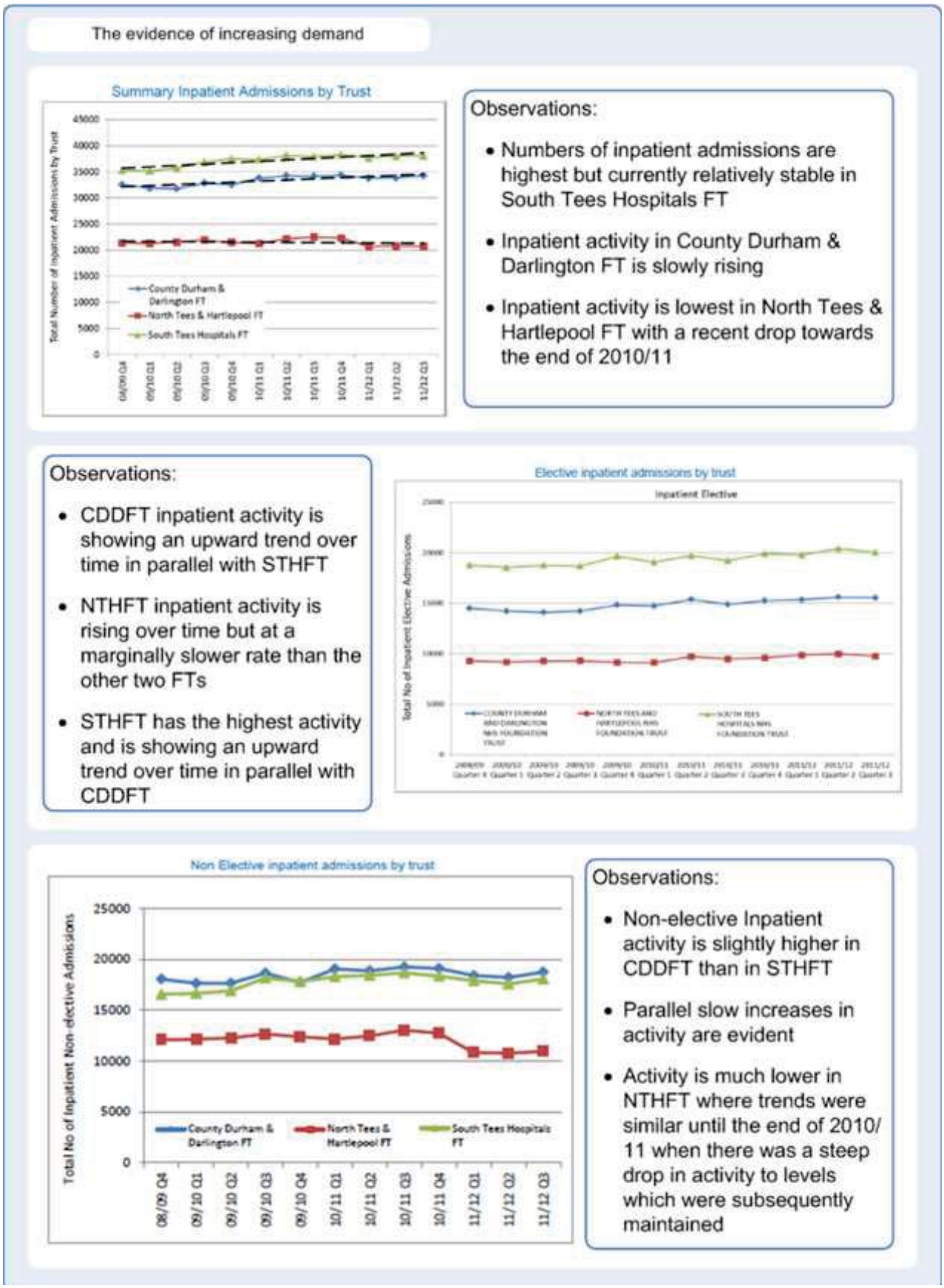



Figure 4: current activity in the acute sector

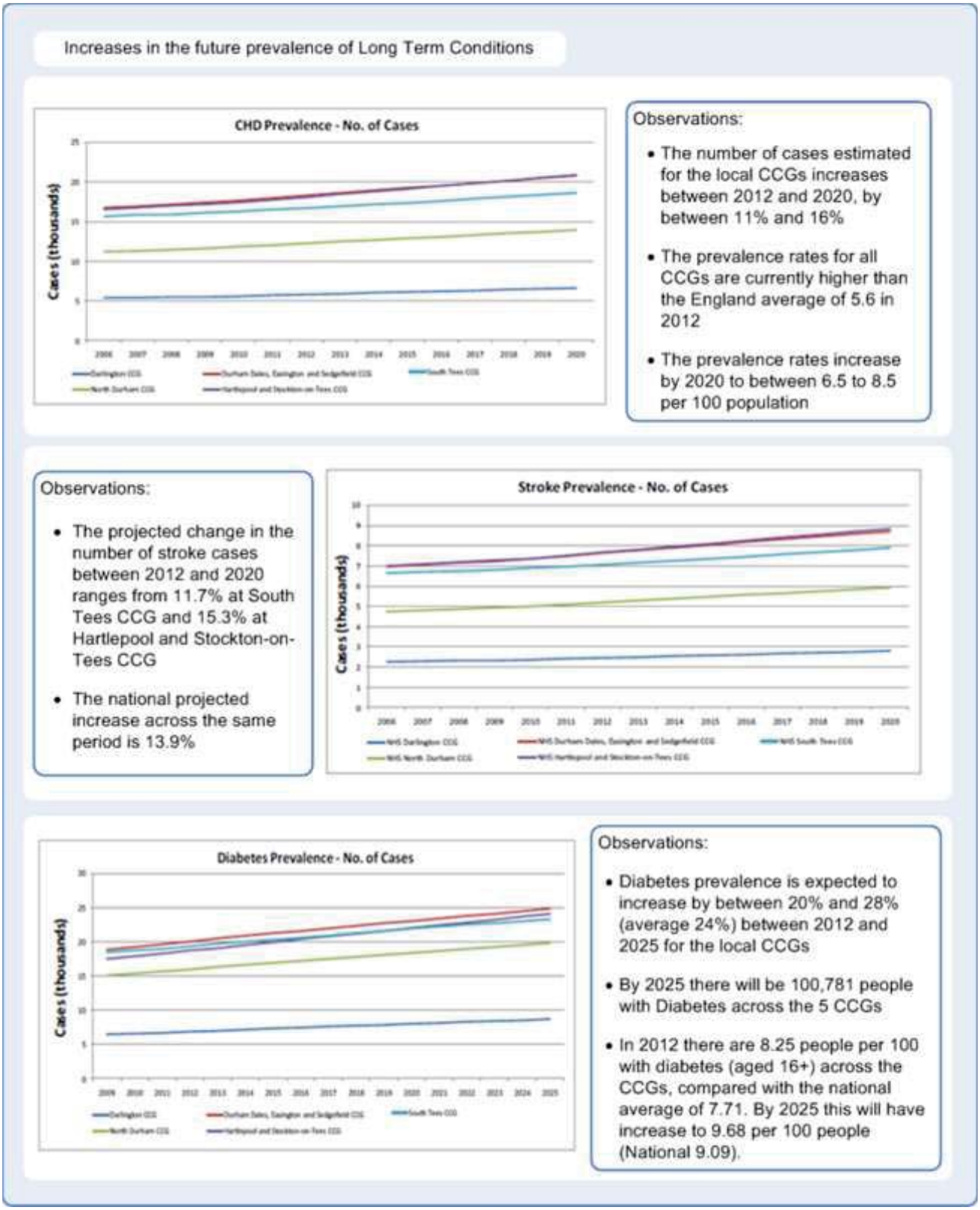



Figure 5: predicted increases in prevalence for CHD, Stroke and Diabetes

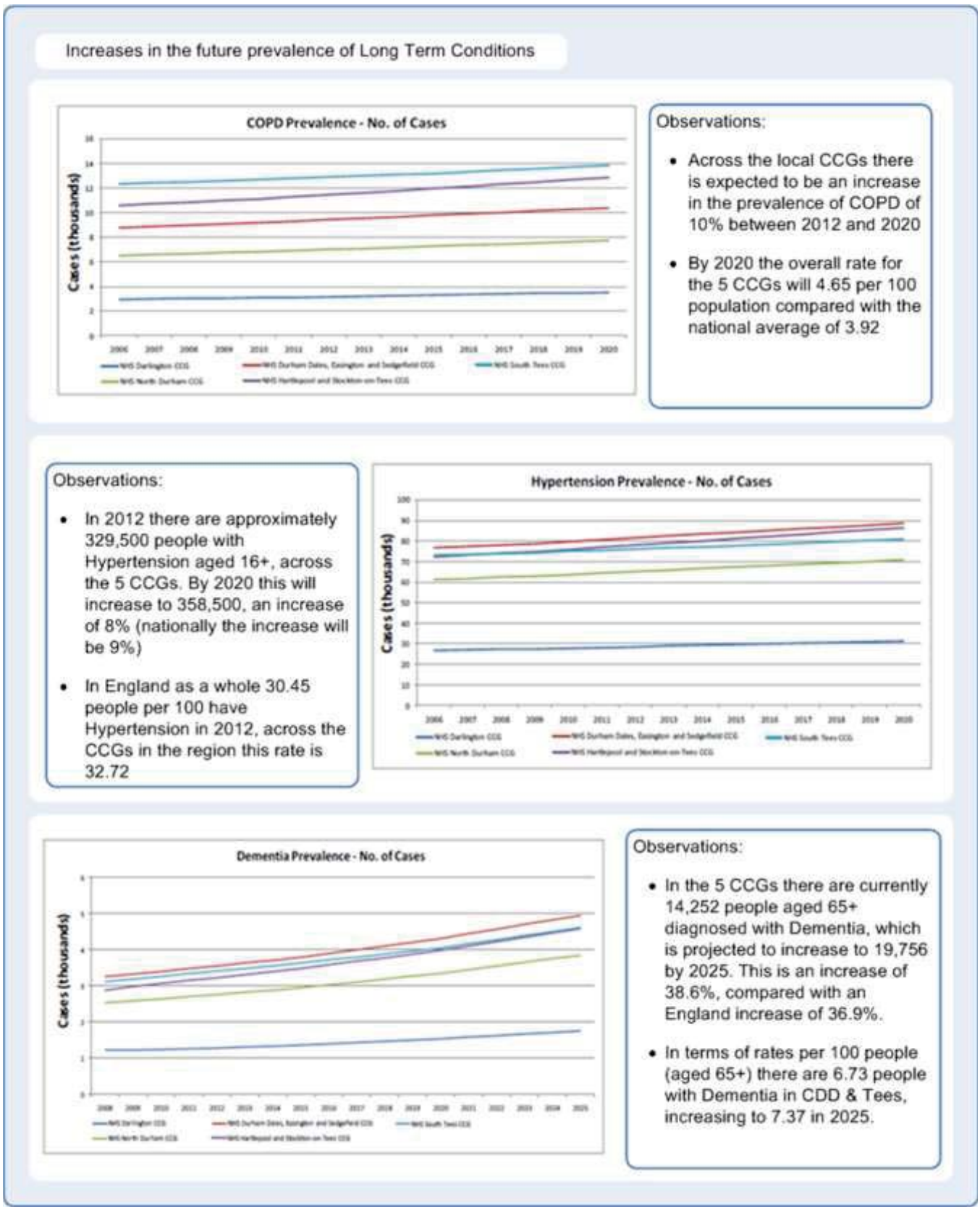



Figure 6: predicted increases in prevalence for COPD, Hypertension and Dementia

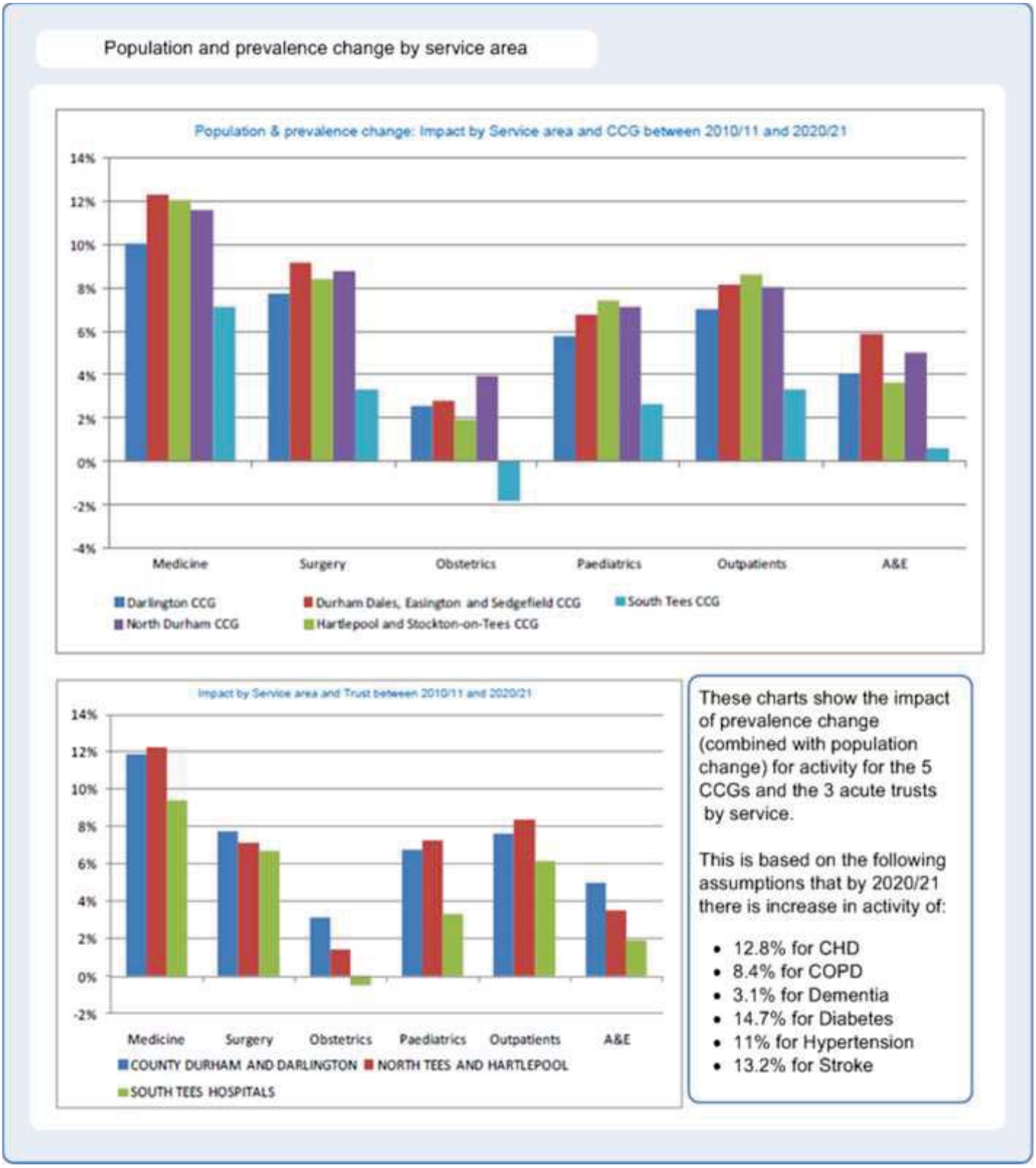



Figure 7: Impact of increased LTC prevalence and population changes on services

## Economic context - commissioners

The financial implications of this forecasted increase in activity and utilisation has been assessed using a ten year financial model built on costed acute PBR activity. The use of PBR costed activity only gives a simplified message on the potential impact to commissioners, avoiding complications of changes in commissioning budgets to reflect the re-alignment of Public Health and Specialised Commissioning budgets in the future and also doesn't take into account local risk-sharing arrangements.

### Historic spend

Acute spend has grown at 7% p.a. from 2008/09 (Compound Average Growth Rate 2008/09 - 2011/12) in services paid for under the Payment By Results (PBR) mechanism (figure 8).

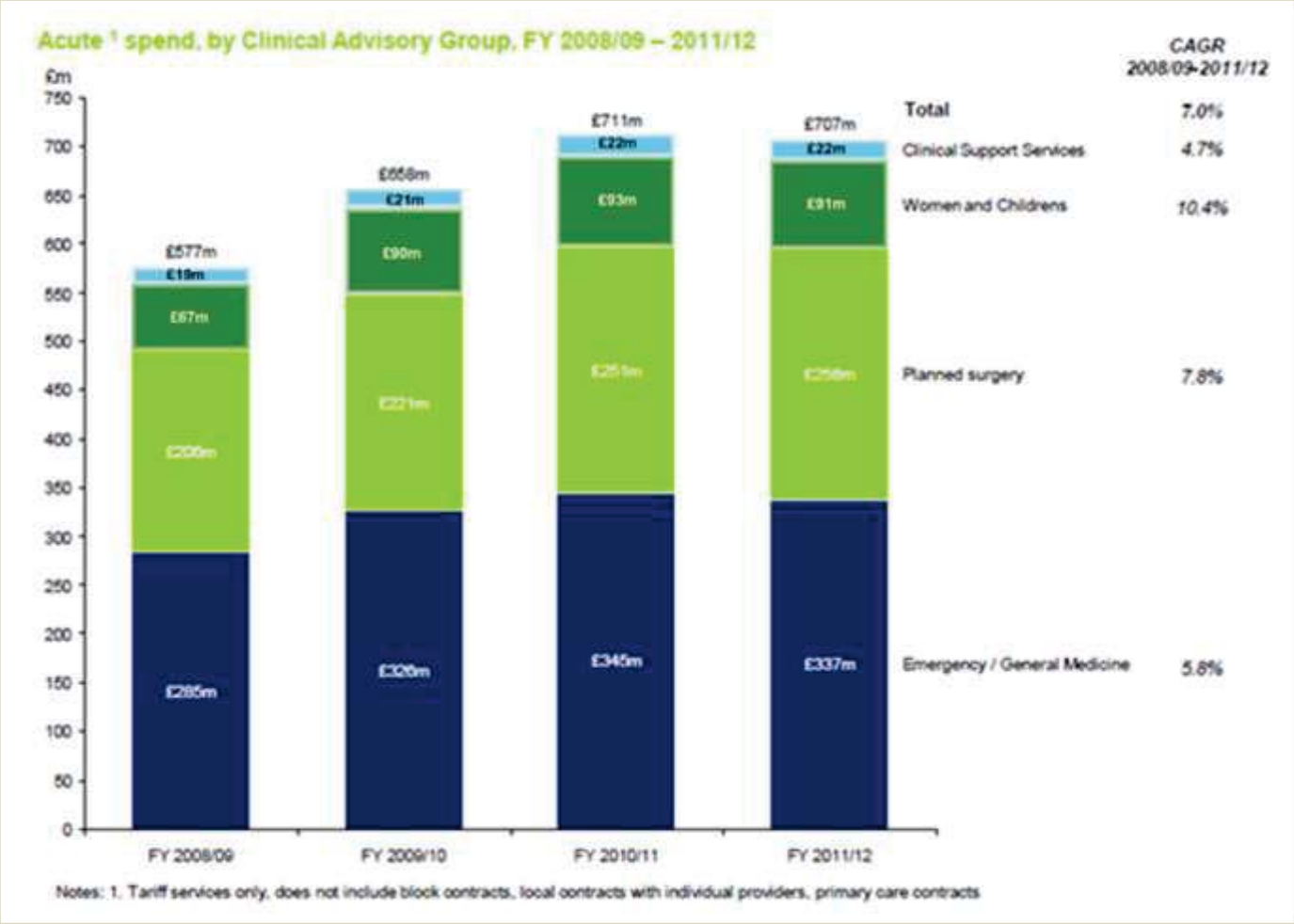



Figure 8: Historic spend on acute services paid for under PBR

In the first five years of the forecasted model, this increase is a modest 0.1 percent growth (as outlined in figure 9) as the financial impact of the ageing and growing population is offset by lower costs of procedures due to the impact of the tariff deflator, which is particularly high in these first 5 years.

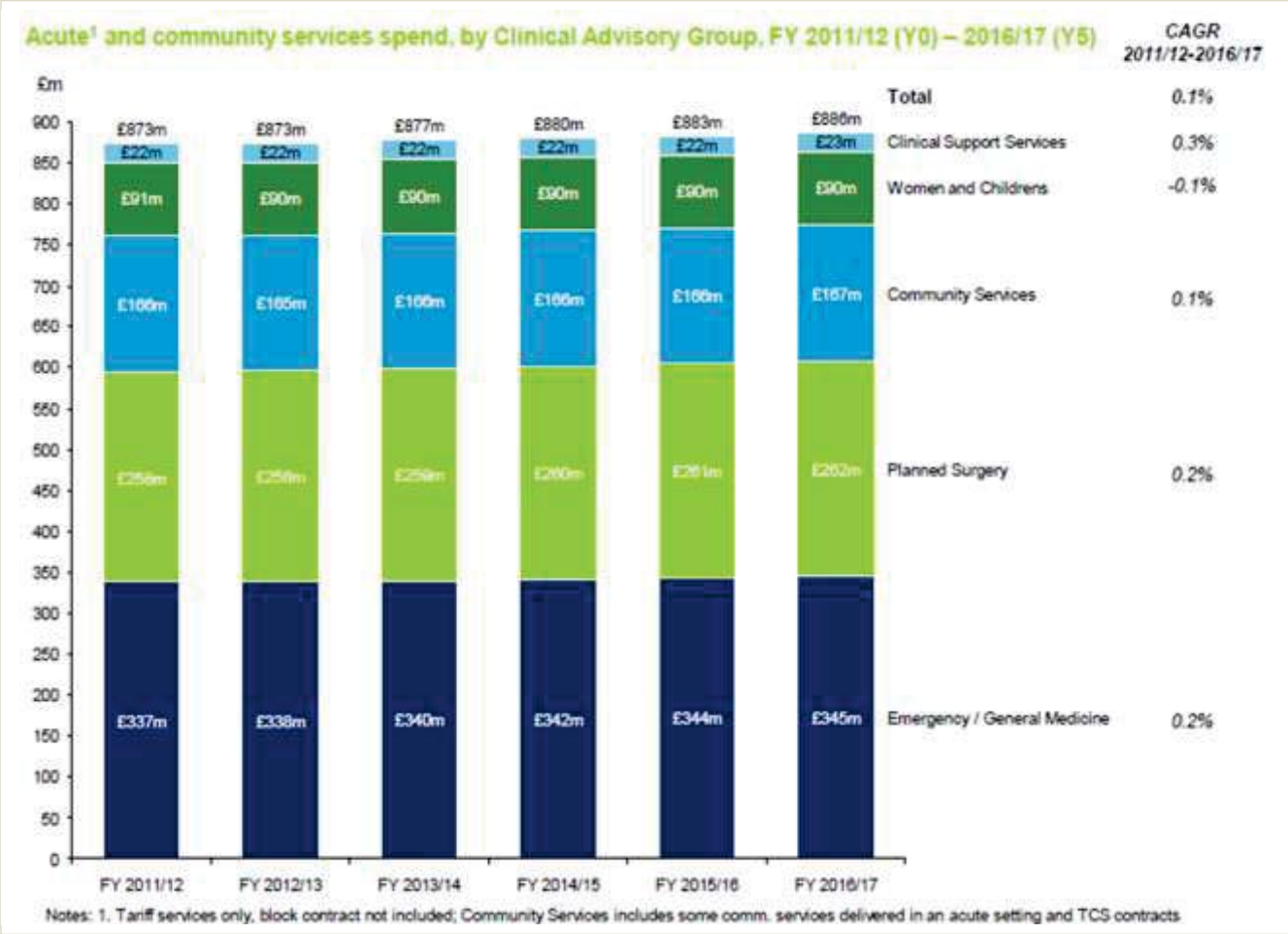



Figure 9: Forecast acute spend on acute services 2012/13 – 2016/17

Despite this slow rise in the early years of the forecast, the increasing proportion of the population being aged 65 or over suggest that the following five years will see more significant pressure.

Speciality by speciality modelling shows that this ageing population will drive an increase of 0.8% p.a. over the ten year period (figure 10) The primary causes of this increase are likely to be in the use of clinical support services (clinical haematology and clinical oncology) and in usage of emergency, general medicine, cardiology, ophthalmology and geriatrics medicine services.

Further increases in spending in the acute sector can also be anticipated outside of PBR related activity from the introduction and uptake in new drug therapies and advances in medical technology.

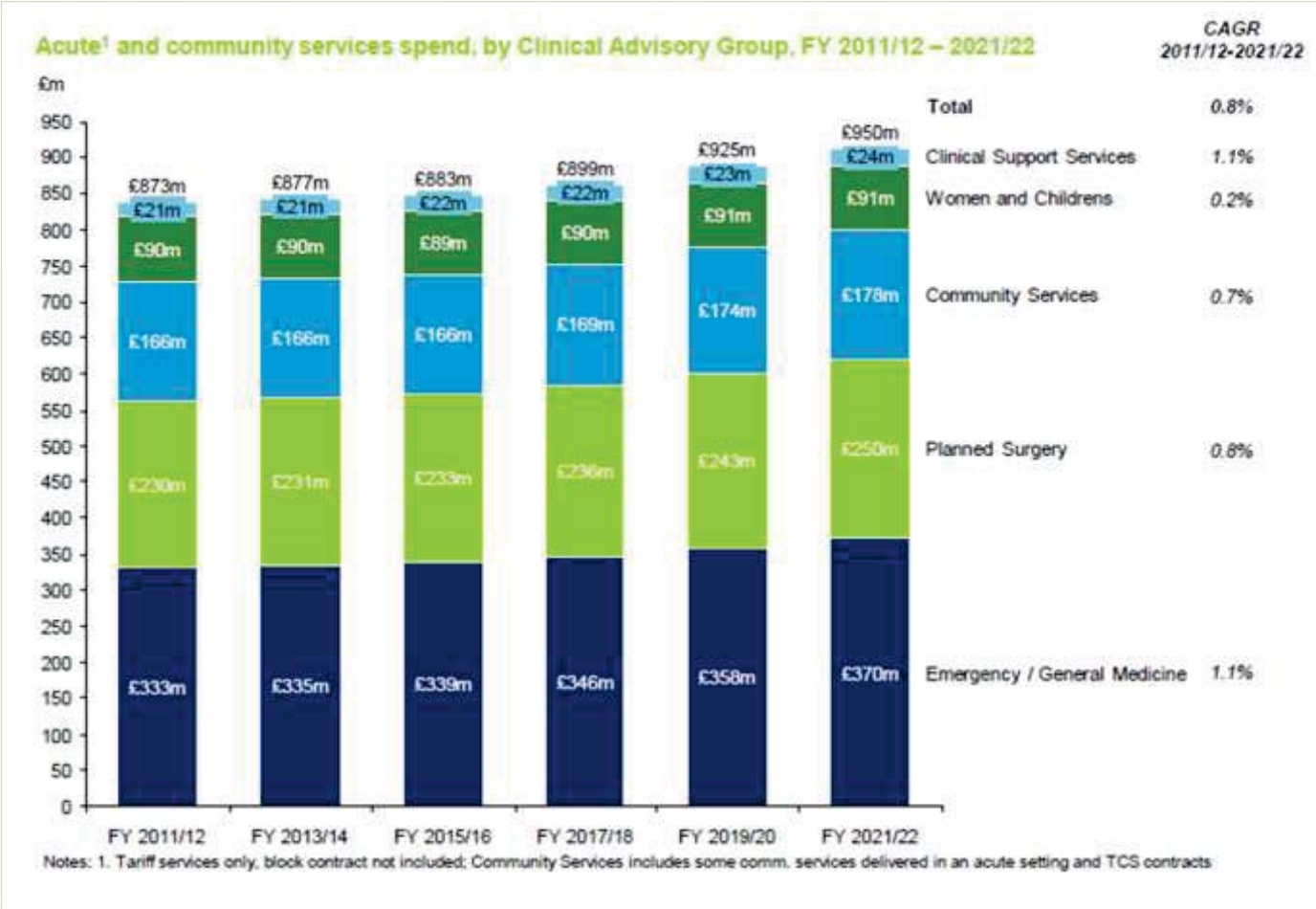



Figure 10: Forecast acute spend on acute services 2012/13 – 2021/22

## Economic context - providers

As well as commissioners looking to keep expenditure on services within their likely allocated resources, provider organisations must work hard to deliver the level of efficiency required of them (as outlined in the financial rules of the Operating Framework for the NHS in England). Forecasts on the financial performance, ambition of cost improvement and resultant sustainability of profitability of the three local acute foundations trusts have been made over the next five years based on their current Medium Term Financial Plans.

### Financial performance

The EBITDA (Earnings Before Interest, Taxes, Depreciation and Amortization) is a measure of the financial health of a provider organisation as it gives a simple measure of the operational profitability of each Trust and their ability to service their debts and pay a return to the taxpayer.

Another measure of financial performance is to look at Net Return After Financing. This measure is a step further on from the EBITDA as it considers specifically the surplus generated by the entity from which dividends can be paid back to the taxpayer in the form of public dividends.

The forecast EBITDA and Net Return After Financing levels can be seen in figure 11. Monitor assigns a risk factor to the EBITDA and Net Return After Financing calculation on a scale of 1 to 5 (1 being the worst, 5 the best). On the EBITDA measure, all three local providers are operating at a risk rating of 3 for the next 5 years and for Net Return After Financing a risk rating between 3-4.

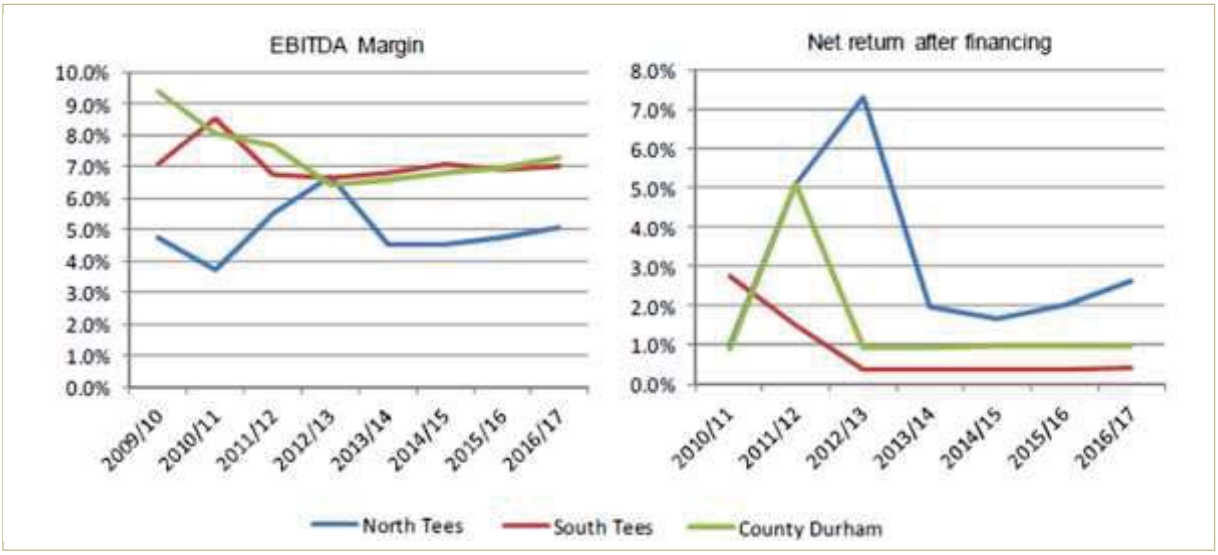



Figure 11: Forecast EBITDA and Net Return After Financing measures

Income and Expenditure (I&E) surplus margin is the simplest (and crudest) measure of performance and considers the surplus after deducting interest, depreciation and dividends as a fraction of operating revenues. All three trusts forecast an I&E surplus margin of around or below 1% in the final 3 years of the forecasted model (figure 12). This would represent a risk rating of between 2 and 3.

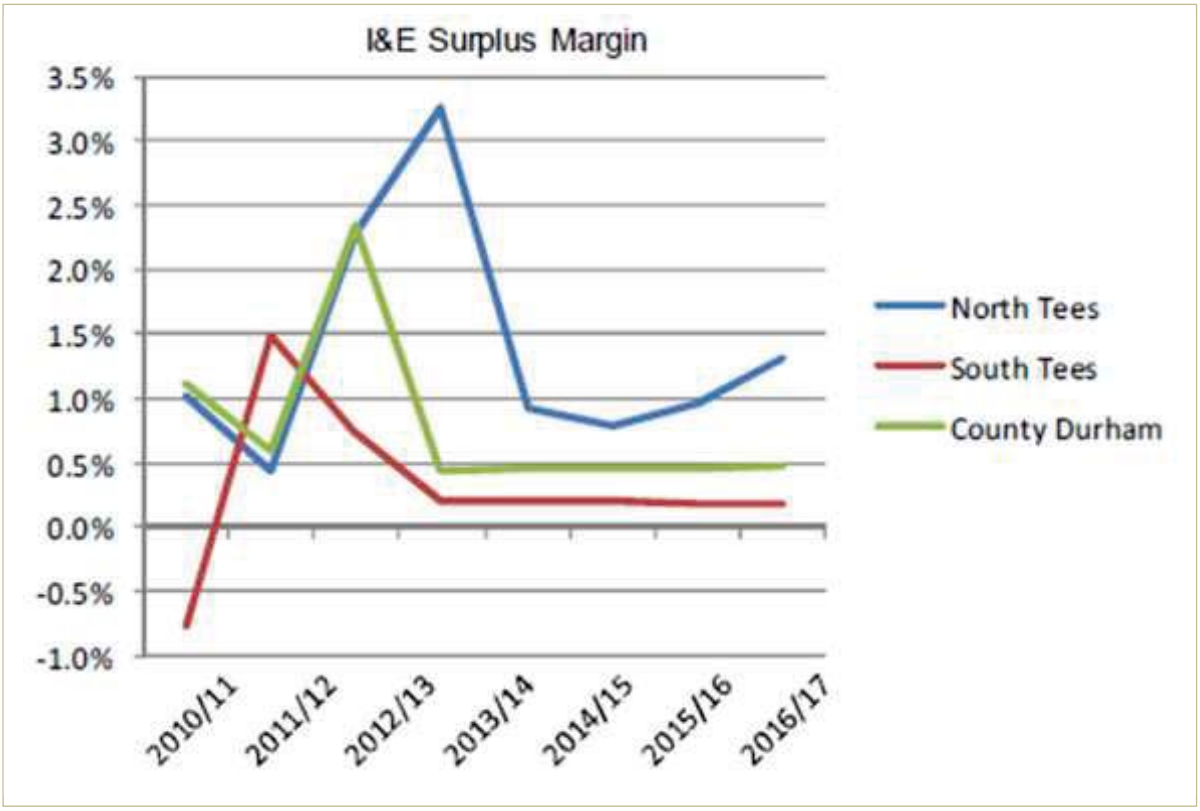



Figure 12: I&E Surplus Margin

## Cost Improvement Plans

Cost Improvement Plans (CIPs) consist of a range of transactional and transformational changes that can release efficiencies which can be used by providers to re-invest in improving front-line care or reduce the need to bring in additional revenue in order to balance the books. Monitor assesses foundation trust CIP ambition against two scenarios; the Assessor and Downside cases as outlined in figure 13.

| | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 |
|---|---|---|---|---|---|
| Monitor (Assessor) | 4.50% | 5.00% | 5.00% | 4.20% | 4.20% |
| Monitor (Downside) | 5.25% | 5.50% | 5.50% | 5.00% | 5.00% |

Figure 13: Monitor Assessor and Downside CIP levels

The level of individual trust CIPs within each year of the five year forecasts can be seen in figure 14 and differ trust-to-trust and year-on-year, ranging from those that do not meet Monitor Assessor case levels to some that go well beyond them.

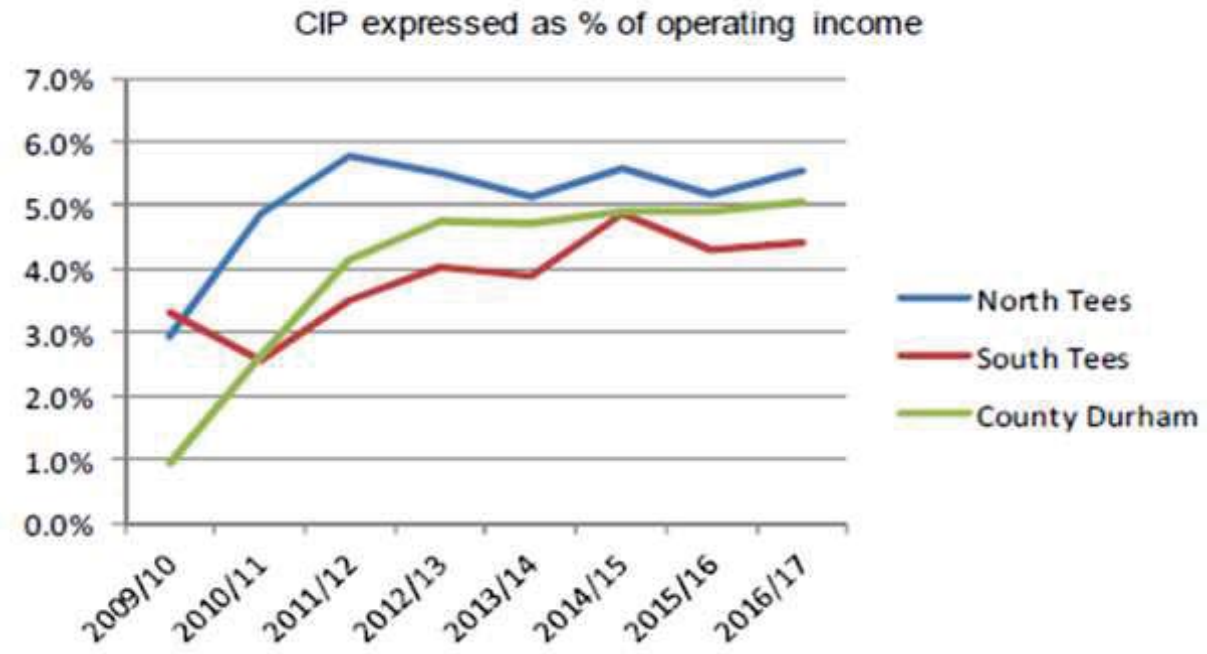



Figure 14: CIP expressed as a percentage of operating income

The implications of failing to achieve these cost improvement targets could have significant implications if further income could not be raised or alternative efficiencies found.

A sensitivity analysis was applied to the cost improvement plans that assessed the impact of achieving only a 3%, 2% or 1% cost improvement against expected income in each of the five years. The results are as follows:

- In the least severe scenario (3% CIP achievement every year) and if all other aspects of the financial plans remained constant, each trust would fall into an operating deficit by the end of 2013/14 but with sufficient cash in reserve to maintain financial balance until 2016/17.

- In the mid-case scenario (2% CIP achievement each year) one foundation trust would run out of cash reserves in 2014/15 with another following in 2016/17.

- In the most severe scenario (only 1% CIP achievement each year) one foundation trust would run out of cash reserves in 2013/14 with another following in 2014/15.

## Wider economic implications

Whilst the NHS is forecasting constrained increases in allocation and increased demands on the services it provides, local authorities have experienced real terms cuts in grants since the comprehensive spending review. These cuts, which when forecast into the future against future demand and further changes/reductions in grants show a likely shortfall in revenue to meet spending pressures.

The Local Government Association (LGA) has modelled all future sources of council revenue, including grants, local taxes, fees and charges, investment income and reserves drawdown to the end of this decade on assumptions that offset grant cuts against the potential for growth in other revenue sources.[1]

Whilst social care spending is a statutory obligation in the short- to medium-term, longer term financial constraint may lead to discussions on the payment models for social care as the proportion of local authority funding rises, squeezing out funding for other currently provided services.

This scenario could lead to an increased risk of cost shifting between the health and social care sectors if opportunities to integrate services or commissioning services jointly aren't taken.

[1] LGA Funding outlook for councils from 2010/11 to 2019/20: Preliminary modelling, June 2012

## Workforce context

As well as the likely future financial environment, the workforce context must be taken into account when understanding the constraints on delivering heightened levels of service quality. An assessment of the workforce issues and challenges has been undertaken together with a workforce model developed to understand specific current and future gaps against the Clinical Advisory Group recommendations about workforce quality standards.

The national and local workforce issues are outlined below and the specific findings of the workforce modelling are contained in the findings of the Clinical Advisory Groups sections of this report.

### National workforce – policy drivers and key issues

There are a number of key policy and strategic workforce issues that will all have an impact on the available supply of the workforce delivering services in the clinical areas within the scope of the ASQLP

- Pensions reforms. The effect of reforms to the NHS Pension scheme will make it more difficult to predict retirement choices across different professions and therefore workforce planning.
- Move to all degree registration for nursing. Diploma nurses may be more likely to stay in the local area whilst degree nurses may be more likely to move out of the region on completion and therefore the north east, with relatively stronger ratio of diploma nurses, may find that graduate nurses will become more geographically mobile and therefore more difficult to retain after graduation
- European Working Time Directive .The challenge of delivering EWTD during financially constrained circumstances is ongoing and pressures on junior doctor rotas.
- Reaccreditation of doctors. Medical revalidation and the process through which fitness to practice/licensing is carried out, could lead to greater levels of attrition
- Consultant led services. A body of evidence is emerging that Consultant Delivered Care (CDC) can provide better outcomes for patients and recent papers published by the Academy of Medical Royal Colleges (AoMRC), and additional survey data by the Royal College of Paediatrics and Child Health (CPCH) appears to support this
- As well as these factors, the Francis 2 Report into the failings in Mid-Staffordshire is due to report in January 2013, the recommendations of which may have further implications for the acute services workforce.

## Local workforce factors

There are also several local issues, challenges and constraints that will need have been taken into account in the production of this set of recommendations. These include:

- Weighted Capitation. Measures are used to provide an overview of the expected number of doctors proportionate to the regional population. The North East appears to be over-capitated for some of the consultant areas which are in scope for the project. The potential implication of over capitation is that it may be difficult to secure additional training posts e.g. in Obstetrics and Gynaecology (O&G). The recommendation from the Centre For Workforce (CfWI) Intelligence is to reduce National Training Numbers (NTNs), in the North East due the degree of over-capitation.

- Reduction in the numbers of medical trainees. Reduction in NTNs will need to be considered very carefully in terms of the impact for specific specialties and longer term planning. The CfWI recommendations are made on the basis of no reconfiguration of services and the impact of service changes in other parts of the region, e.g. Northumbria Emergency Care Centre will need to be considered as a local risk to supply.

- Maintaining specialist skills. At present there are often no standards set nationally that define the minimum number of procedures needed in each specialty to ensure doctors keep their clinical skills up-to-date once they qualify (although the reaccreditation of doctors has been introduced).

- Configuration of local services and impact on the labour market. There are different service models emerging and it will be important to address any capacity gaps as a result of these and also to identify skill mix opportunities which can be used to address these issues. In addition, developments in other parts of the North East may see staff migrate away from the three providers in County Durham, Darlington and Tees.

- Trainee satisfaction. The latest survey (GMC National Training Survey 2012) of trainee doctors rates the Northern Deanery highest in England overall. For Nursing and Radiography, Teesside University scores above average student satisfaction scores in the 2010 national student survey.

**Key shortage supply areas not covered by CAG specific analysis**

Shortages can be defined in a number of ways:

- Through analysis of national intelligence, e.g. CfWI drawing on likely changes in demographics and supply issues

- Reviewing weighted capitation which can provide a sense of 'relative' shortage

- National shortage list. Each year the Migration Advisory Committee (MAC) publishes a list of national shortage occupations under what is known as 'tier 2'. This list of occupations provides important intelligence as to areas of current labour market shortages. These occupations can then be eligible for the consideration of recruitment of overseas (non EEA) individuals. Last year's list included a number of professional groups which are relevant for the delivery of the services in the scope of the ASQLP.

**Current staffing levels**

Figure 15 shows the current staffing levels for senior staff per site and nurses per organisation for each 100 beds.

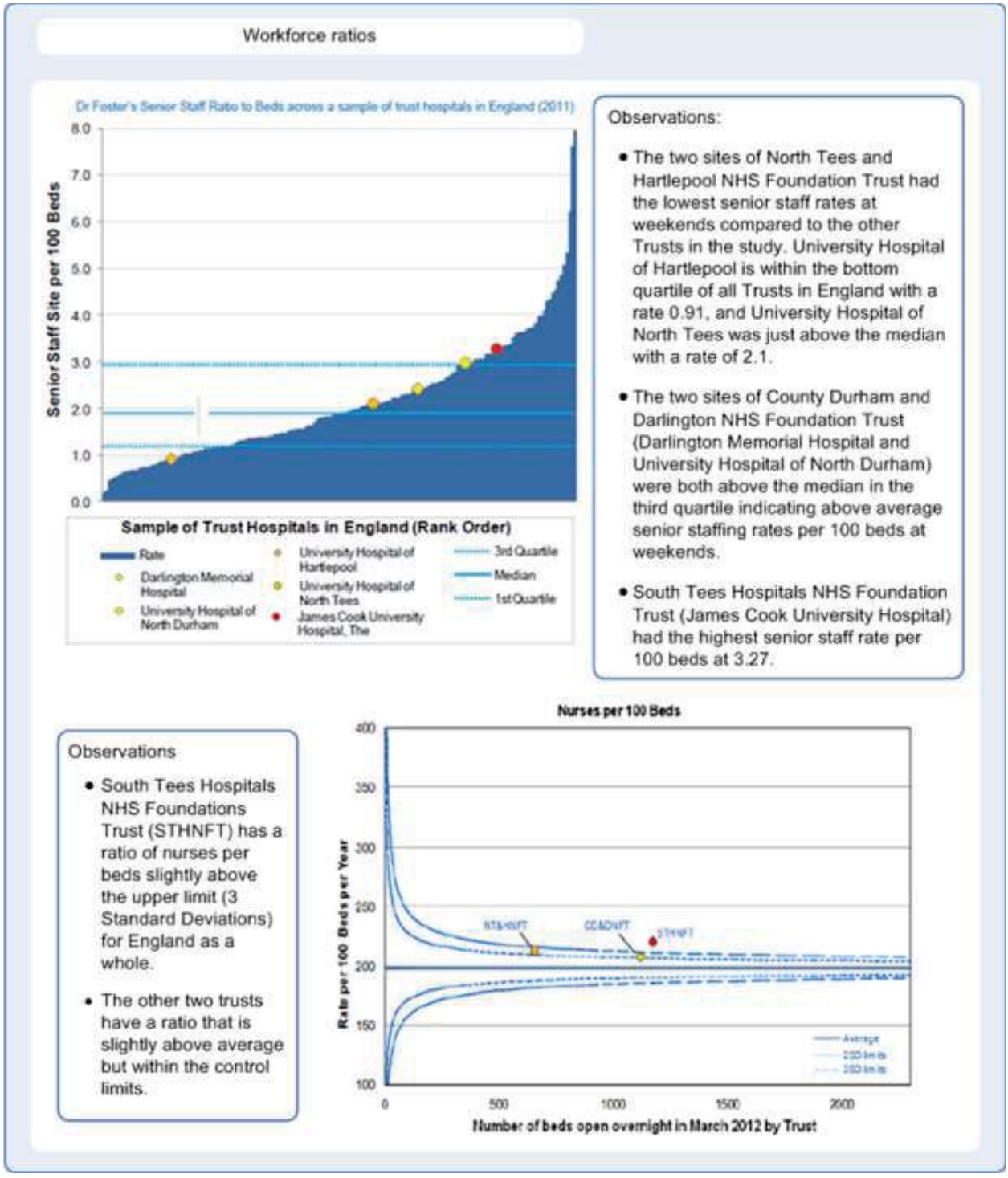



Figure 15: Commentary on high level staffing benchmarks

## Clinical Advisory Groups

As identified earlier in the report, four CAGs were established to lead the definition and review of clinical standards that would best define high quality to care, as well as an informal gap analysis against these standards and an understanding of the barriers to introducing them.

Of the four clinical advisory groups established, three followed a standard approach to the review of quality standards as outlined in figure 16. These groups were as follows:

- Acute Paediatrics, Maternity and Neonatology
- Acute Care
- End of Life Care

The types of standards the CAGs were really interested in were those that related closest to the long term sustainability of services or were linked to staffing/rota requirements rather than those that focused on individual clinician-to-patient practice.

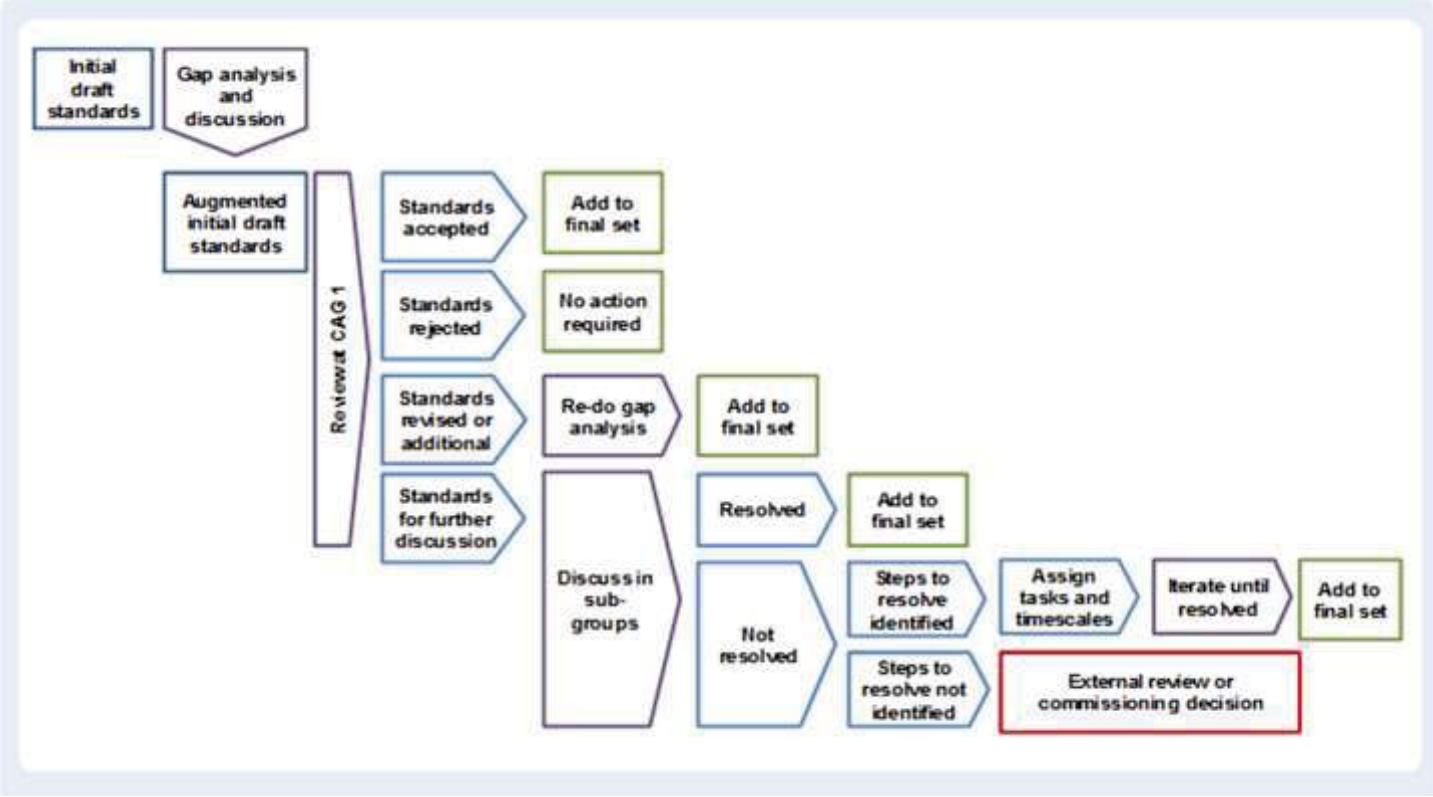



Figure 16: CAG process for the review of clinical standards

The Long Term Conditions CAG carried out a desk-top review of the financial impact to commissioners and providers of the introduction of a range of potential LTC interventions/service models.

Due to the sheer number of specialties involved in planned care, this section of the report will focus on quality issues identified in the North East Quality Observatory Briefing Paper and whilst looking to understand the current level of choice and competition across County Durham, Darlington and Tees.

**Workforce modelling to support Clinical Advisory Groups**

The ASQLP has focused on using quality standards as the basis of the models within the workforce assessment.

The workforce workstream combines two components:

- Qualitative analysis based on national and local workforce intelligence for all of the 5 areas;

- Quantitative analysis based on detailed staffing analysis for the areas of Maternity, Paediatrics and Neonatal services.

The quantitative models developed combine workforce data, baseline data and quality standards to provide an insight into three key things: current compliance with agreed quality standards, likely future compliance with standards and an illustration of the workforce implications of different scenarios (figure 17).

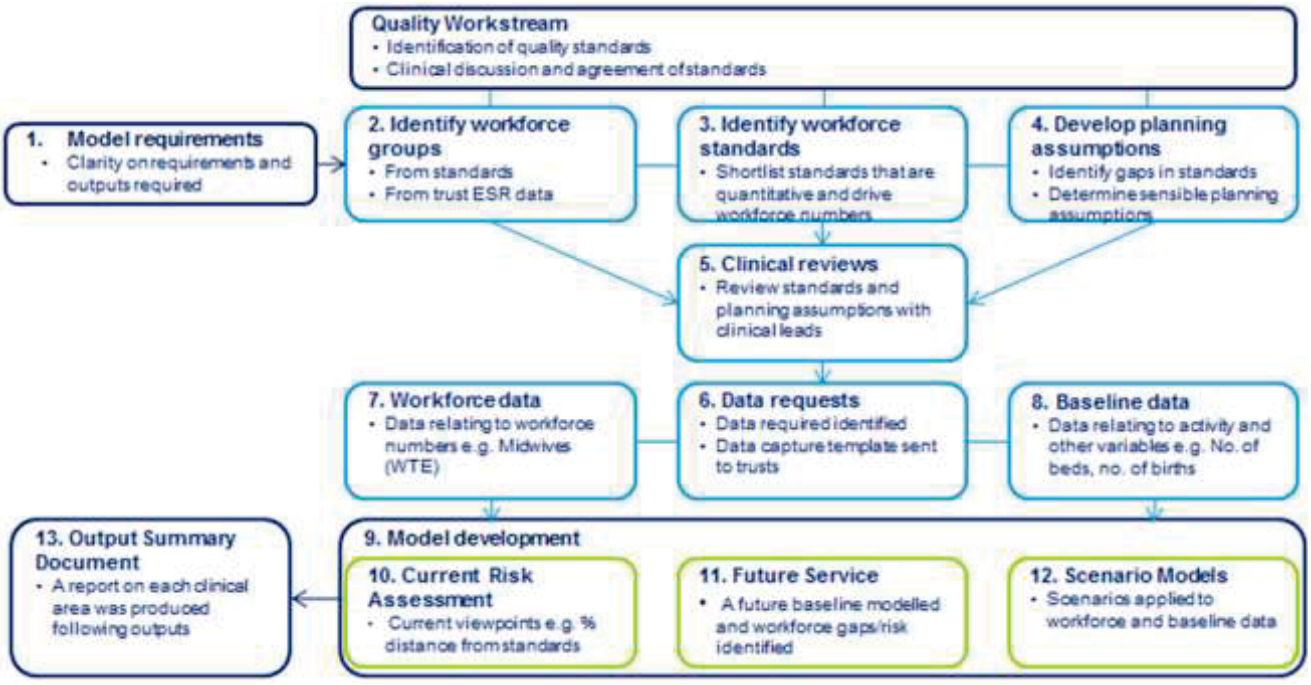



Figure 17: The workforce model process and outputs

## Summarised Clinical Advisory Group sections

The following sections contain summarised information for each CAG area taken from two or more of the following perspectives as outlined in figure 18:

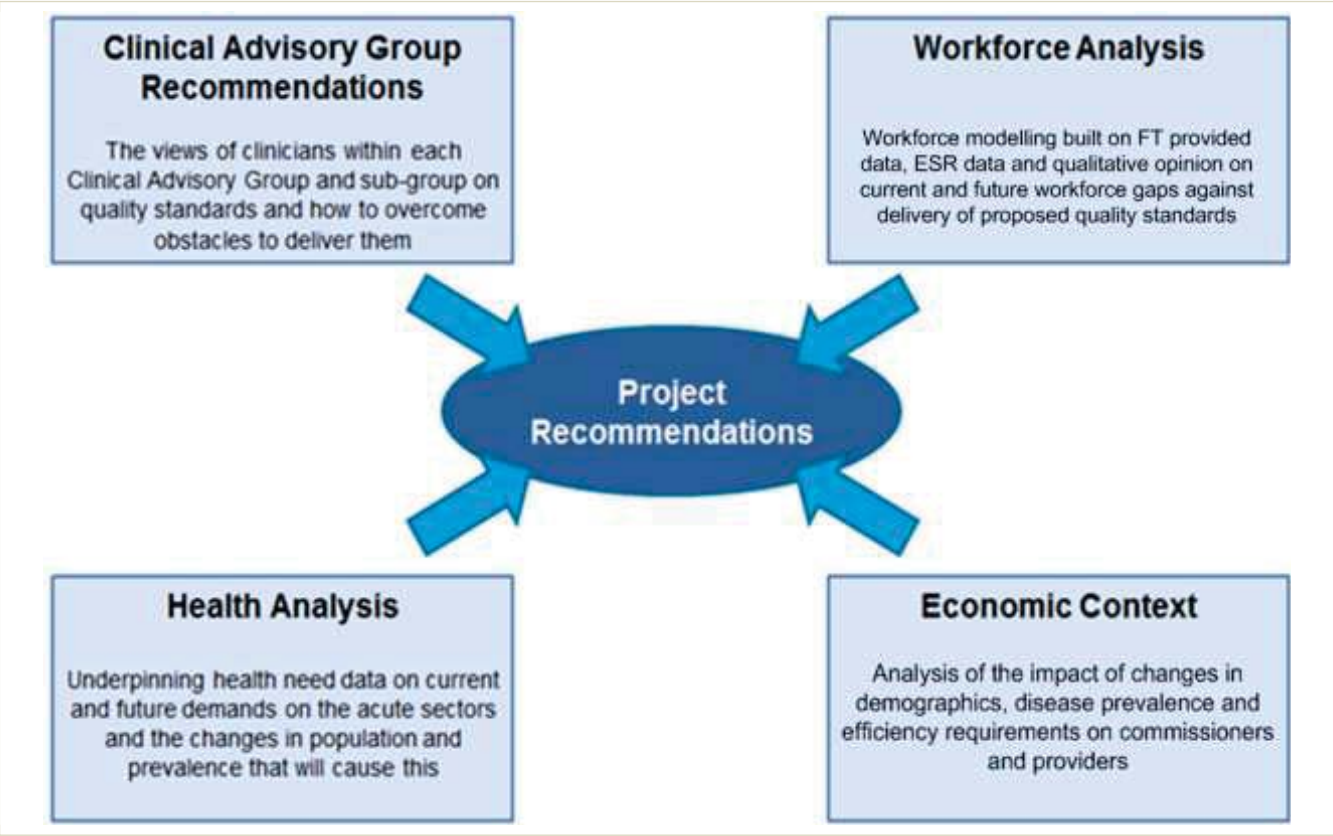



Figure 18: Perspectives of information

Details of the following are also given where appropriate:

- The Chair and membership of the CAG
- A summary of the key source documents that were used as the starting point for discussion by the CAG
- The key quality indicators identified by the CAG that may be best acted upon using CQUIN incentives or service redesign
- The key quality indicators identified by the CAG that are high unlikely to be achieved in the current service configuration
- Scenarios (other than the use CQUIN incentives or service redesign) that may address these challenges
- Final recommendations from the CAG / CAG sub-group
- Final recommendations from the Acute Services Quality legacy Project.

## Acute Paediatrics, Maternity and Neonatology

The membership of Acute Paediatrics, Maternity and Neonatology CAG was as follows:

**Chair:** Robin Mitchell, Medical Director, CDDFT

**Vice Chair:** Derek Cruickshank, Chief of Service, Consultant Gynaecologist

***Obstetrics***

- Bob Aitken, Clinical Director, Women and Children , CDDFT
- Steve Wild, Clinical Director, Obstetrics and Gynaecology, NTFT
- Helen Simpson, Labour ward lead, SFTFT

***Midwifery***

- Anne Holt, Head of Midwifery , CDDFT
- Janet Mackie, Head of Midwifery, NTFT
- Yvonne Regan, Head of Midwifery, STFT

***Paediatrics***

- Stephen Cronin, Associate Medical Director, Head of Paediatrics , CDDFT
- Jagat Jani, Clinical Director, Child Health, NTFT
- Fiona Hampton, Clinical Director, Paediatrics, STFT

***Neonatology***

- Chidambara Harikumar, Consultant Neonatologist, NTFT
- Jonathan Wyllie, Consultant Neonatologist, STFT

***Anaesthetics***

- Paul Mowbray, Clinical Director, Anaesthetics, CDDFT
- Mike Tremlett, Clinical Director, Anaesthetics, STFT

**CCG representatives**

- Kate Bidwell, Chair, North Durham
- Henry Waters, Chair, South Tees
- Boleslaw Posmyk, Chair, Hartlepool and Stockton-on-Tees

The group met three times as a whole with specialty level sub-groups meeting in-between.

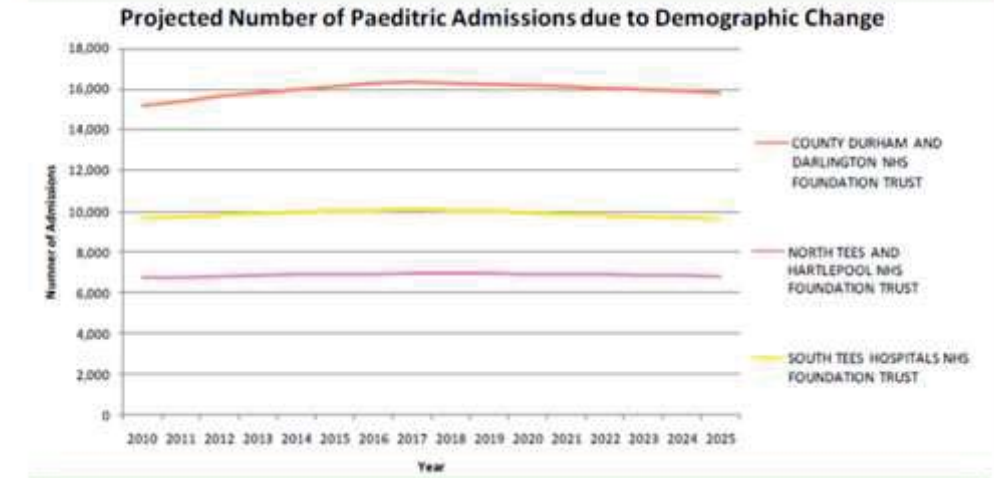
## Acute paediatric services

Three trusts provide acute paediatric services across six sites. These services were the focus of the paediatric quality standards and the key health indicators are as follows:

**Key indicators for paediatric services**


**Observations:**

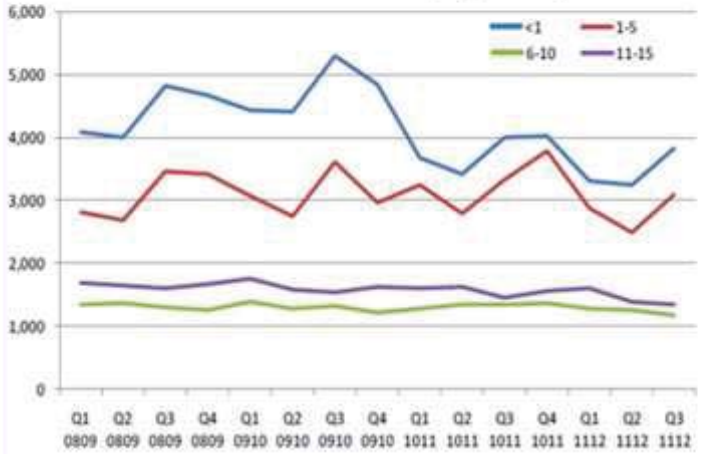
- In the last 2 quarters of 2011/12 the number of beds at County Durham & Darlington increased from around 20 to 40;
- In the first 3 quarters of 2011/12 the number of Beds at South Tees dropped to half the usual amount of beds.




**Observations:**

- By 2025 the number of paediatric admissions (<16) is expected to increase by 2.2%, over 700 per annum.
- The biggest changes are expected at the Durham and Darlington CCGs, all 3 increasing by over 4%
- Hartlepool CCG is expected to stay almost the same and South Tees will reduce slightly
- As seen in the changes by CCG, the Trust admissions are expected to change in County Durham and Darlington, increasing by 4.2% in the next 15 years.

## Paediatric Admission by Age Group



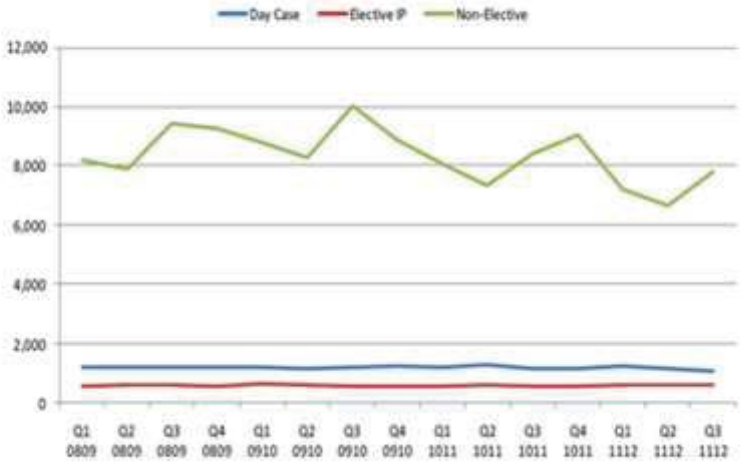

Observations:

- Overall children's admissions have reduced from the beginning of 2008/09 to Q1 2011/12 by 9%;
- The biggest reduction (19%) has been for <1 year olds
- Admissions for 6-10 year olds and for 10-15 year olds have reduced by 5%;
- Only admissions for 1-5 year olds have increased (by 3%).

## Paediatric Admissions by Method

Observations:

- Elective admissions have increased by 7% over the 3 year period;
- Non-elective admission have seen a reduction of 12% between Q1 2008/09 and Q1 2011/12.




## Paediatric Admissions by Trust


Observations:

- Between Q1 2008/09 and Q1 2011/12 North Tees has seen a reduction of almost 46% in paediatric admissions, this is evident across both sites
- South Tees has seen an increase in admissions of almost 9% and County Durham & Darlington and increase of almost 3%.

## Acute paediatric clinical standards

Standards for acute paediatric care were sourced from a number of key documents as shown in figure 19. Early conversations within the paediatric subgroup highlighted a number of key issues and challenges that informed the selection of the key standards.


Figure 19: Source documents for acute paediatric clinical standards

A total of 32 acute paediatric standards were proposed by the sub-group and the initial gap analysis across the three Foundation Trusts identified a total of 12 acute paediatric quality standards were not being met by one or more of the trusts.

This information provides commissioners with opportunities to drive improvements in quality through mechanisms such as CQUIN incentive and to support service improvement work within current organisation configuration (which could feature in the service improvement schedules in acute contracts in future years).

The areas where standards are not being met by one or more trust include:

- Staffing: paediatricians – this includes paediatric consultant presence in the hospital at times of peak activity, the number of doctors available at different grades, and paediatric anaesthesia.
- Staffing: nursing – this includes the number of qualified children's nurses on each children's ward, and nurse to child ratios in different settings taking into account the level of complexity of the children's condition.
- Staffing: PICU – this includes medical staffing at all levels and nurse to baby ratios.

Four paediatric quality standards that have been agreed by the sub-group are not met by two or more trusts. Improved performance against these standards could possibly be driven through mechanism such as CQUIN incentives.

However, the sub-group agreed that achievement of these standards should be considered in the context of the current number of paediatric units as trusts are likely to be competing for staff and will require significant investment.

The four acute paediatric quality standards not being currently met by two or more trusts are:

- A paediatric consultant (or equivalent) is present in the hospital during times of peak activity.
- Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician (or equivalent staff, specialty and associate specialty grade doctor who is trained and assessed as competent in acute paediatric care) within the first 24 hours.
- All general acute paediatric rotas are made up of at least ten wte, all of whom are WTD compliant.
- Paediatric short stay assessment units and inpatient units should apply a dependency model to nurse: patient care that is validated by commissioners. For planning this should be based on a ratio of 1:7 for SSPAUs and 1:4 for inpatient units.

**Scenarios to address the gap**

Based on the standards the paediatric sub-group agreed a set of paediatric network 'building blocks'. The sub-group used these to develop five scenarios (including the status quo) for addressing the key challenges facing paediatric services, which were assessed for their relative strengths and weaknesses (figure 20).

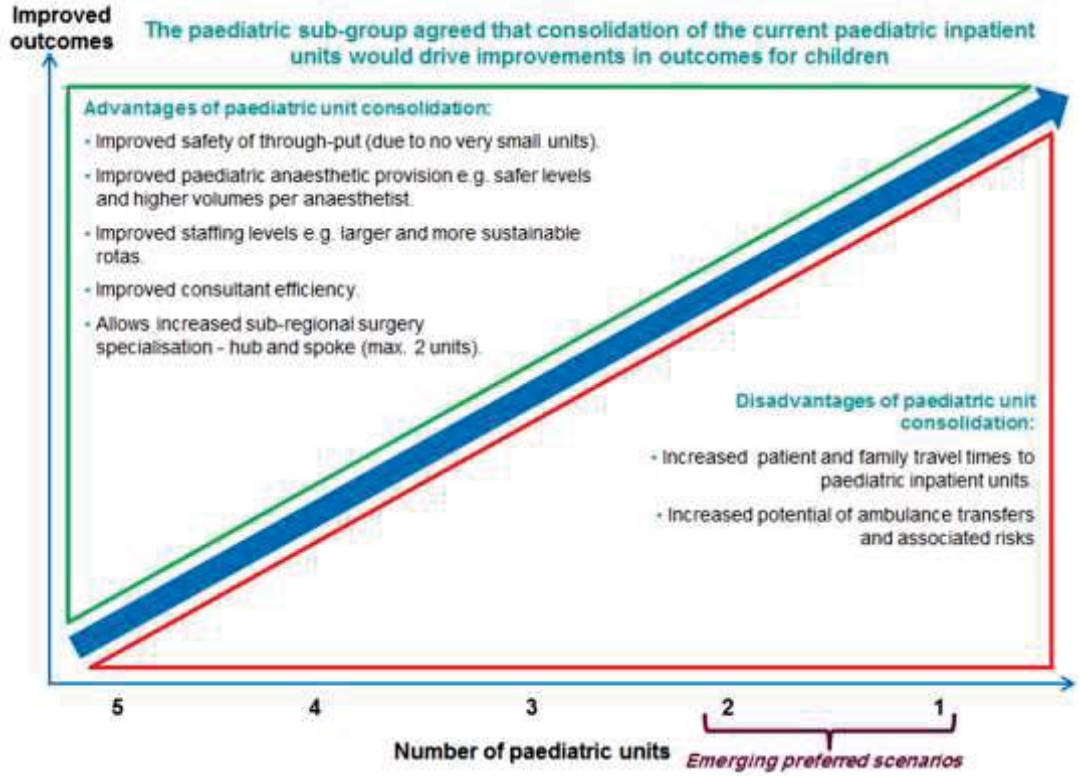



Figure 20: Review of scenarios

**Recommendations from the Clinical Advisory Group sub-group**

The Acute Paediatric sub-group identified that a reduction in the number of current paediatric units from the status quo would be the best way to address the expected shortage of staff to achieve the agreed consultant cover standards across all four units. The health analysis data made available to the CAG is listed in Appendix 1 and the final set of agreed standards can be found in Appendix 2.

**Developments since November 2012**

The acute paediatric sub-group continued to work on a more stringent set of standards for paediatric anaesthesia. A second draft of the paediatric surgery and anaesthesia standards has been produced but these have not been agreed across all three Trusts. The final report from the sub-group outlines the key issues still to be resolved.

The group looked at the implications of reducing the current number of paediatric in-patient units. This included further work on the expected staffing levels for Short Stay Paediatric Assessment Units (SSPAUs, and the implications for paediatric surgery and anaesthesia.

The group also looked at service specifications and CQUINs for some of the key standards.

## Analysis of specific workforce constraints

Currently there are significant gaps in staffing when compared to the quality standards in some key groups:

| Current Assessment | Workforce Group | Key issue in Quality Workstream? | Current Gap (estimate) | | Notes |
|---|---|---|---|---|---|
| 🔴 | Consultants | Yes | 8 WTE | 16% | • Shortage of qualified doctors on rota |
| 🔴 | Tier 2 doctors | | 31 WTE | 62% | |
| 🟢 | Trainees doctors | | - 2 WTE (surplus) | - 4% (surplus) | • Relative surplus, supported by GPVTS ~1/3 of tier |
| 🔴 | Sister/Charge Nurses | Yes | 13 WTE | 51% | • Significant shortages against sister nurse standards<br>• Slight surplus in staff nurse numbers |
| 🟢 | Staff Nurses | | - 1 WTE (surplus) | 0.5% (surplus) | |
| 🟡 | SNPs | Not specifically | - 4 WTE (surplus) | 85% (surplus) | • Figures based on planning assumption reinforcing existing delivery model. No specific targets to achieve hence perception of surplus. |
| 🟢 | HCAs | No | - 9 WTE (surplus) | - 15% (surplus) | |

Output from the qualitative workforce assessment into paediatrics highlights comparable issues to those identified by the quantitative assessment:

| Staffing group | National | RAG | Local | RAG |
|---|---|---|---|---|
| Consultants | Do not foresee a retirement bulge | 🟡 | Age profiles of consultants are a concern and vacancies, Paediatrics noted in local collaborative risk assessments | 🔴 |
| Junior Doctors | ST4 posts on the MAC list, RC highlights high vacancy levels at ST4 and ST7 | 🔴 | 100% fill rate for specialty in 2010, however, average rate of posts filled shows degree of attrition over time | 🟡 |
| SSASG | A significant number of doctors in the specialty are SSASG. Non Consultant non training posts on the MAC list | 🔴 | Associate Specialist Age Profiles | 🟡 |
| Anaesthetic Doctors | Non Consultant Non training doctors in this specialty and on the MAC list | 🔴 | NE is over-capitated on both consultants and junior doctors. N Tees age profile for consultants. | 🟡 |
| Paediatric Nurses | Low vacancy level in 2010 at 0.7%. Relatively younger age profile | 🟢 | Highlighted in CDD risk assessment last year, in relation to possibility of taking up Health Visitor vacancies. Overall under weighted capitation for children's nurses (0.9% under) | 🟡 |
| Operating Department Practitioner (ODP) | Important role in paediatric anaesthesia; contained in the MAC shortage list. Degree length changing | 🔴 | Relatively low vacancy rate in the North East | 🟢 |
| Paediatric Surgery | 2011 vacancy level 0%, Recruitment to sub-specialty training has been difficult | 🟡 | NE is under- capitated on consultants, | 🟡 |
| Paediatric Emergency Medicine | Consultants in Emergency Medicine are on the MAC list | 🔴 | Threshold for recommendation for 1 consultant with Paediatric Emergency Training is 16,000 admissions | 🟡 |

The risks were prioritised by severity:

| Risk rating | Workforce risks in Paediatrics |
|---|---|
| 1 (Top Risk) | Consultant age profiles and capacity for the near term |
| 2 | Mismatch of trainees to service needs in the medium term |
| 3 | Possible restrictions on NTNs in the future |
| 4 | Lack of SSASG doctors and international recruitment challenges |
| 5 | Paediatric Surgery |

Future paediatric services are expected to face significant challenges in staffing given the current service configuration arrangements

| Overall Assessment | Workforce Group | Current Gap (estimate) | | 2017 Gap (estimate) | | Notes |
|---|---|---|---|---|---|---|
| 🔴 | Consultants | 8 WTE | 16% | 17 WTE | 32% | • Persistent shortage of qualified doctors is projected.<br>• Shortage equates to between 1 and 2 entire rotas of doctors |
| 🔴 | Tier 2 doctors | 31 WTE | 62% | 17 WTE | 32% | |
| 🟢 | Trainees doctors | - 2 WTE (surplus) | - 4% (surplus) | -3 WTE (surplus) | - 6% (surplus) | • Likely to be reduced by expected reductions in national trainee posts (assumptions are currently based on previous years) |
| 🟢 | Sister/Charge Nurses | 13 WTE | 51% | - 4WTE (surplus) | - 16% (surplus) | • Potential undersupply of staff nurses which is expected to be offset by potential oversupply of senior nurses and SNPs |
| 🟡 | Staff Nurses | - 1 WTE (surplus) | 0.5% (surplus) | 9 WTE | 5% | |
| 🟢 | SNPs | - 4 WTE (surplus) | 85% (surplus) | - 12 WTE (surplus) | - 250% (surplus) | |
| 🟡 | HCAs | 2 WTE | 3% | 13 WTE | 22% | • Potential shortfall on current recruitment and attrition basis. Expected to be readily addressable |

The future risks for the nursing and medical workforce in acute paediatrics can be seen in figure 21 and figure 22.

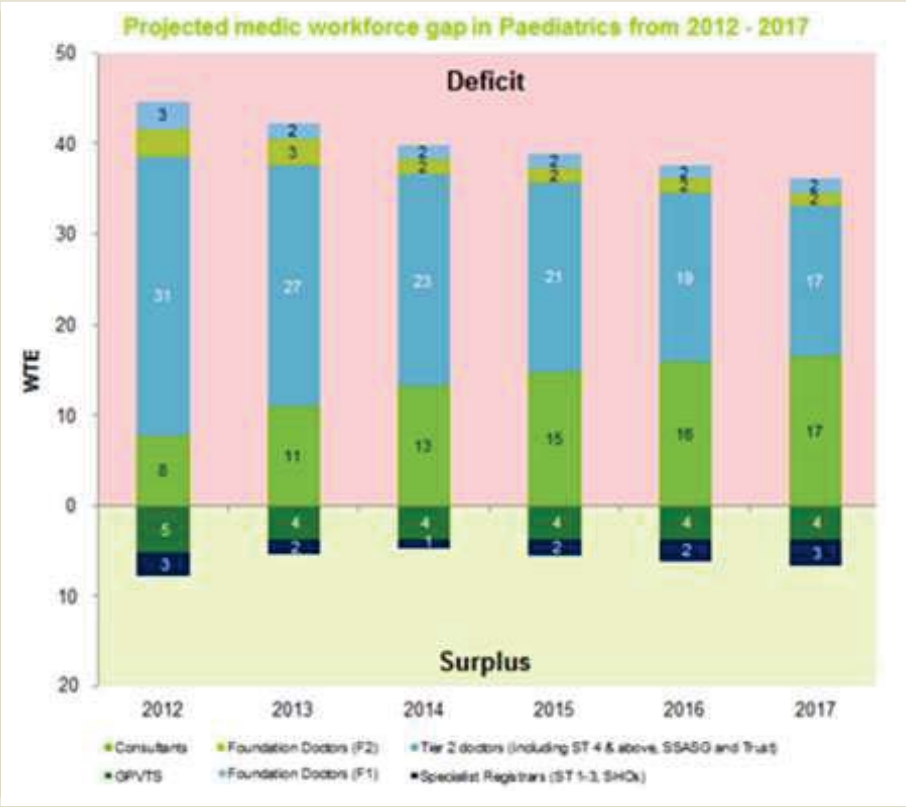



Figure 21: medical workforce in paediatrics 2012 -2017

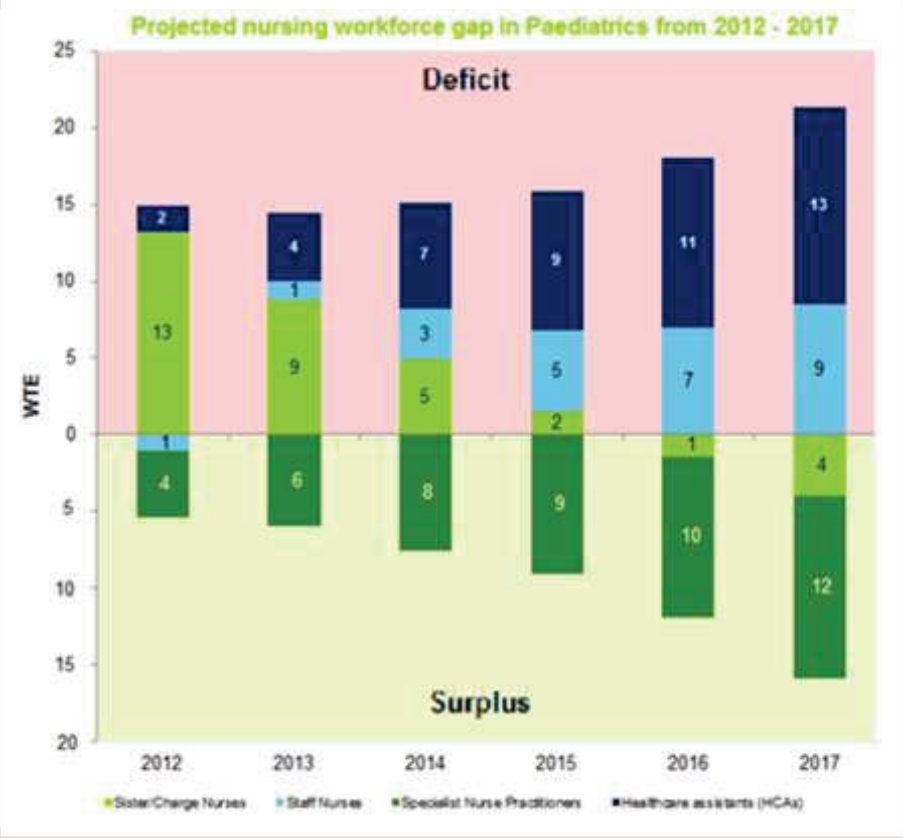



Figure 22: nursing workforce in paediatrics 2012 -2017

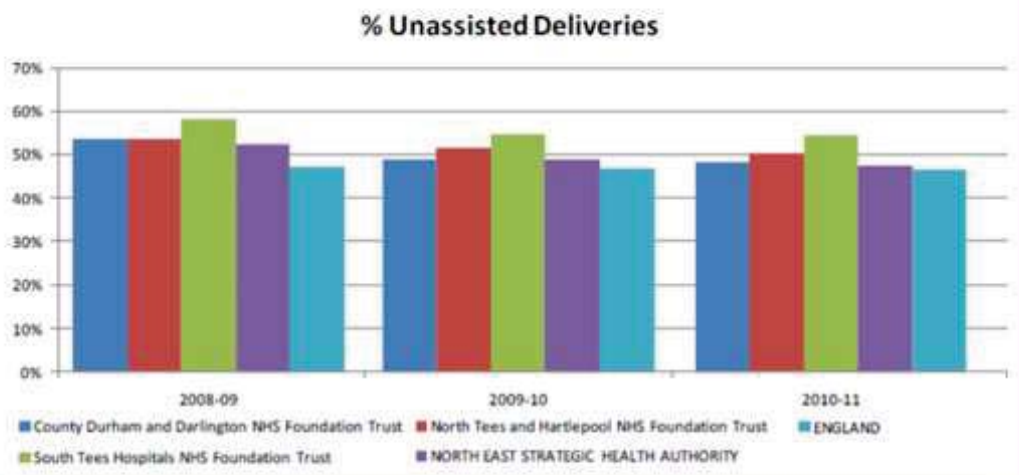
The findings of the CAG sub-group specific workforce assessment are:

- Rota consolidation appears necessary if quality standards are to be achieved. 5 rotas appears unsustainable, 4 is challenging but 3 would be readily achievable
- Nursing numbers are likely to remain appropriate but some sub-groups are over staffed and other under staffed. Career planning will be required to smooth progression and ensure appropriate utilisation of skills.

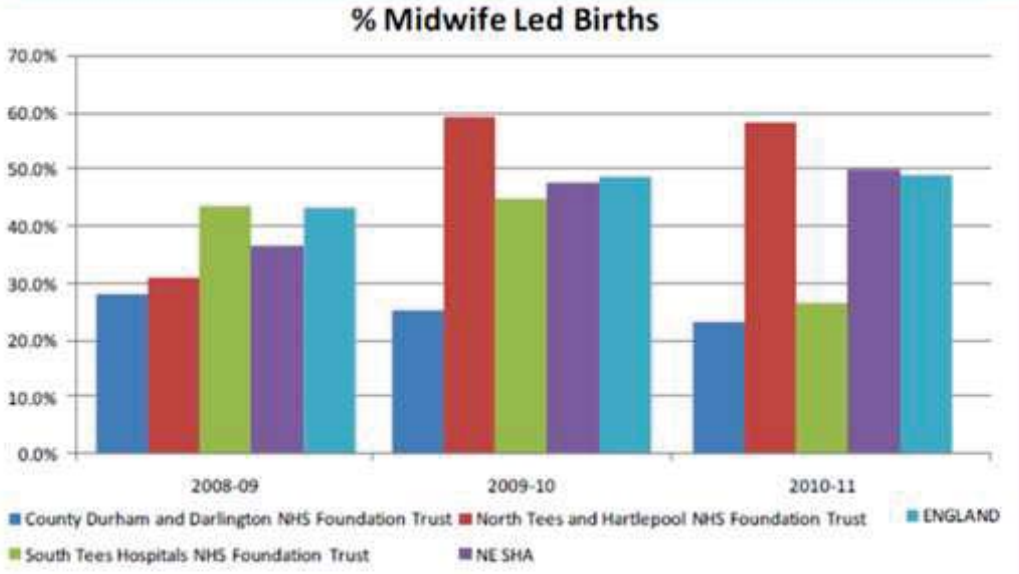
## Acute maternity services

The key health indicators for acute maternity services are as follows:

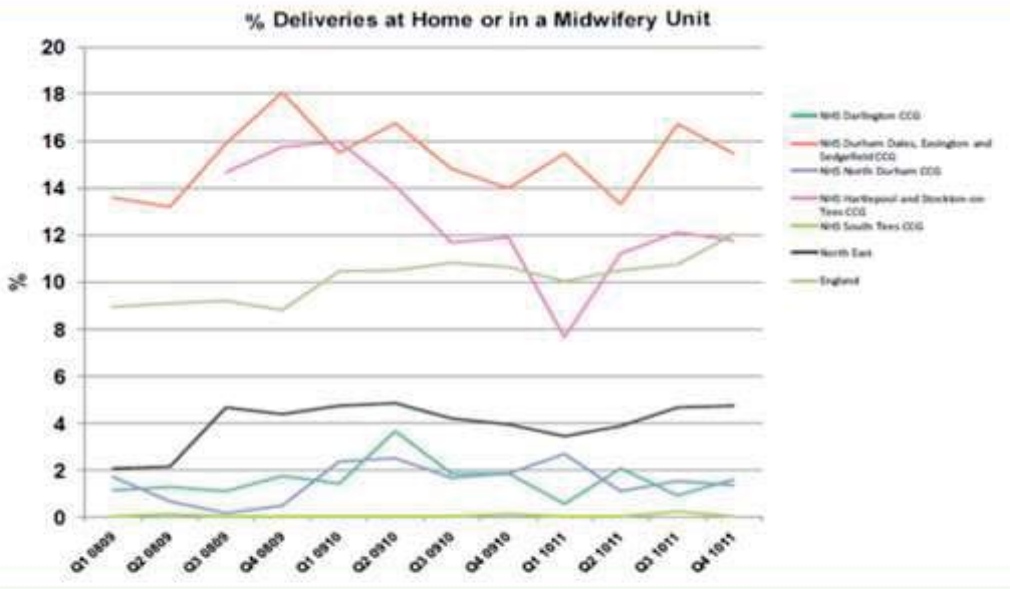
**Key indicators for maternity services**




In recent years there has been a considerable rise in intervention rates in women giving birth and therefore fewer 'normal' deliveries, The overall Caesarean section rate in the North East is lower than the national average (over 24%) with fewer than 22% of women undergoing a Caesarean section. This is similar across the 3 Trusts in 2010/11. Nationally 46% of deliveries in 2010/11 were normal, all 3 Trusts in the area have a higher than average normal delivery rate, with South Tees being the highest at 55%.

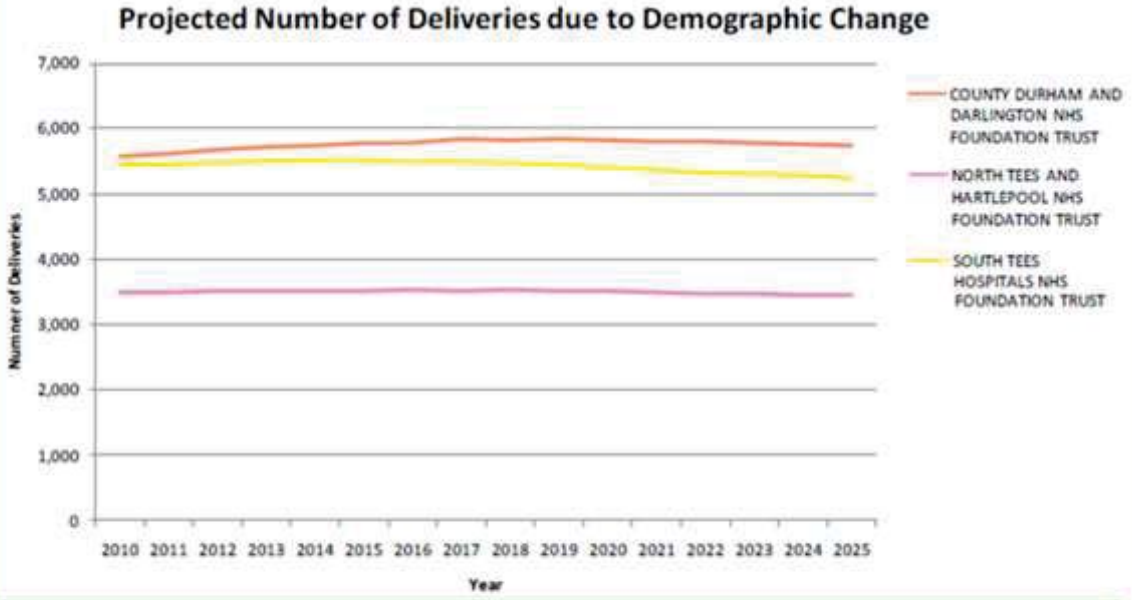



In 2010/11 nationally 33% of deliveries were conducted by a doctor and 49% by a midwife, which is similar to the North East average.
County Durham & Darlington have 76% being delivered by a doctor and 23% by a midwife. North Tees have a 58% midwifery delivery rate. For South Tees (using 2009/10 due to the data quality issues with 2010/11), 45% of births are by a midwife.



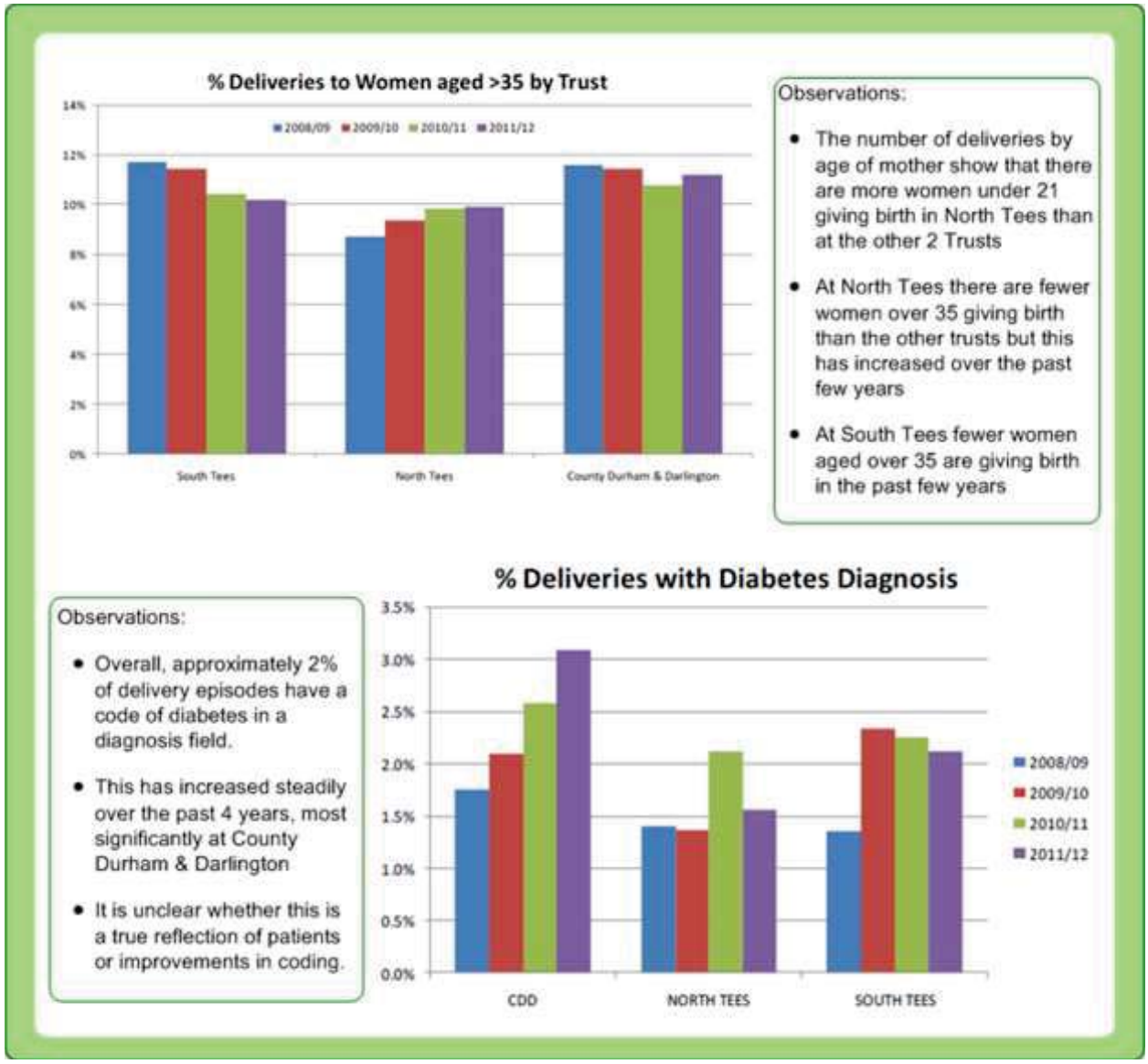

Observations:

- NHS Darlington CCG and NHS North Durham CCG have the lowest number of home births out of all the local CCGs. NHS Durham Dales, Easington and Sedgefield CCG has the highest number of home births.
- 
- These differences are explained by the availability of midwife led units in different areas




Observations:

- There is expected to be a 2.8% increase in deliveries at County Durham & Darlington by 2025, an increase of 154 deliveries per year, almost 3 per week;
- At South Tees, deliveries are expected to reduce by 205 per annum, almost 4 per week
- Deliveries at North Tees are expected to stay almost the same.


% Deliveries to Women aged >35 by Trust
2008/09
2009/10
2010/11
2011/12
14%
12%
10%
8%
6%
4%
2%
0%
South Tees
North Tees
County Durham & Darlington
Observations:
The number of deliveries by age of mother show that there are more women under 21 giving birth in North Tees than at the other 2 Trusts
At North Tees there are fewer women over 35 giving birth than the other trusts but this has increased over the past few years
At South Tees fewer women aged over 35 are giving birth in the past few years
% Deliveries with Diabetes Diagnosis
Observations:
Overall, approximately 2% of delivery episodes have a code of diabetes in a diagnosis field.
This has increased steadily over the past 4 years, most significantly at County Durham & Darlington
It is unclear whether this is a true reflection of patients or improvements in coding.
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
CDD
NORTH TEES
SOUTH TEES
2008/09
2009/10
2010/11
2011/12

## Acute maternity clinical standards

Standards for acute maternity care were sourced from a number of key documents as shown in figure 23. Early conversations within the maternity subgroup highlighted a number of key issues and challenges that informed the selection of the key standards.


Figure 23: Source documents for acute maternity clinical standards

A total of 30 acute maternity standards were proposed by the sub-group as those that define high quality care. Across County Durham, Darlington and Tees, a total of 17 maternity quality standards are not being met by one or more of the trusts.

This information provides commissioners with opportunities to drive improvements in quality through mechanisms such as CQUIN incentive and to support service improvement work within current organisation configuration (which could feature in the service improvement schedules in acute contracts in future years).

Areas where 17 standards are not currently met:

- Access to antenatal services
- Access to EPU
- Networks
- Throughput
- Theatre capacity
- Midwife Led Unit (MLUs)
- Staffing: obstetrics
- Staffing: midwifery
- Staffing: anaesthetics
- Staffing: paediatrics

Nine maternity quality standards that have been agreed by the sub-group are not met by two or more trusts.

Improved performance against these standards could be driven through mechanism such as CQUIN incentives but the sub-group felt that this would not reflect the financial and workforce resources available to the health system as a whole, and therefore the ability of all trusts to meet the agreed standards.

Areas where 9 standards are not currently met:

- Developed maternity and neonatal care networks
- Obstetric units should have co-located Alongside Midwifery Units.
- Units with between 2500-4000 births should have 98 hour consultant presence and units of 4000 births + should have 168 hour presence
- There should be a minimum of 10 WTE on medical staff rotas
- 1:1 midwifery care during established labour - based on 1:28 midwives:births
- Anaesthesia and analgesia service with consultant supervision
- Separate consultant anaesthetist for each formal elective C-section list
- Maintain care of anaesthetic care level 2 patients on labour ward
- Paediatric middle grade cover should be available 24/7

**Scenarios to address the gap**

Based on the standards the maternity sub-group agreed a set of maternity network 'building blocks'. The sub-group used these to develop seven scenarios (including the status quo) for addressing the key challenges facing maternity services. Having defined the scenarios the maternity sub-group considered the advantages and disadvantages of them (figure 24).

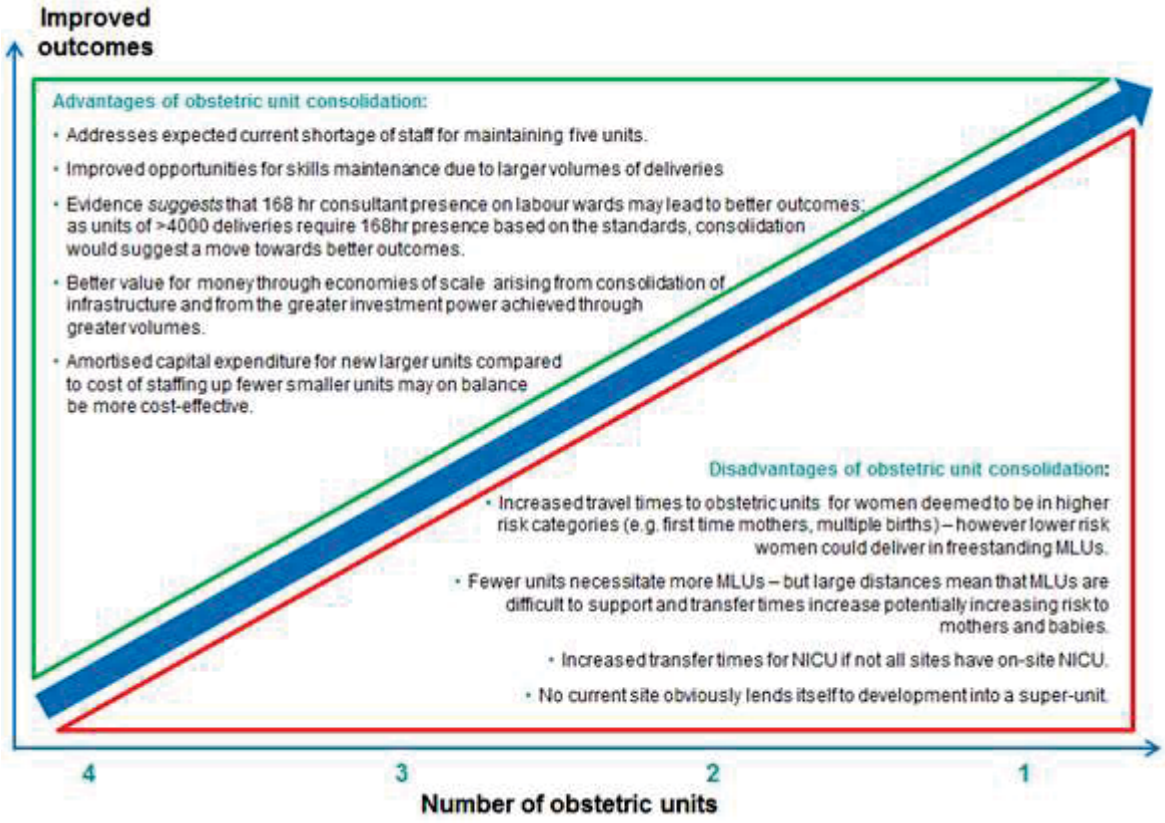



Figure 24: Review of scenarios

## Recommendations from the Clinical Advisory Group sub-group

The sub-group identified that a reduction in the number of obstetrics units from the status quo would address the expected shortage of staff to achieve the agreed consultant cover standards across all four units. The health analysis data made available to the CAG is listed in Appendix 1 and the final set of agreed standards can be found in Appendix 2.

## Developments since November 2012

The maternity sub-group looked at the interface between obstetrics and gynaecology due to the agree standards for obstetrics cover of the labour wards. These included discussions around the proportion of a consultant's job plan allocated to labour ward cover, and the level of clinical experience needed for consultants to maintain their competence. The group considered adopting a locally agreed set of quality indicators around the management of 2$^{nd}$ stage labour.

The groups also looked at service specifications and possible CQUINs for key standards.

## Analysis of specific maternity and obstetrics workforce constraints

Currently there are significant gaps in staffing when compared to the quality standards across all key groups:

| Current Assessment | Workforce Group | Key issue in Quality Workstream? | Current Gap (estimate) | | Notes |
|---|---|---|---|---|---|
| 🔴 | Tier 3 Consultant Workforce | Yes | 10 WTE | 17% | • Shortages across all rotas<br>• Basis for consultant comparison is 98 hour presence target at all sites |
| 🔴 | Tier 2 Medical Workforce | | 19 WTE | 37% | |
| 🔴 | Tier 1 Medical Workforce (Trainees) | | 7 WTE | 14% | |
| 🟢 | Senior Midwifery Workforce | Yes | - 22 WTE (surplus) | - 61% (surplus) | • Surplus of senior midwifery workforce<br>• Shortages across midwives in region |
| 🟡 | Midwifery Workforce | | 47 WTE | 9% | |
| 🟡 | Student Midwifery Workforce | Not highlighted | 1 WTE | 4% | |
| 🟡 | MCAs | Not highlighted | 6 WTE | 5% | • The gap in the number of MCAs is not a key area of concern given the training required to address this |

Output from the qualitative workforce assessment into Maternity highlights comparable issues to those identified by the quantitative assessment:

| Staffing group | National | RAG | Local | RAG |
|---|---|---|---|---|
| O&G consultants | Recommendation of reduction of 40 NTNs for 4 years from 2011 | 🔴 | Some relatively high levels of turnover locally , over capitated in NE | 🟡 |
| O&G junior doctors | Issues of attrition have been identified for specialty trainees | 🟡 | 94% of vacancies filled in Deanery in 2010 | 🟡 |
| SSASG O&G doctors | Non consultant non training posts on the MAC list | 🔴 | Most of AS workforce close to retirement age locally | 🔴 |
| Midwives | Relatively older age profile; quarter or workforce is over 50 | 🟡 | Under capitated for midwives Age profile issues | 🔴 |
| Sonographers | MAC shortage list | 🟡 | Highlighted in 2 local risk assessments | 🔴 |

The risks were prioritised by severity:

| Risk rating | Workforce risks in Maternity |
|---|---|
| 1 (Top Risk) | Midwifery age and retirement profiles |
| 2 | Sonography Capacity |
| 3 | Possible reduction in NTNs |
| 4 | Mismatch of available number of trainees and service needs |
| 5 | SSASG doctor capacity (including age profiles) |

The highest identified risk created by the age profile of the midwife population and estimate retirement date is start when modelled forward to 2017. The future risks for the nursing and medical workforce in maternity can be seen in figure 25 and figure 26.

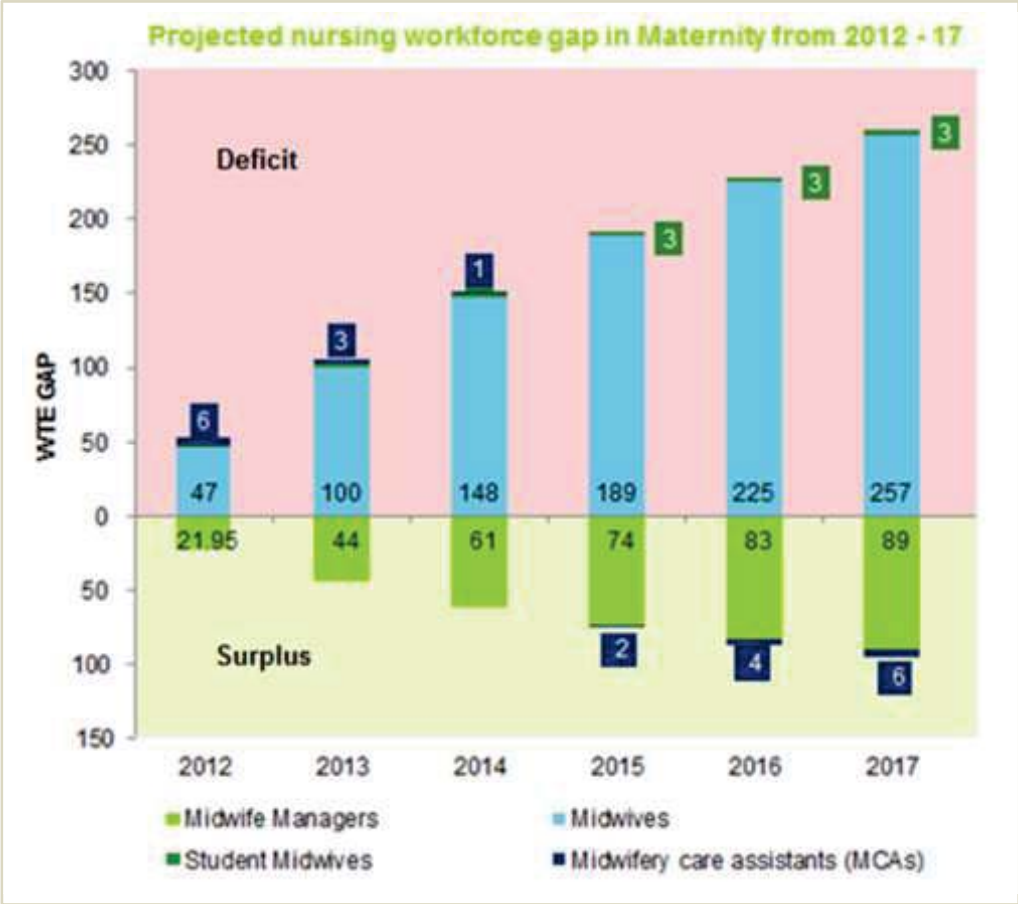



Figure 25: Projected gap in midwife numbers

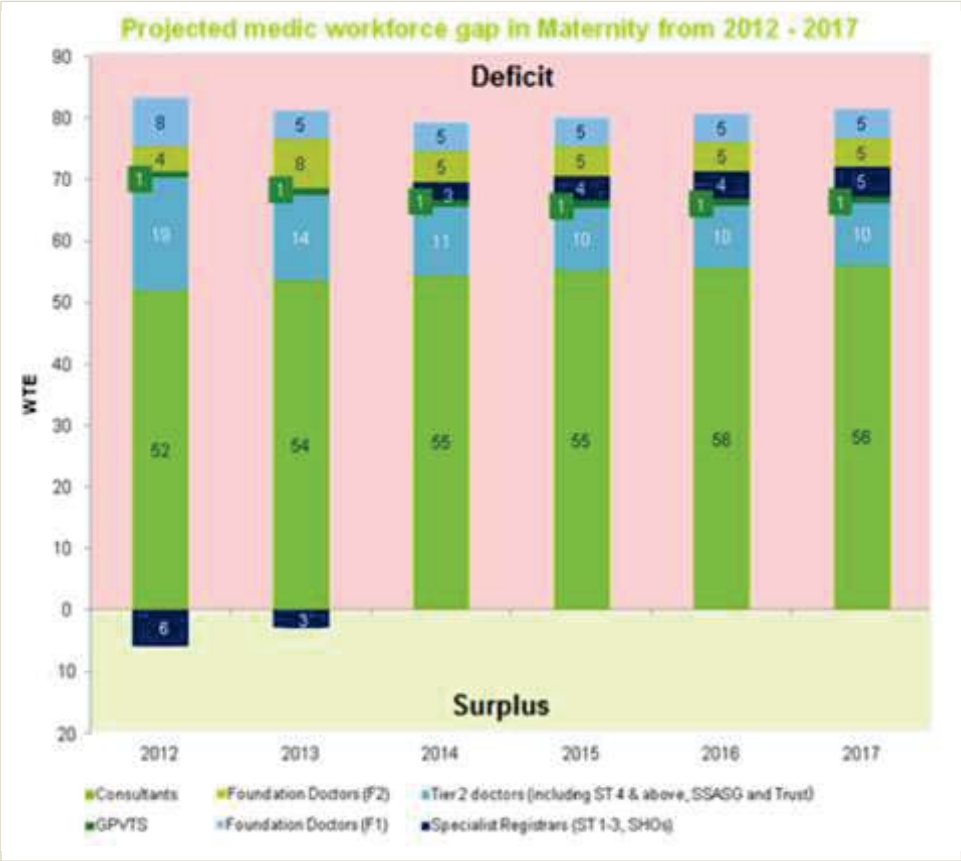



Figure 26: Projected gap in midwife numbers

Future Maternity services are expected to face significant challenges in staffing given the current service configuration arrangements.

| Overall Assessment | Workforce Group | Current Gap (estimate) | | 2017 Gap (estimate) | | Notes |
|---|---|---|---|---|---|---|
| | Tier 3 Consultant Workforce | 10 WTE | 17% | 14 WTE | 24% | • Consistent material shortfalls across all rotas, primarily driven by the number of rotas that currently require staffing in the area<br>• Sufficient resources to cover 3 rather than 5 rotas |
| | Tier 2 Medical Workforce | 19 WTE | 37% | 10 WTE | 20% | |
| | Tier 1 Medical Workforce (Trainees) | 7 WTE | 14% | 15 WTE | 30% | |
| | Senior Midwifery Workforce | - 22 WTE (surplus) | - 61% (surplus) | - 89 WTE (surplus) | - 235% (surplus) | • Growing shortage of midwives, fuelled by retirements<br>• Potential to utilise high number of senior midwives to lead unit / drive quality / staff medical trainee rotas<br>• Shortage of trainees to meet replenishment rates, let along meet demand increases |
| | Midwifery Workforce | 47 WTE | 9% | 257 WTE | 45% | |
| | Student Midwifery Workforce | 1 WTE | 4% | 3 WTE | 11% | |
| | MCA | 6 WTE | 5% | - 6 WTE (surplus) | - 4% (surplus) | • Potential for increased utilisation of MCAs to free up as much midwifery capacity as possible where appropriate competencies have been demonstrated. |

The findings of the CAG sub-group specific workforce assessment are:

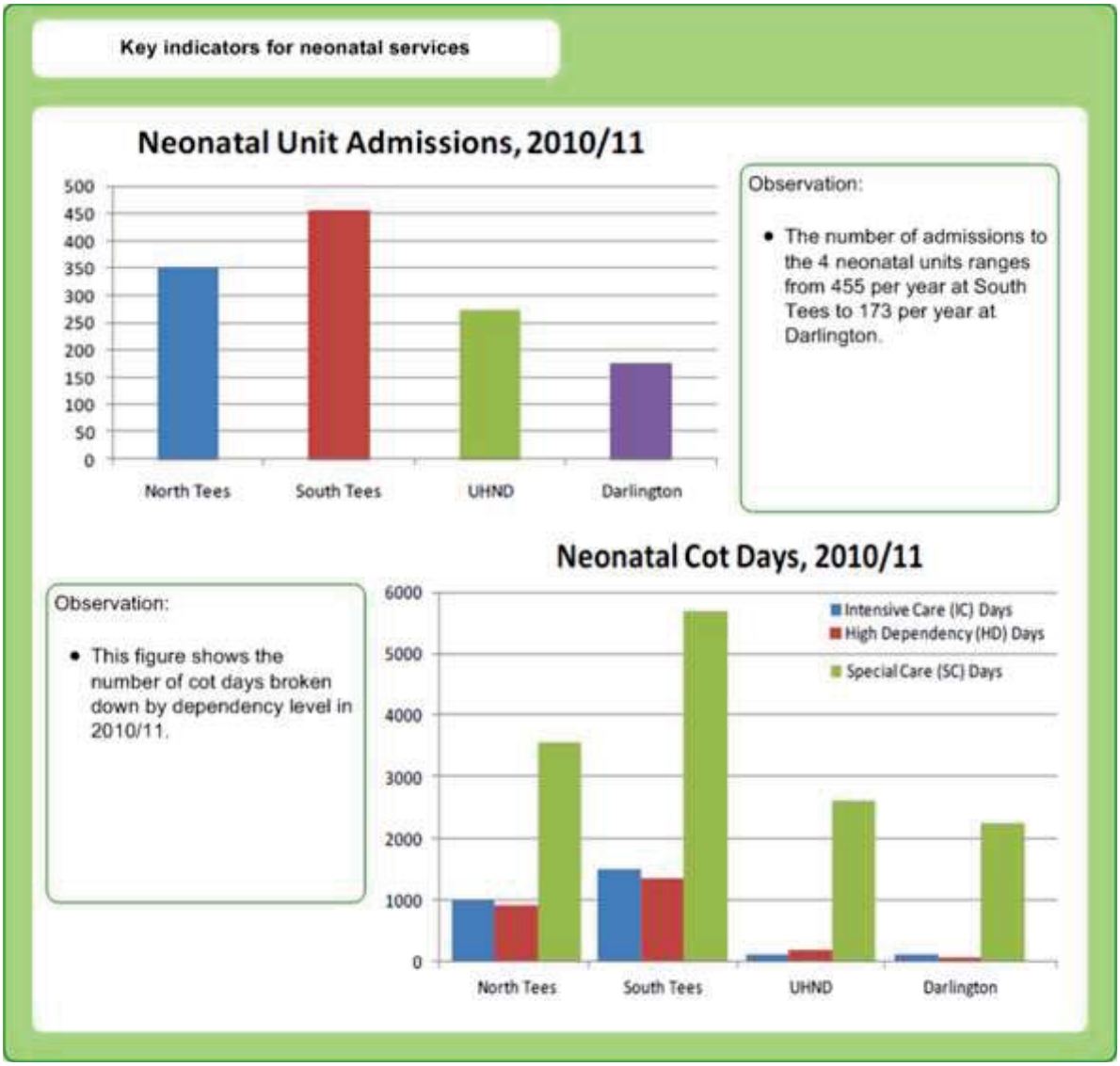
- Rota consolidation appears necessary if quality standards are to be achieved. 3 rotas could be reasonably staffed but 4 would be extremely challenging to staff.

- A variety of strategies need to be quickly established to manage the midwife retirement “time-bomb”. This could include rapid training increases, attracting resourcing from elsewhere or incentivising retirees to stay on.

- Given the experience within the midwifery workforce and the resource challenge in the medical workforce, midwife led units (from a workforce perspective) appear an attractive option.

## Acute neonatology services

Three trusts provide acute neonatology services across six sites but only South Tees and North Tees provide ITU units. These services were the focus of the neonatology quality standards and the key health indicators are as follows:



## Acute neonatology clinical standards

Standards for acute neonatal care were sourced from a number of key documents as shown in figure 27. Early conversations within the neonatology subgroup highlighted a number of key issues and challenges that informed the selection of the key standards.


Figure 27: Source documents for acute neonatology clinical standards

A total of 14 acute neonatology standards were proposed by the sub-group as those that define high quality care, with four neonatal quality standards that have been agreed by the sub-group as not met by either trust.

This information provides commissioners with opportunities to drive improvements in quality through mechanisms such as CQUIN incentive and to support service improvement work within current organisation configuration (which could feature in the service improvement schedules in acute contracts in future years).

However, a constant theme throughout the discussions of the sub-group was the financial and workforce resources available to the health system as a whole, and therefore the ability of both trusts to meet the agreed standards as follows:

- Eight wte on tier 2 medical rota
- Eight wte on tier 3 medical rota
- 1:1 nurse: baby ratio for ITU cots
- Presence of a dedicated nurse co-ordinator on every shift

## Scenarios to address the gap

Based on the standards a set of neonatal network 'building blocks' were established. These were used to develop seven scenarios (including the status quo) for addressing the key challenges facing neonatal services (figure 28). The health analysis data made available to the CAG is listed in Appendix 1 and the final set of agreed standards can be found in Appendix 2.

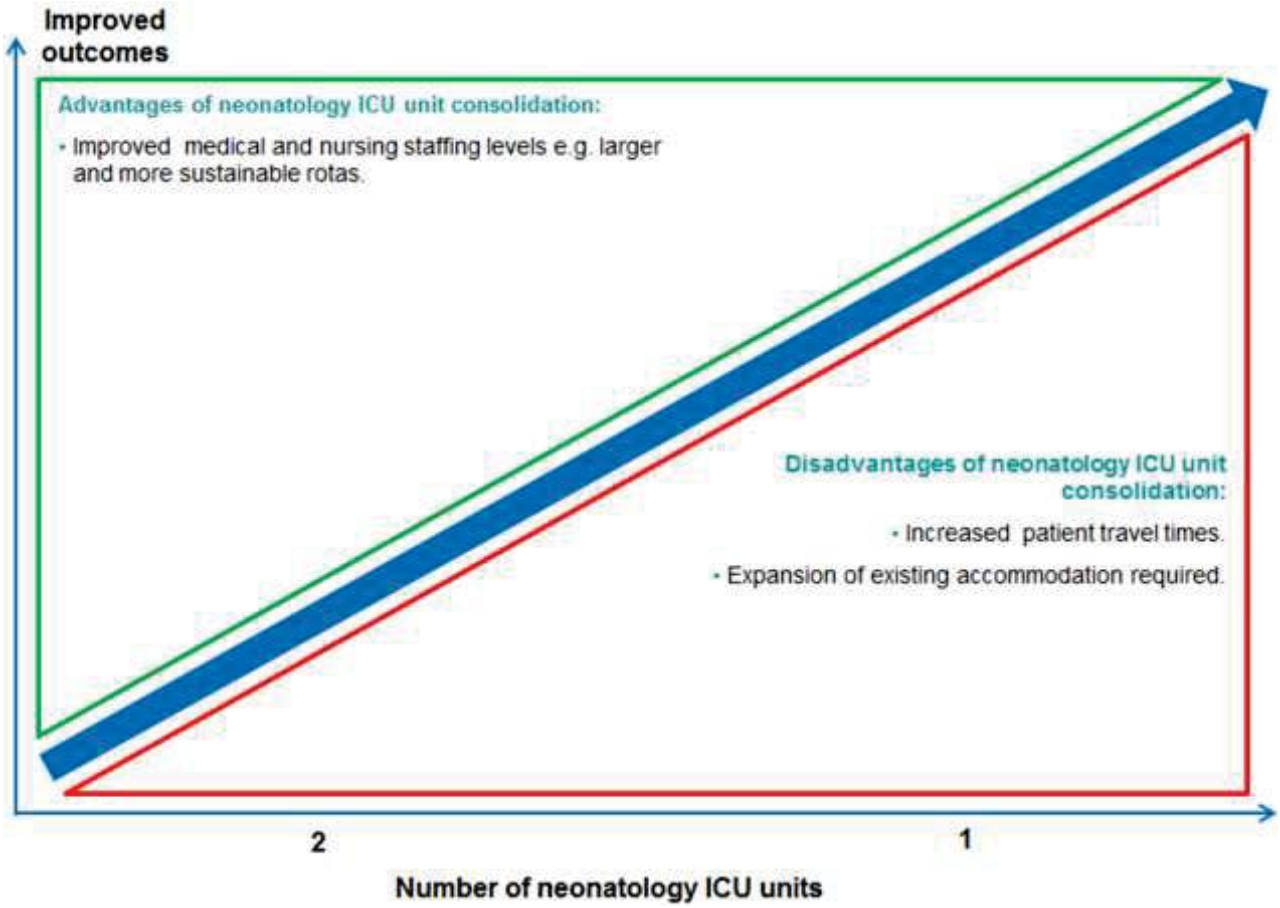



Figure 28: Review of scenarios

## Recommendations from the Clinical Advisory Group sub-group

The neonatologists have expressed a desire to move from two neonatal ITU units in the County Durham and Tees Valley area to one unit, as single super SCBU/HDU unit networked to the single ICU unit would reduce travel times for clinicians and provide the economies of scale a large SCBU unit would bring.

### Developments since November 2012

Members of the project team met the specialist services commissioners responsible for neonatal intensive care services. They will take part in the optional appraisal process in the next stage of the project.

## Analysis of specific workforce constraints

Currently there are significant gaps in staffing when compared to the quality standards in some key groups:

| Current Assessment | Workforce Group | Key issue in Quality Workstream? | Current Gap (estimate) | | Current Quantitative Assessment |
|---|---|---|---|---|---|
| 🔴 | Consultant Workforce | Yes | 7 WTE | 43% | • Shortages across qualified doctor rotas |
| 🔴 | Tier 2 Medical Workforce | | 4 WTE | 25% | |
| 🟢 | Tier 1 Medical Workforce (Trainees) | | 0 WTE | 0% | • Relative surplus of trainee grades given utilisation of AANPs on tier 1 rotas<br>• Shortfall if staffing purely with medical trainees |
| 🔴 | Sisters / Charge Nurses | Yes | 17 WTE | 53% | • Structural issues between shortage of seniors and surplus of more junior nurses |
| 🟢 | Staff Nurses | | -16 WTE | -12% | |
| 🔴 | AANPS | Not highlighted | N/A | 0 | • Lack of standards for AANPs. There is opportunity for them to play a greater role in service delivery if available |
| ⚫ | HCAs | Not highlighted | 0 WTE | 0% | • Current planning assumption is based on current HCA ratios – hence current standard appears to be being met exactly |

Output from the qualitative workforce assessment into neonatology highlights comparable issues to those identified by the quantitative assessment:

| Staffing group | National | RAG | Local | RAG |
|---|---|---|---|---|
| Neonatology | Facing the Future recommendations would require significant increases in specialists | 🔴 | Some difficulties in covering rotas in Tees | 🔴 |
| Neonatal Nurses | Issues of attrition have been identified for specialty trainees | 🔴 | Neonatal nurses included in S Tees risk assessment | 🔴 |

The risks were prioritised by severity:

| RAG | Workforce risks in Neonatology |
|---|---|
| 1 (Top Risk) | Neonatology Consultant capacity in a reconfigured service to meet rotas |
| 2 | Neonatal Nurse capacity in the future |
| 3 | Securing sufficient Neonatal trainees if there is a reduction in the number of paediatric trainees |
| 4 | Potential recruitment and retention of nurses from the local area as a result of introduction of all graduate workforce |
| 5 | Relatively small number of training venues for all different types of staff |

Future Neonatal services are expected to face significant challenges in staffing given the current service configuration arrangements:

| Overall Assessment | Workforce Group | Current Gap (estimate) | | 2017 Gap (estimate) | | Notes |
|---|---|---|---|---|---|---|
| 🔴 | Tier 3 Consultant Workforce | 7 WTE | 43% | 7 WTE | 44% | • Consultant staffing levels will remain insufficient to staff 2 full rotas |
| 🟡 | Tier 2 Medical Workforce | 4 WTE | 25% | -1 WTE (surplus) | - 6% -(surplus) | • Tier 2 workforce standards will improve from a low base over the period |
| 🔴 | Tier 1 Medical Workforce (Trainees) | 0 WTE | 0% | 2 WTE | 25% | • Tier 1 medical staffing will be supported by ANNPs resulting in a lower medical workforce requirement and adherence with standards<br>• Longer term the use of ANNPs may create tier 2 and 3 issues over a longer period |
| 🔴 | Senior Nurse | 17 WTE | 53% | 3 WTE | 12% | • Material shortages of senior nurses are expected to continue over the period |
| 🟢 | Staff Nurses | - 16 WTE (surplus) | - 12% surplus) | - 6 WTE (surplus) | - 6% (surplus) | |
| 🟢 | AANPs | 2 WTE | 32% | - 2 WTE (surplus) | - 25% (surplus) | • The surplus in this group is driven by a lack of an aggressive standard<br>• This group should be seen as an opportunity to offset issues elsewhere |
| 🟢 | HCAs | N/A | N/A | N/A | N/A | • No shortage, but unlikely to be able to play significantly increased roles given nature of the work |

The future risks for the medical and nursing workforce in maternity can be seen in figure 29 and figure 30.

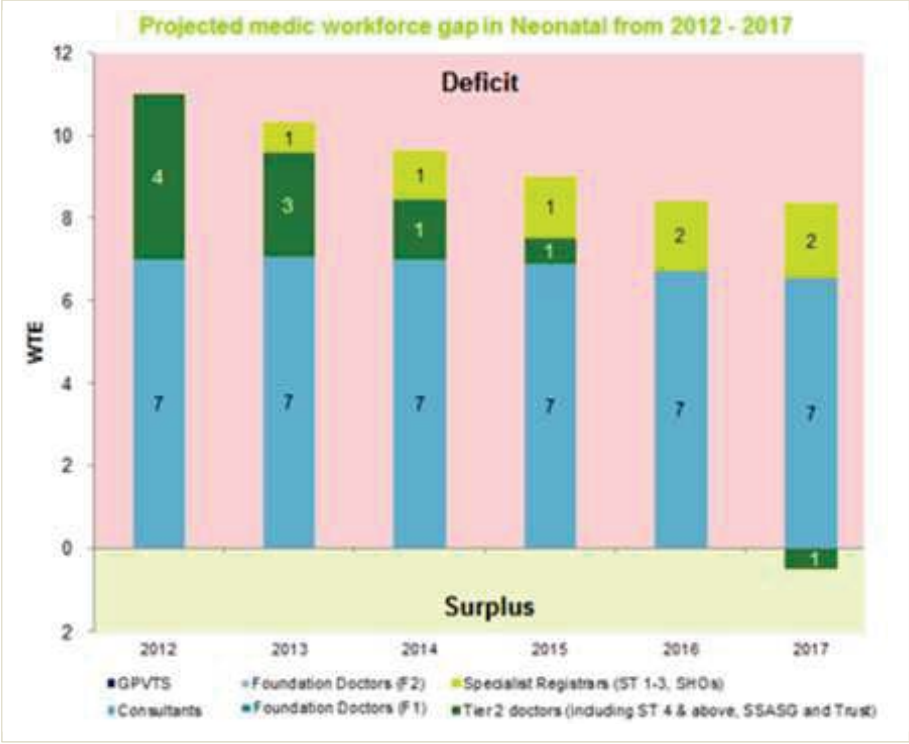



Figure 29: Projected medical workforce gap in Neonatology


Figure 30: Projected nursing workforce gap in Neonatology

The findings of the CAG sub-group specific workforce assessment are:

- Rota consolidation appears necessary if medical staffing quality standards are to be achieved
- Achievement of nursing standards (particularly ICU) are extremely challenging however staffing within the area is likely to remain broadly appropriate to meet these standards
- Increased use of AANPs appears both feasible (supply available) and desirable in terms of providing support to the challenged nursing workforce

## Combined recommendations from the Acute Paediatrics, Maternity and Neonatology CAG

Delivery of the agreed quality standards under the status quo is felt to be unsustainable by all three CAG sub-groups. All three groups identified advantages and disadvantages of a consolidation in the number of units.

Paediatrician view:

- None of the units currently meet the agreed quality standard for general acute inpatient paediatric rotas (10 wte on each of the three tiers of medic rotas).
- The current number of inpatient paediatric rotas is not seen as a sustainable position and does not enable sub-regional surgical specialisation.
- The sub-group identified a reduction in the number of units to two or one as the emerging preferred options

The views of the sub group can be summarised as follows: Focusing inpatient provision at 2 centres is seen as an opportunity to drive improvements in outcomes and staffing levels. Focusing down to 2 centres enables sub-regional surgical specialisation. There may be an increase in patient travel times and potentially patient transfers, but this could be minimised by a network of short stay paediatric assessment units.

Obstetrician and Midwifery view:

- Delivery of the agreed standards of 98hrs consultant cover for units of <4000 births and 168 hours over 4000 births is felt to be unsustainable across the current number of sites.
- The sub-group identified that a reduction in the number of obstetric units from the status quo would address the expected shortage of staff to achieve the agreed consultant cover standards

The views of the sub-group can be summarised as follows: Consolidation of obstetric units is seen as an opportunity to drive improvements in outcomes and there would be potential significant economies in medical workforce. Travel times for women unable to deliver in Midwife Led Units would increase however and it could also increase exposure to risk for women in Midwife Led Units due to travel distances from obstetric units. This would make the relationship to the North of the NE region and North Yorkshire important when considering changes to future patient flows.

Neonatologists view:

- Neither ITU currently meets the agreed quality standards for medical and nurse provision
- Future achievement of these standards across both units is seen to be extremely challenging.
- Two ITU units is not seen to be a sustainable position.
- Two small SCBU units is not seen to be as a good use of scare resources (workforce and finance) due to minimum staffing requirements.
- The sub group expressed a desire to move to one neonatal ICU/HDU unit

The views of the sub group can be summarised as follows: A single ITU unit supported by a large SCBU/HDU is seen as the preferred solution to meet the quality standards, drive improvements in outcomes and optimise resources and access.

Following the third CAG meeting which looked specifically at the workforce modelling, the conclusion reached from the combined sub-groups is that the current configuration of services will not be able to achieve the agreed quality standards.

Although the CAG did not come to a conclusion on a preferred option, the number of viable alternatives was limited to a three centre or two centre model, while not ruling out the option of a single centre of excellence.

**Conclusion**

Since the project began, the Royal College of Obstetricians and Gynaecologists has published a report on the future of the specialty ('Tomorrow's Specialist; RCOG September 2012). This report includes the following statement – 'The College is adamant that the obstetric delivery suite needs fully qualified specialists available at all times …' The RCOG recognises that not all consultant-led units need resident specialists 24 hours a day at present, but recommends that all units with a high number of deliveries and managing complex cases do need specialists resident at all times. However, the RCOG anticipates a reconfiguration of services with fewer obstetric units in maternity networks so that 24 hour specialist care is available.

The basis of the RCOG position is the emerging evidence for a significant difference in outcomes between deliveries during office hours and at other times. The view of the RCOG is that 'the lottery of time of birth for women and their babies should not be accepted as the status quo by commissioners, policy makers, providers or women themselves.

The report cites the findings from a recent study in Scotland that showed an increased risk of neonatal death due to anoxia among women delivering outside office hours.  About one in four deaths from intrapartum anoxia at term could be prevented if all women had the same risk of this event as those delivering during office hours. Preliminary data from the North East Perinatal Morbidity and Mortality Survey shows a similar difference in risk for County Durham and Tees Valley.

Whilst there was a minority view within the Clinical Advisory Group that 98 hours consultant presence should be established as the standard for units with less than 4000 deliveries a year, there was insufficient clinical evidence identified to justify going against the RCOG standard.

Therefore, the recommendation of the ASQL Project to the CCGs is to recognise a standard of 168 hours per week for consultant presence on each labour ward in line with the RCOG guidance (and the standard set by the NE Clinical Innovation Team), with a minimum of 98 hours per week for units with less than 4000 births per year by 2014 as an interim step.

## Acute medicine, acute general surgery and intensive care medicine

The Acute CAG was chaired by Dr David Emerton, Medical Director of North Tees and Hartlepool NHS Foundation Trust and had the following membership:

**Chair:** David Emerton, Medical Director, NTFT
**Vice Chair:** Vincent Connolly, Clinical Lead for Medicine, STFT

***Acute medicine***

- Jean MacLeod, Clinical Director for Medicine, NTFT
- Vincent Connolly, Clinical Director for Medicine, STFT
- Bernard Esisi, Clinical Director for Medicine, CDDFT
- Mike Jones, Consultant Physician, CDDFT
- Nick Roper, Clinical Lead for Acute Medicine, NTFT

***Acute surgery***

- Iain Bain, Clinical Director of Surgery, CDDFT
- Pud Bhaskar, Clinical Director of Surgery, NTFT
- Ous Alozairi, General Surgeon, NTFT
- Chris Tulloch, Clinical Director, Trauma and Orthopaedics, NTFT
- Richard Wight, Head of Surgery, STFT
- Peter Davis, Clinical Director, General Surgery, STFT
- Andrew Simpson, Clinical Director A&E, NTFT

***Anaesthetics/ Intensive care***

- Narayanan Suresh, Clinical Director, Anaesthetics, NTFT
- Steve Bonner, Clinical Director, Intensive Care, STFT
- Dominic Errington, Consultant Intensivist, CDDFT

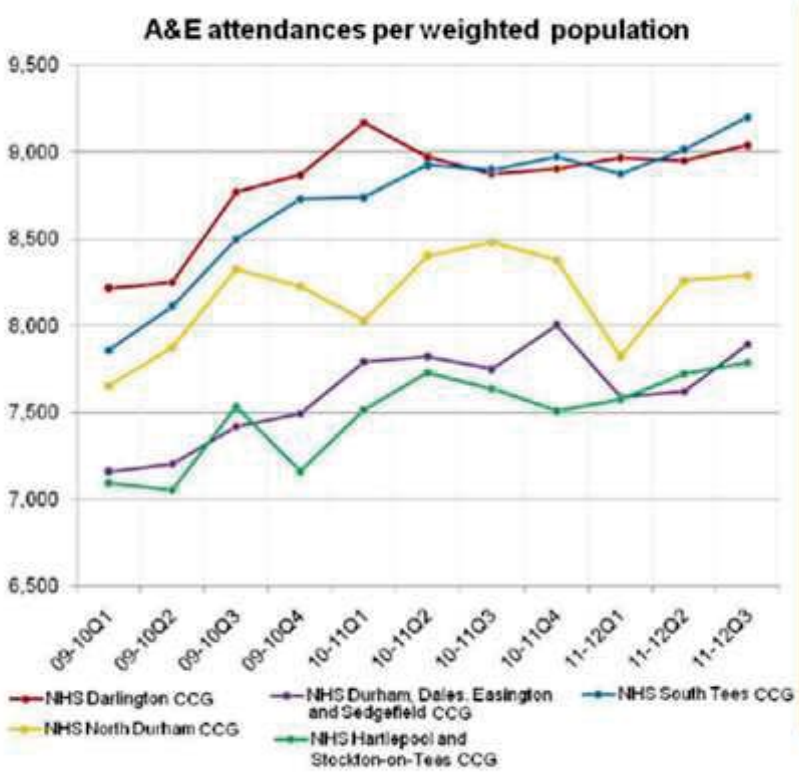
**CCG representatives**

- Neil O'Brien, North Durham
- Ian Davidson, North Durham CCG

## Acute services

Three trusts provide acute services across six sites in County Durham, Darlington and Tees. The key headline indicators for acute care are shown below:

**Key indicators for Acute services**

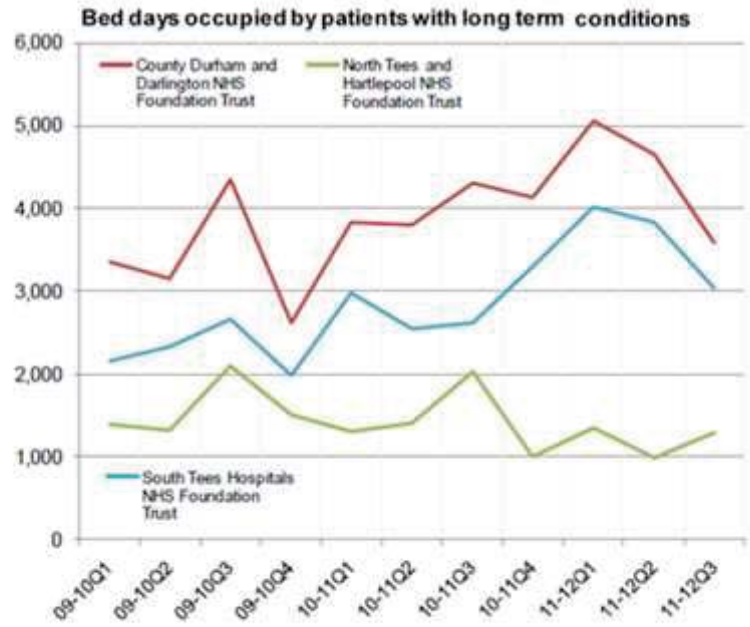



Observations:

- In general, all CCGs show a gradual rising trend over the period
- NHS Darlington CCG and South Tees CCG exhibit a rate of between 8,000 and 9,500 A&E attendances per hundred thousand patients
- NHS North Durham CCG fluctuates between 7,500 and 8,500 A&E attendances per hundred thousand patients.
- NHS Durham Dales, Easington and Sedgefield CCG and Hartlepool and Stockton-on-Tees CCG are below around 8,000 A&E attendances per hundred thousand patients throughout the period.

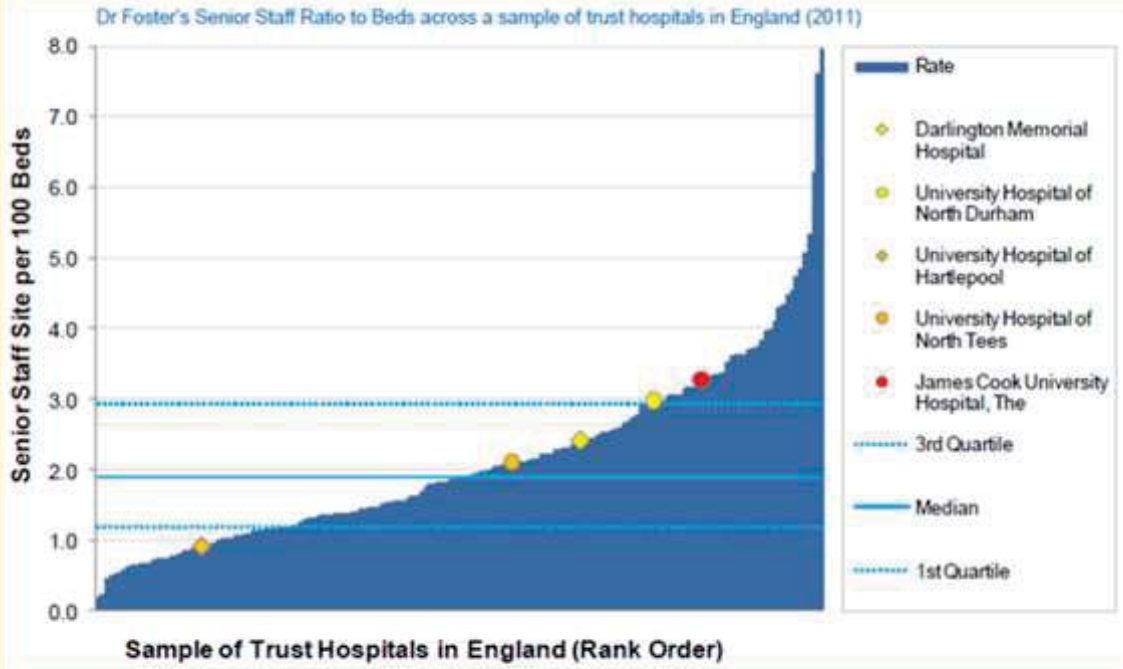
Observations:

- Total bed days for Long Term Conditions are calculated by summing the total time spent in each Trust or CCG by patients with a long term condition. On this basis, County Durham and Darlington had the highest number of LTC bed days, averaging just less than 4000 per quarter.
- North Tees and Hartlepool NHS Foundation Trust had the lowest number of bed days occupied by patients with an average of just under 1500 LTC bed days per quarter from Q1 2009/10 to Q3 2011/12.



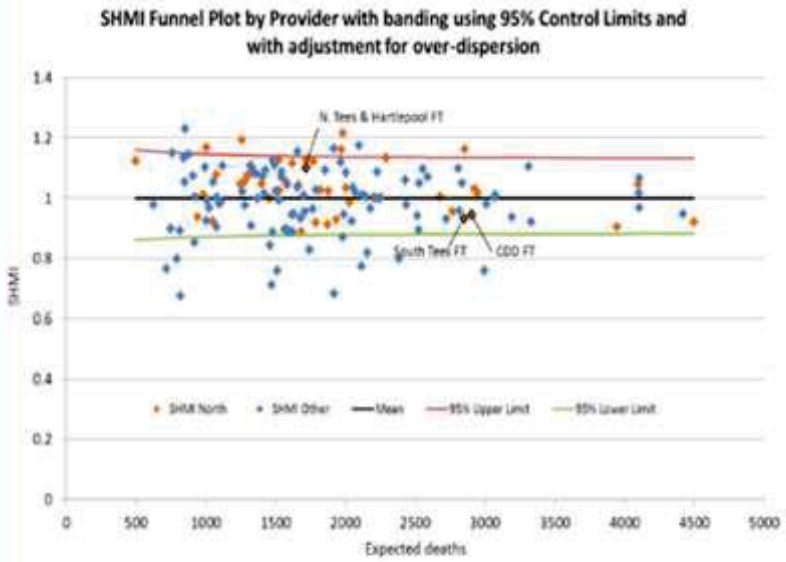

Observations:

- Mortality on weekdays is consistent across the three Trusts, with a Relative Risk of 95, indicating slightly below expected mortality but within the expected range and not significantly high or low when compared to national variation. Weekday Relative Risk is within 2.5 percentage points of overall HSMR for the entire week (see data table for figures).
- Mortality at weekends is higher for all three Trusts, with South Tees having the highest Relative Risk at 109.5. This approaches the upper quartile when compared to all Trusts nationally; however it is still within the expected ranges meaning it is not considered significantly high. This compares to a weekday relative risk of 95.8 and an overall RR of 98 for South Tees. Mortality rates for County Durham and North Tees are only slightly higher than on weekdays, at 103 and 100 respectively compared to a Relative Risk of 95 for both during weekdays, and a 97 and 95 overall.



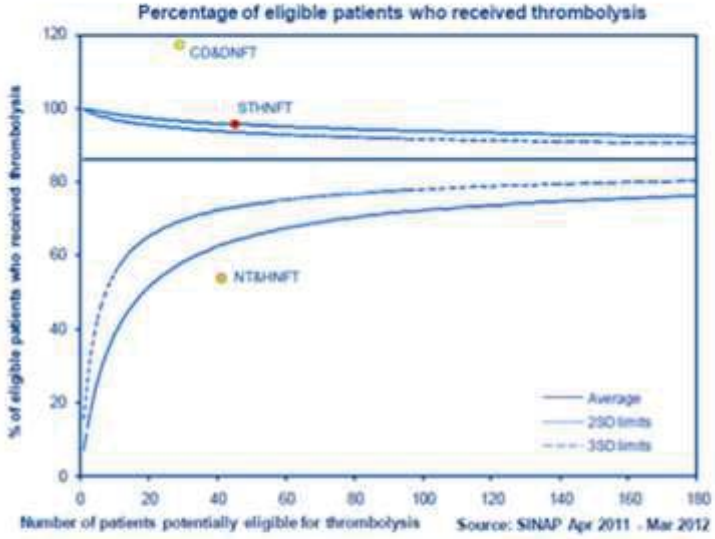

Observations:

- A point prevalence exercise undertaken for the Dr Foster's 2011 Good Hospital Guide assessed the number of senior staff physically on site at weekends on two weekends in 2011. The research suggested a correlation between senior staffing levels at weekends and mortality, in that more senior staff per bed at weekends is associated with a lower weekend emergency mortality rate (DFI, 2011).
- The two sites of North Tees and Hartlepool NHS Foundation Trust had the lowest senior staff rates at weekends compared to the other Trusts in the study. University Hospital of Hartlepool is within the bottom quartile of all Trusts in England with a rate 0.91, and University Hospital of North Tees was just above the median with a rate of 2.1. On the surface however, this does not seem to correlate to higher mortality as North Tees and Hartlepool NHS Foundation Trust had the lowest weekend mortality of the three Trusts.
- The two sites of County Durham and Darlington NHS Foundation Trust (Darlington Memorial Hospital and University Hospital of North Durham) were both above the median in the third quartile indicating above average senior staffing rates per 100 beds at weekends.
- South Tees Hospitals NHS Foundation Trust (James Cook University Hospital) had the highest senior staff rate per 100 beds at 3.27, and interestingly also had the highest weekend mortality of the three trusts.
- There are many other factors which contribute to a higher relative risk at weekends such as complexity and severity of casemix. These findings likely indicate that senior staff rates is only one contributing factor to increased weekend Relative Risk, and should not be looked at in isolation.



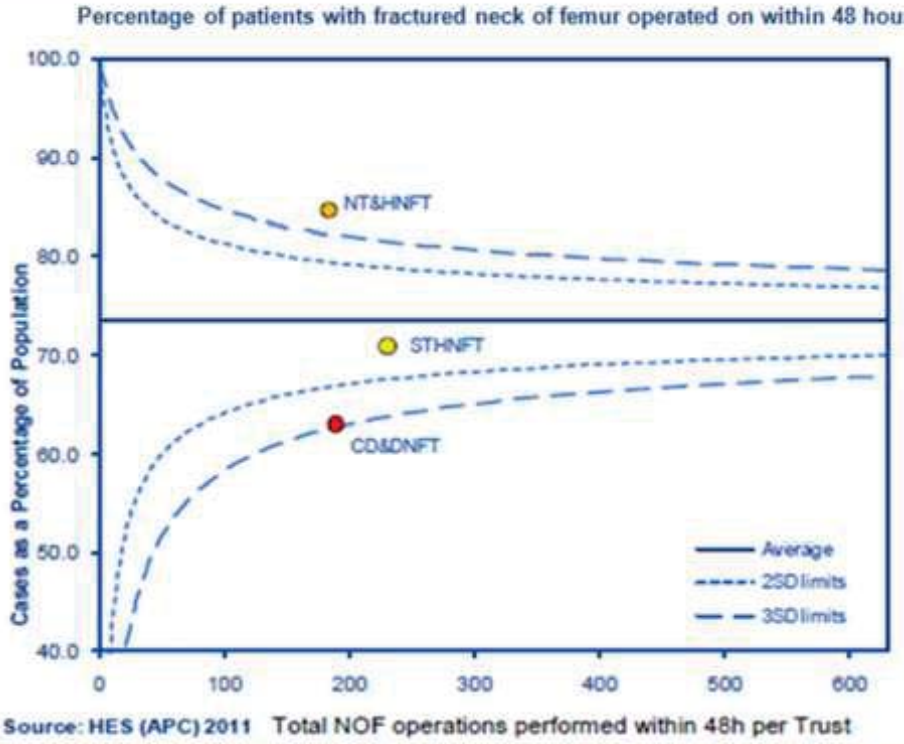

Observations:

- SHMI (Summary Hospital-level Mortality Indicator) is the new hospital-level indicator which reports all deaths in hospital and all deaths that occur within 30 days of discharge from hospital across the NHS in England. It compares the observed number of deaths for each hospital with the number expected from a statistical model that takes account of patients" age, sex, method of admission to hospital and comorbidities. None of the three Trusts has SHMIs outside the control limits, i.e. none has a higher or lower SHMI than expected.




Observations:

- County Durham and Darlington NHS Trust (RXP) provided thrombolysis to eligible patients well above the upper 3SD limit for England trust data, at 117%. This indicates that for the period they provided a statistically significantly higher rate of thrombolysis post stroke when compared to other trusts in England.
- South Tees Hospitals NHS Trust (RTR) provided thrombolysis to 96% of eligible patients, which was just within the upper 3SD limit, indicating that for the period this Trust provided a high rate of thrombolysis compared to the English average.
- North Tees and Hartlepool NHS Trust (RVW) provided thrombolysis to only 54% of eligible patients below the upper limit for England trust data, indicating that for the period they provided a statistically significantly lower rate of thrombolysis post stroke when compared to other trusts in England.




Observation:

- For the 2011 calendar year, the funnel plot compares the local Trusts to the distribution across all Acute Trusts in England. South Tees is well within the control limits and close to the national average. North Tees has a rate higher than the upper 3 standard deviation control limit. County Durham and Darlington, falls between the two lower limits.

## Acute medicine clinical standards

Standards for acute medicine were sourced from a number of key documents as shown in figure 31. Early conversations within the acute medicine sub-group highlighted a number of key issues and challenges that informed the selection of the key standards.


Figure 31: Source documents for acute medicine clinical standards

A total of 23 acute medicine standards were proposed by the sub-group as those that define high quality care, with 21 quality standards that have been agreed by the sub-group as not met by either trust.

Many of these relate to changing working practices which may provide commissioners with opportunities to drive improvements in quality through mechanisms such as CQUINS and service improvement schedules.

Three key areas were identified as being particularly difficult to address. Improved performance against these standards could be driven through mechanism such as CQUINS. However the sub-group agreed that achievement of these standards could require more significant infrastructural change and will require significant investment:

- On-admission assessment within 4 and 12 hours (in and out of hours respectively)
- 24hr access to diagnostics.
- Efficient discharge processes (both internal and with partners)

It should be noted that the 12 hour response OOH is to ensure that a consultant sees anyone admitted overnight as soon as they are on duty. Demand for acute medicine is not evenly spread over 24 hours with admissions to acute medicine dropping significantly overnight, whereas the timing of maternity deliveries is evenly spread throughout 24 hours with a slightly higher than expected proportion OOH.

A 12 hour response for all admissions OOH is a pragmatic standard that makes better use of consultant time. Standard 3 for acute medicine (see agreed list of standards) should ensure that high risk patients are seen within 1 hour, thereby ensuring a prompt response for high risk patients.

**Recommendations from the Clinical Advisory Group Acute Medicine sub-group**

The acute medicine sub-group prioritised the following standards:

- Emergency admissions seen and assessed by a relevant consultant within 4 hours in hours and 12 hours out of hours

- Clear multi-disciplinary assessment undertaken and clear case management plan in place within 4hrs in hours and 12hrs out of hours

- Emergencies to have access to key diagnostics 24/7:
    - Critical – imaging and reporting within 1hr of request.
    - Non-critical – imaging and reporting within 12hrs of request.

- Emergencies to have access to interventional radiology 24/7:
    - Critical – imaging and reporting within 1hr of request.
    - Non-critical – imaging and reporting within 12hrs of request.

- Patients discharged to their GP with a complete discharge summary sent within 24 hours – the issue is not the standard itself, but the availability of external partners such as social services to support the discharge when ready.

**Developments since November 2012**

The project team began to work on a plan to implement an interventional radiology service to achieve the standard set by the Royal college of Radiologists for a 24/7 service for all hospitals admitting medical and surgical emergencies. Progress could not be made as we were unable to engage clinicians from James Cook University Hospital.

## Acute general surgery services

Standards for acute surgery were sourced from a number of key documents as shown in figure 32. Early conversations within the acute surgery sub-group highlighted a number of key issues and challenges that informed the selection of the key standards.


Figure 32: Source documents for acute surgery clinical standards

A total of 28 standards were proposed by the sub-group. Across North Tees NHS FT, South Tees NHS FT and County Durham only 5 of the 28 standards are being met and many of those not being achieved relate to changing working practices.

The identification of these gaps provides commissioners with opportunities to drive improvements in quality through mechanisms such as CQUINS and service improvement schedules.

Two key areas were identified as being particularly difficult to address. Improved performance against these standards could be driven through mechanisms such as CQUINS. However the sub-group agreed that achievement of these standards require more significant infrastructural change will require significant investment:

- On-admission assessment within 4 and 12 hours (in- and out –of-hours respectively)
- 24hr access to diagnostics
- 24hr access to interventional radiology

The sub-group suggested that there were some clear implications for the organisation of future services:

- Small units are likely to close

- Greater co-dependencies between hospital sites and between trusts, e.g. through networks or specialty healthcare groups.

**Recommendations from the Clinical Advisory Group Acute Surgery sub-group**

The acute surgical sub-group priorities the following standards:

- When on-call, a consultant and their team are to be completely freed from any other clinical duties or elective commitments

- In order to meet the demands for consultant delivered care, senior decision making and leadership on the acute surgical unit to cover extended day working, seven days a week, amounting to a minimum of 70 hours per week

- All hospitals admitting medical and surgical emergencies have access to all key diagnostic services in a timely manner 24 –hours-a-day, seven-days-a-week to support clinical decision making:

    - Critical – imaging and reporting within 2 hours
    - Urgent – imaging and reporting within 12 hours
    - All non-urgent – within 24 hours

- Rotas to be constructed to maximise continuity of care for all patients in an acute medical and surgical environment. A single consultant is to retain responsibility for a single patient on the acute surgical unit. Subsequent transfer or discharge must be based on clinical needs

- Patients admitted for unscheduled care to be nursed and managed in acute surgical unit, a specialty ward relevant to the patient's clinical need, or critical care environment

- All hospitals admitting emergency general surgery patients to have access to fully staffed emergency theatre immediately available and a consultant on site within 30 minutes at any time of the day or night

- Establish a 24/7 interventional radiology service, especially for trauma services

**Developments since November 2012**

The acute general surgical sub-group looked at the sustainability of acute surgical services. The main factors are an increase in sub-specialising reducing the number of consultants available for an acute general surgical rota and the uncertainty around the availability of middle grade doctors. Further work is needed to model these factors and to establish what a viable service might look like.

## Intensive Care

During the Clinical Advisory Group process for Acute Care, it was decided to initiate a third sub-group to review Intensive Care Standards. As Intensive Care Medicine is emerging as a standalone school, standards were also based on the conversations with clinical leads. This sub-group has reviewed the national guidance (figure 33) and is reviewing a draft set of 29 standards.


Figure 33: Source documents for intensive care clinical standards

The sub-group will continue to meet to:

- Revise the standards before they are finalised,
- Carry out a self- assessment of each Trust against the agreed standards
- Make recommendations on any priorities for service change or developments.

At the point in the process that this report was written, the members of the Intensive Care Sub-group do not predict that the review and self-assessment against the initially identified standards will lead to recommendations for significant/multi-organisational reconfiguration.

**Developments since November 2012**

The Intensive Care sub-group completed their review of standards and carried out a self-assessment. Among the final set of 28 standards, only 6 are being met in all units. The group looked at the key enablers to delivering the standards including a tariff-based funding system and the development of additional staff groups such as critical care nurse practitioners.

## Top 5 Risks for the Workforce in Acute Services

The CAG specific workforce analysis produced a set of key risks for the acute surgical and medical workforce outlined in figure 34.

| RAG | Top 5 Risks for the Workforce in Acute Services |
|---|---|
|  | **Surgical Workforce** – converging factors of MAC list professions, large numbers of Associate Specialists nearing retirement, over capitation for junior doctors (but low 2010 fill rates for training |
|  | **Anaesthetics** – some difficulties in recruiting locally and age profiles |
|  | **GIM/AIM** – age profiles of consultants, but relatively low training fill rates in 2010 and under capitated for junior doctors (impact of restrictions of future NTN growth |
|  | **Respiratory Medicine** – under capitation (possible future restriction of NTN growth) |
|  | **Supporting professions** – difficulties in recruiting Sonographers locally, nationally MAC list includes ODPs and Nurses working in operating theatres |

Figure 34: Acute surgery and medicine workforce risks

## End of Life Care

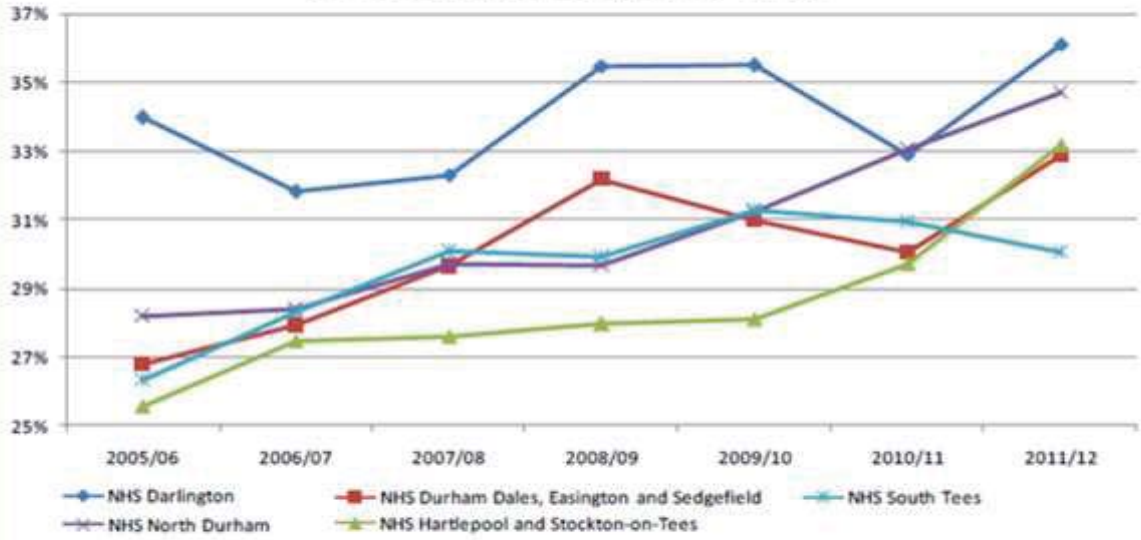
The End of Life CAG was chaired by Professor Edwin Pugh, Consultant in Palliative Medicine, North Tees and Hartlepool NHS Foundation Trust and had the following membership:

**Chair:** Professor Edwin Pugh
**Vice Chair:** Dr Elizabeth Kendrick

- Carol Lancaster, Community Matron
- Christine Hearmon, General Practitioner
- Kay McAlinden, Macmillan Lead Nurse for Cancer & Palliative, CDDFT
- Paddy O'Neill, NTHFT
- Paula Swindale, Community Matron
- Sarah Hepburn, Consultant in Psychiatry of Old Age, CDDFT
- Sarit Carlebach, Research Fellow - Centre for Health and Social Evaluation (CHASE), Teesside University
- Sue Burke, Macmillan Nurse for Care and Nursing

**Key indicators for EOL services**

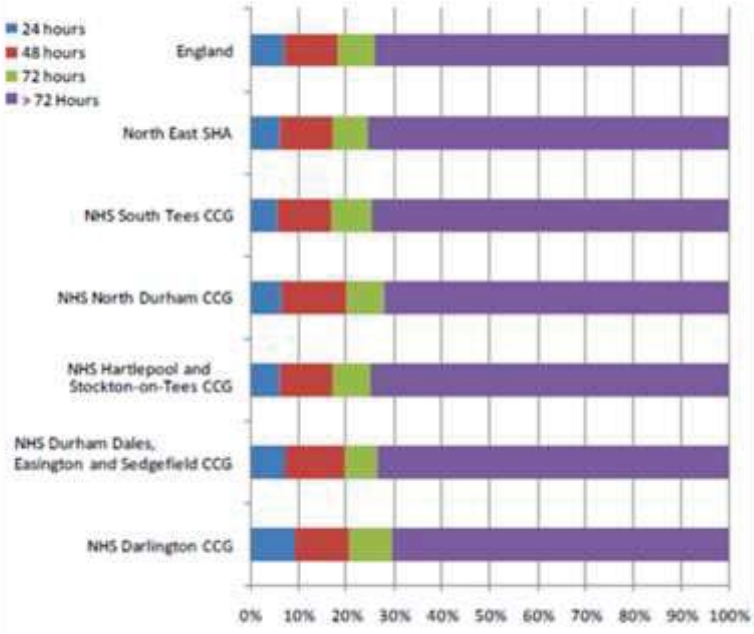
## % Deaths Aged 85+ by Year & CCG




Observations:

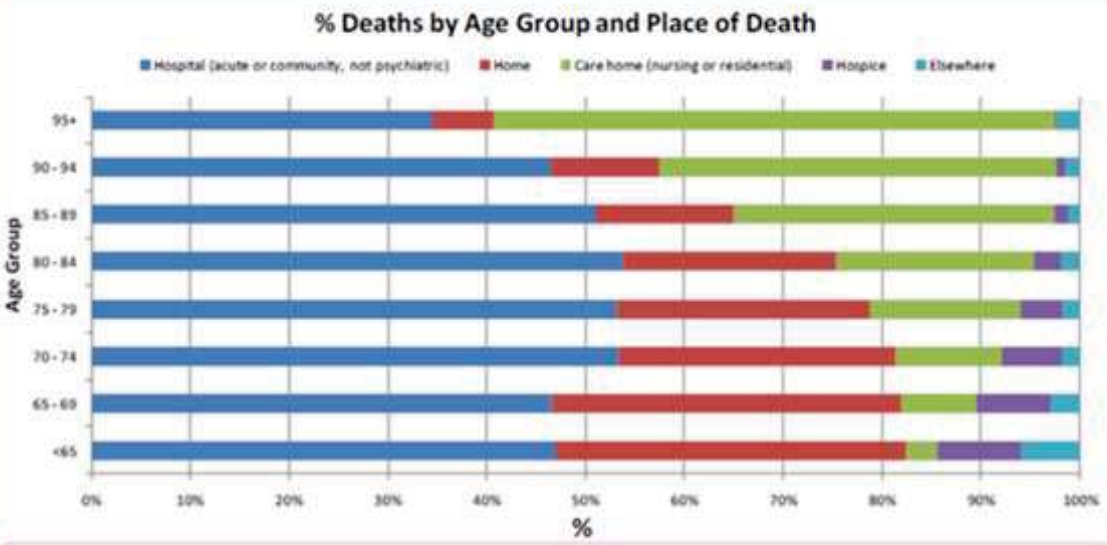
- Looking at the proportion of deaths aged 85 plus, this has increased since 2005/06 across all CCGs, increasing from 27% of all deaths in 2005/06 to 33% in 2011/12.
- Darlington CCG has seen the least change with 34% of deaths for over 85"s in 2005/06, increasing to 36% in the current year.

## % Deaths in Hospital by Hours, 2010/11




Observations:

- In England of the total number of people who are admitted at the end of their life, 26% die within 72 hours of admission. In the North East this is slightly lower at 24.4%.
- Across the CCGs the range is from 25% at Hartlepool and Stockton-on-Tees to 29.7% at Darlington.
- Darlington CCG has the highest proportion of people who die within 24 hours, the highest within 48 hours and the highest within 72 hours.




Observations:

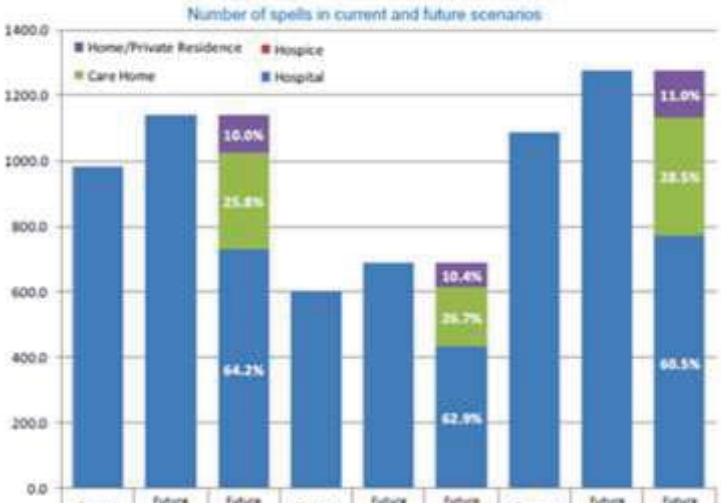
- The number of deaths by place of death varies significantly by age group
- People under 65 are more likely to die in hospital (47%) or at home (36%), with only 3% dying in a care home
- With increasing age, it becomes far less likely for someone to die at home and more likely for them to die in a care home


Observations

- The use of Z518 to record the Liverpool Care Pathway use was mandated in national coding guidance from April 2011. The rate of using this code was negligible before 2010/11, and it has slowly increased until the end of 2011/12.
- The indicator is averaging around 5 episodes per 1,000 provider spells in quarter 4 2011/12, across England and the North East.
- South Tees and North Tees Trusts have slightly higher rates than average.
- County Durham and Darlington's rate is lower with only 4 per 1,000 spells.


Observations:

- In 2010/11, across the 5 CCGs, 94% of practices have a complete palliative care register, compared with 96% in the North East SHA and England.
- North Durham CCG has an above average rate of completion, but all other CCGs are lower than the comparators, especially Darlington which has a completion rate of only 83%.




| | Current | Future Present | Future Scenario | Current | Future Present | Future Scenario | Current | Future Present | Future Scenario |
|---|---|---|---|---|---|---|---|---|---|
| | | LTFT | | | NTHFT | | | CDDFT | |
| Home/Private Residence | 0.0 | 0.0 | 114.2 | 0.0 | 0.0 | 71.5 | 0.0 | 0.0 | 141.2 |
| Care Home | 0.0 | 0.0 | 293.7 | 0.0 | 0.0 | 183.8 | 0.0 | 0.0 | 363.1 |
| Hospice | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Hospital | 962.0 | 1140.3 | 732.5 | 602.0 | 688.8 | 433.5 | 1087.0 | 1275.6 | 771.4 |

Observations:

- The End of Life Care modelling tool is designed to allow predictive modelling of local health and social care systems for specific conditions or groups of people. This shows the current number of spells in each of the three Trusts associated with End-of-Life care in 2011-12 along with the projected number of spells in five years' time if the current configuration of services is left as-is (Future Present) and the number of spells that would occur in alternate care settings if service changes occur based on the modelling projections (Future Scenario). The model shows that roughly one quarter of future spells could be diverted to Care Homes and one tenth to Home/Private Residence.

## End of Life clinical standards

Standards for end of life care were sourced from a number of key documents as shown in figure 35. Early conversations within the End of Life CAG highlighted a number of key issues and challenges that informed the selection of the key standards.


Figure 35: Source documents for acute neonatology clinical standards

The 16 NICE Quality Standards for End of Life Care for Adults were accepted by the CAG as those that define high quality care.

Across County Durham and Tees, a total of 5 End of Life Care standards are not being met by two or more of the trusts. These provide commissioners with opportunities to drive improvements in quality through mechanisms such as CQUINS and service improvement schedules.

Areas where the 5 standards are not completely met:

- Co-ordinated Care - People approaching the end of life receive consistent care that is coordinated effectively across all relevant settings and services at any time of day or night, and delivered by practitioners who are aware of the person's current medical condition, care plan and preferences.
- Urgent Care - People approaching the end of life who experience a crisis at any time of day or night receive prompt, safe and effective urgent care appropriate to their needs and preferences.
- Care after death – This includes the verification and certification of the death and bereavement support.

Of these 16 standards, 4 were only being met partially by two or more of the trusts. These provide commissioners with opportunities to drive improvements in quality through mechanisms such as CQUINS and service improvement schedules.

Areas where the standards are partially achieved currently:

- Identification - People approaching the end of life are identified in a timely way
- Communication and information - People approaching the end of life and their families and carers are communicated with, and offered information, in an accessible and sensitive way in response to their needs and preferences.
- Holistic support - psychological and physical - People approaching the end of life have their physical and specific psychological needs safely, effectively and appropriately met at any time of day or night, including access to medicines and equipment.
- Specialist palliative care - People approaching the end of life that may benefit from specialist palliative care, are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night.

**Recommendations from the End Of Life Clinical Advisory Group**

The End of Life CAG recommends a focus on the following priorities:

- Promotion of the North East 'Good Death Charter'

- Identification of resources to support individuals at end of life.

- Effective use of palliative care registers in supporting appropriate and personalised care planning.

- Development of access to 24/7 support for those with end of life needs, ensuring that patient choice and wishes are respected.

## CAG Specific Workforce Assessment

The key pressures and workforce risks perceived to key facing the area are outlined in (figure 36).

| Staffing group | National | RAG | Local | RAG |
|---|---|---|---|---|
| Palliative Care Consultants | No impending age retirement pressure for Palliative care consultants<br><br>National Council for Palliative Care (NCPC) note various estimates put the national figure between 251 – 362 headcount of consultants.<br><br>27.5% of Consultant workforce aged over 50, vacancies stand at 7.8% | | The NCPC survey points to a consultant body which is older than the England average in the North East (32.4%) with vacancies standing at 15.9%<br><br>However SHA Workforce data from ESR shows that the numbers of consultants aged over 50 in CDD and Tees is lower than the figures highlighted by the NCPC. | |
| Doctors in Training for Palliative Medicine | CfWI modelling indicates there is a possibility that growth in CCT holders could become too strong from 2015. There was a 65% national speciality training fill rate in 2010 | | Information from the Northern Deanery indicates that 5 trainees are due to complete training in 2012. CfWI figures indicate in 2010 a 25% fill rate to specialty training in the Deanery | |
| SSASG Doctors in Palliative Medicine | NCPC 2010 data shows a national vacancy rate of 10% | | NCPC 2010 data shows a NE vacancy figure at 28.1% | |
| Specialist palliative care nurses | NCPC data shows that 38.2% is aged over 50 (48% for bands 2-4) | | NCPC data shows that 41.2% is over 50 (52.2% for bands 2-4) in the NE. | |

Figure 36: End of Life workforce risks

The following risks were prioritised:

| Risk rating | Workforce risks in End of life care |
|---|---|
| 1 (Top Risk) | Undercapitation for Palliative Care Consultants |
| 2 | Future supply of trainees to become consultants (potential NTN restrictions) |
| 3 | Relatively low rate of training fill rate in Deanery |
| 4 | High levels of SSASG vacancies in NE |
| 5 | Capacity issues for the wider workforce e.g. sonographers, Emergency Care Consultants |

The findings of the CAG specific workforce assessment are:

- The number of consultants in palliative care medicine meet the recommended standards

- The emphasis should be on collaborative working across the health economy to provide specialist palliative care advice 7 days a week, and that all health and social care workers have the knowledge, skills and attitudes necessary to be competent to provide appropriate high-quality care and support for people approaching the end of life and their families and carers.

# Long Term Conditions

As the majority of long term conditions management can, and arguably should, be provided closer to patients' home from community or primary care settings and often benefits from a multi-agency approach, the Long Term Conditions Clinical Advisory Group worked to the following remit:

- Consider the information in the Technical Papers describing the current population profile and demand for health care, and the estimated future demand for health care based on demographic change and increasing prevalence of long-term conditions
- Advise the project team on the assumptions to include in the modelling work we plan to do looking at the potential for managing care for patients with long term conditions closer to home. This involves agreeing on some assumptions about the potential impact of evidence based interventions and consistent standards of care on future care provision
- Make recommendations on the scope and timescale for more detailed work across primary and secondary care, health and social care on assessing the quality of services against the agreed standards, and identifying priorities for developing integrated services

### Focus of discussion of the LTC CAG

The LTC CAG used financial scenarios developed from similar work from other parts of the country to assess the role in LTC management in meeting future economic pressures and then relate them to the most relevant aspects of efficiency management (outlined in figure 37).

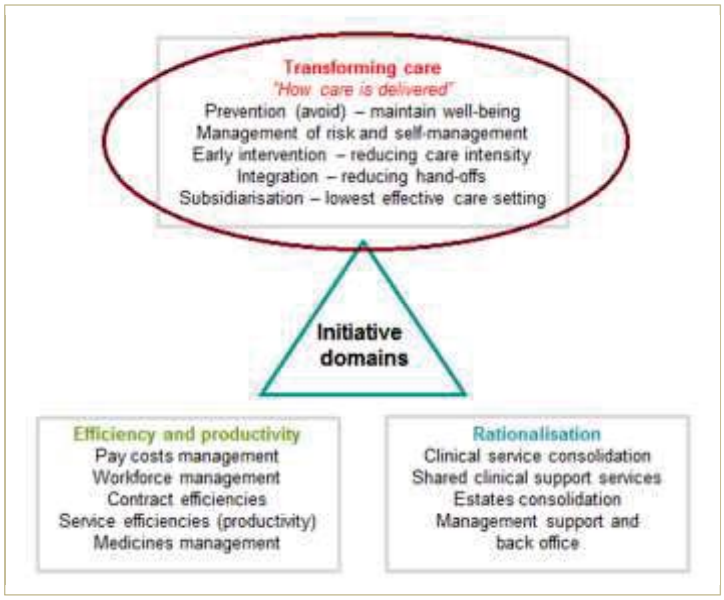



Figure 37: LTC Initiative Domains

**Recommendations from the LTC CAG**

The recommendations from the group are:

- CCGs to come together to share the same case for change. They will consider a whole systems approach that takes account of current progress in local areas and focuses on change that will add value at every level of intervention from the individual patient to interventions and agreed standards across multiple CCGs in order to gain the scale that will allow for the most effective interventions to be implemented on the largest possible footprint.

- A whole system plan spanning e.g. five years should be developed to meet the financial challenge and the opportunity around the management of patients with Long Term Condition as a large part of mitigating the overall risk to the health economy.

- This plan needs to be presented through the lens of improving quality and outcomes, not just the financial drivers: the focus on right person, right place right time, up-streaming of care to prevention services are key and should be able to be described by all CCGs as one coherent message.

- System wide governance will need to be developed to agree and implement the changes required. Decision making processes will need to support some of the difficult politics and compromises that will need to be managed.

This needs to happen as soon as possible because:

- It is clear that a funding crisis is looming - shifting all of the risk to providers will not lead to a sustainable future for Durham and Tees Valley

- There is an opportunity to build on the recent work with acute trusts and use the momentum generated to carry forward a partnership working approach

The LTC CAG agreed that while the analyses presented were reasonable, further work was both necessary and urgent to facilitate the next steps:

- More detailed work on the financial and workforce challenges to provide a better understanding of the required scale of transformation.

- Addressing the mental health needs of people with long term conditions and mental health problems as long term conditions should be included in the scope of the work, understanding that this is a more difficult area in which to quantify opportunities.

- Joint working between the system leaders to establish buy-in to a shared 'aiming point' for a balanced budget.

- Joint working between the system leaders to understand the planning assumptions and establish buy in to the potential scale of change.

- More detailed analysis to understand the activity/spend in the acute sector on scheduled and unscheduled care that is attributable to LTC patient cohorts.

- Analysis to understand the interplay between scheduled and unscheduled care and integrated care.

- Understand the scale and pace of existing QIPP plans –specifically those relating to LTCs – in light of the transformation potential.

- Identify and agree opportunities – cohort/condition specific as necessary – for going further and/or faster.

- Develop detailed cross economy plans for transformation including business cases for investment, phasing of delivery, impact on wte, agreed risk shares and procurement and governance arrangements.

**Developments since November 2012**

The project team has commissioned from NEQOS, a report for each CCG, profiling the unplanned admission rates for ambulatory care sensitive conditions (ACSCs). The purpose of these reports is to support CCGs with their plans to improve the quality of care and reduce costs. The next step is to work with a CCG to develop a core set of standards for the management of ACSCs and to carry out a self-assessment against these standards.

# Planned Care

As outlined in the project methodology, due to the number of specialities, the project focused on variation in practice and levels of competition within planned care.

### Current level of competition in Planned Care

As part of the assessment of the economic analysis, a review of current levels of competition and market share was also carried out (figure 38).

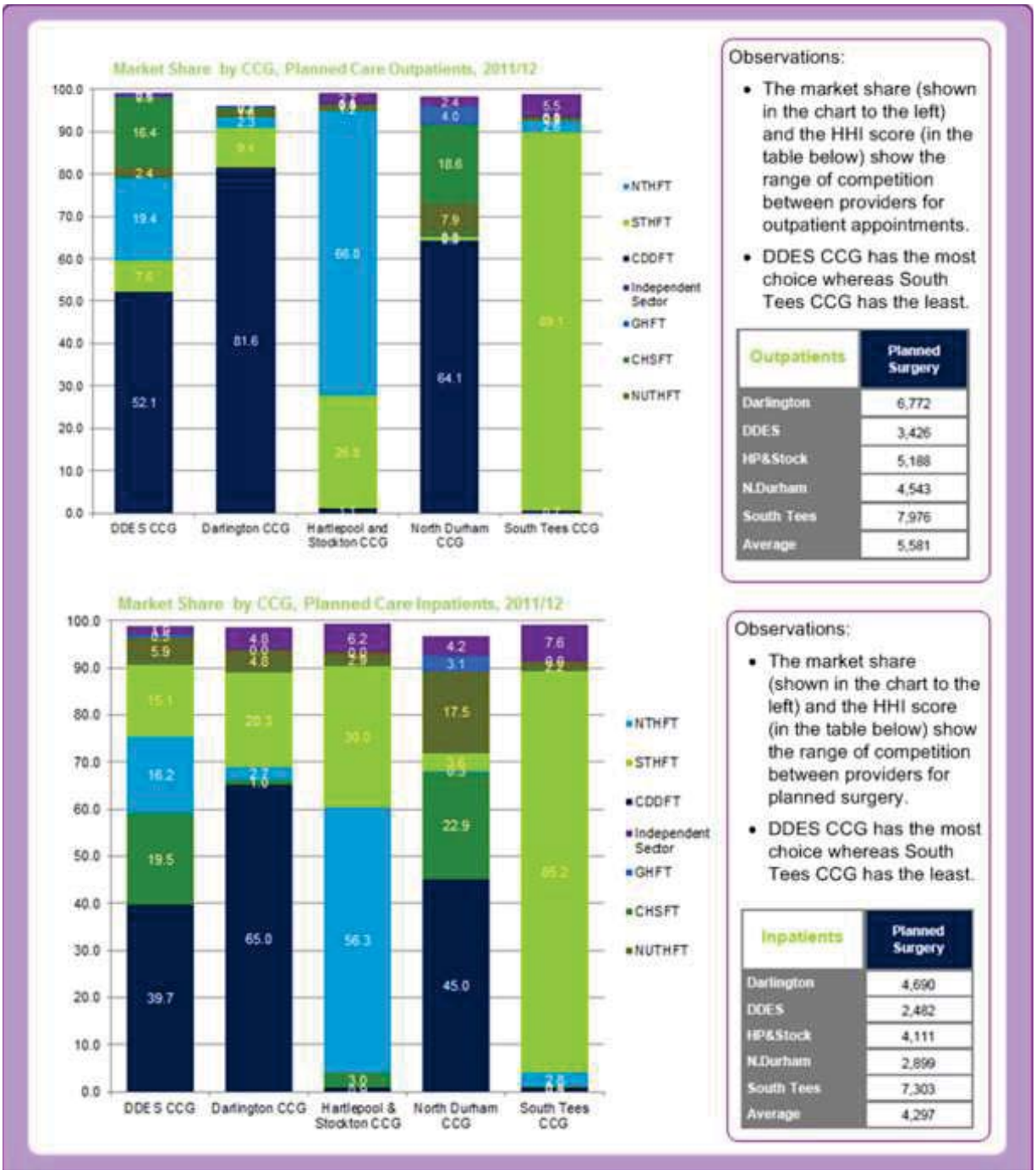



Figure 38: Market share and HHI scores for planned care

To do this, Hirschman Herfindahl Index (HHI) scores were derived for each clinical specialty area and clinical commissioning group area. HHI scores provide a numerical indication of the concentration of competition within a particular market (and as such, an approximation of patient choice).

A high HHI score (>7000) indicates that there is a lack of competition in a particular market and as a result a lack of patient choice (which can often be expected in very niche markets e.g. tertiary services). Scores of <5000 are considered favourable within the UK health sector as this indicates that patients have a reasonable choice of provider.

Overall, the Durham Darlington and Tees health economy has relatively more competitive compared to the national position. DDES CCG scores the lowest HHI scores which represents the greater choice offered by its close locality to four major Trusts (CDDFT, NTHFT, CHSFT & NUTHFT). By contrast STHFT is the predominant supplier to the South Tees area; HHI scores for South Tees CCG are extremely high, indicating a monopolistic market; despite the potential for patient flows to move away from STHFT they are loyal to their local hospital. The same is seen in Darlington where the local culture is such that despite the level of choice in the area, the population of Darlington is very loyal to their local hospital.

**Variation in practice**

Within the supporting documentation, a review of variation in practice and potential impacts of future changes has been undertaken. The main areas of analysis of variation covered in the technical and briefing papers includes:

- Value based commissioning report. This report is a local adaption of one produced by the Midlands and East Quality Observatory to show the relative performance in carrying out certain procedures which may be considered of limited clinical benefit when weighted against their cost (an example is shown in figure 39). The Value Based Commissioning Dashboard compares interventions at a Clinical Commissioning Group level to the national average and displays this on a Statistical Process Control (SPC) chart to show the level at which the CCGs differ statistically from the national average.

- Conversion rates from outpatient to inpatient for elective specialties. This is a variant of a surgical conversion rate metric which looks at the numbers of first outpatient appointments and inpatient admissions by speciality within each quarterly time period.

- Community based recovery and early supported discharge. Enhanced recovery is a method of managing the pre-, intra- and post-operative care of a surgical patient to optimise management and reduce post-operative length of stay. Based on the national programme (which focuses on seven high priority surgical procedures), an analysis on the impact of any pathway changes has been undertaken to inform providers and commissioners on local performance.

- The impact of change drivers. An assessment of the impact on local activity of assumptions relating to a potential change in policy, technology or clinical practice has been undertaken for each CCG.

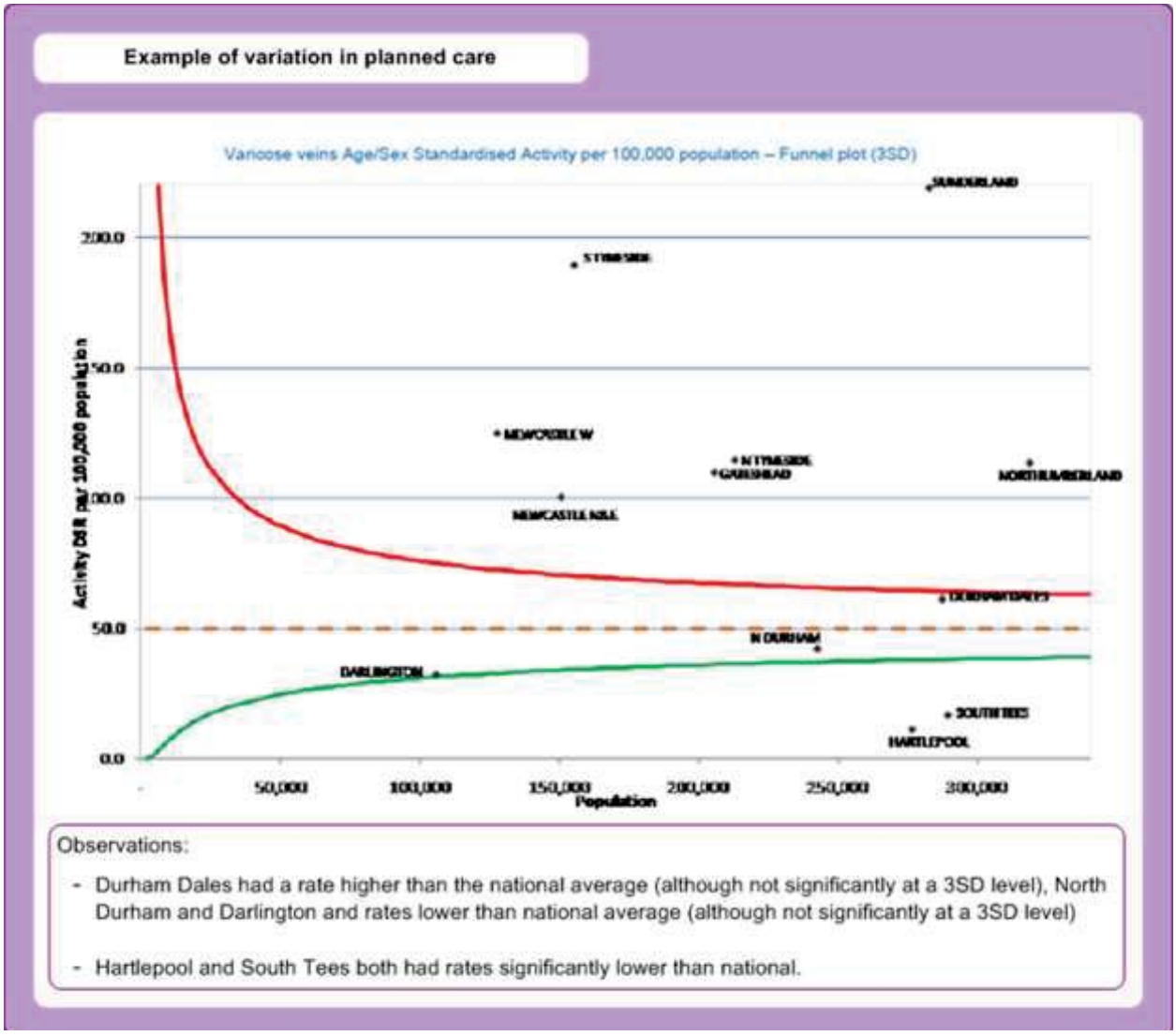



Figure 39: Example of variation across CCGs within planned care

Generally across the NHS, elective services are often more profitable than non-elective services. Commissioners need to be mindful of this when changing commissioning patterns so that movements of activity between or away from providers do not have a destabilising effect on them as they are left with the cost of provision with no income to cover them or a need to increase their cost improvement targets above the levels outlined in the section on economic context.

Access to service line reporting data would be necessary in order to make a full and proper assessment of the scale of this risk however.

## Next steps

NHS County Durham and Darlington and NHS Tees have carried out this work as part of their responsibility to ensure maintenance of quality through the transition. This work goes well beyond the expectations of the Department of Health (DH) for the development of legacy documents as part of the transfer of commissioning responsibilities from PCTs to CCGs and other bodies.

This report describes a synthesised set of analysis and clinical recommendations, supported by wider workforce and economic modeling, developed through a robust clinically led process with a focus on sustainable, high-quality care. The findings and recommendations set out in the report have implications that range from potential changes to be made to provider contracts through incorporating the agreed clinical quality standards, to potential service reconfiguration across County Durham and Tees valley.

As part of the transfer of responsibilities, CCGs have agreed to build on this legacy work and will take this work forward in line with the duty placed upon them to commission high quality sustainable services.

This expectation is consistent with CCG functions and the duties and powers in place to enable them to fulfill these functions as set out in The Functions of Clinical Commissioning Groups (DH June 2012).

When the transition is complete at the end of March 2013, the responsibility for the implementation of the report findings and recommendations will transfer to the five CCGs in County Durham and Tees Valley. They will work in partnership with Hambleton, Richmondshire and Whitby CCG, due to the scale of their patient flows into the Tees Valley area.

It has been agreed that this work will continue to be a commissioning led process and as such, Darlington CCG will lead the work on behalf of the six CCGs across County Durham, Darlington, Tees and Hambleton, Richmondshire and Whitby. The project will also feed into, and be supported by, the work of the Area Team of the NHS Commissioning Board.

Darlington CCG Chief Officer will provide leadership for the project and ensure that it delivers the objectives for the next phase of work which are to assess the feasibility of, and options for, implementing the standards and progressing implementation. This will include working with North of England Commissioning Support (NECS) and the CCGs on including the quality standards in contracts and CQUIN schemes. It is critical that this leadership role encompasses communications and engagement to continue and develop further the stakeholder engagement that has been undertaken to date.

The clinical lead for Hartlepool and Stockton on Tees CCG will work alongside the Darlington CCG chief officer to ensure sufficient clinical focus as the work moves forward.

It is anticipated that the role of steering the project will rest with the project board which will, it is suggested, continue to include the CCG chief officers and clinical leads, the FT chief executives, the Area Team and two local authority chief executives, chaired in the future by the lead CCG chief officer.

In light of the fact that existing project team members are moving into new roles as part of the transition process, project team membership will be reviewed and updated to ensure delivery of the next phase of the project and this team will be accountable to the Darlington CCG Chief Officer as project lead.

The project board will require new terms of reference setting out its role steering the project going forward.

It is anticipated that the role of the project board in the next phase of the work of the project will include:

- steering the feasibility analysis on implementing the report recommendations and standards
- a commitment to reviewing/revising/maintaining the clinical quality standards
- the involvement of clinicians in this process
- ensuring that the standards are included in commissioning intentions, service specifications, CQUINs and clinical network development
- supporting wider engagement as the project moves forward

It is anticipated that the project board will meet bi-monthly, starting in May 2013.

The key actions going forward therefore will be:

- To review the project board terms of reference and membership to enable it to oversee the next phase of the project, to include transferring leadership to CCGs.
- To ensure that the project continues to have dedicated resources to support the next phase of work.
- To undertake a feasibility analysis on implementing the recommendations of the ASQLP report.
- To maintain the engagement of the clinicians who have contributed to this work.
- For FTs to consider the report recommendations, with particular reference to the implications for their own organisations and areas where they will work together and with the CCGs, to support the next phase of the project.
- For FTs to consider the report recommendations in regards to their own workforce planning and subsequent recommendations they make to the NELETB on education and training commissions.

# Appendix 1: List of Supporting Documents

The following documents have been produced in support of this project report and will be available via the North East Quality Observatory System website (http://www.neqos.nhs.uk/ ):

**Health analysis**

- Technical Paper A: Current and future demand. Produced by NEQOS, 288 pages, file size 13.7MB.
- Technical Paper B: Future Activity. Produced by NEQOS and Mott Macdonald, 102 pages, file size 1.5MB.
- Technical Paper C: Quality. Produced by NEQOS and Mott Macdonald, 213 pages, file size 6.3MB.
- Acute Paediatrics, Maternity and Newborn Briefing Paper. Produced by NEQOS and Mott Macdonald, 267 pages, file size 4.2MB.
- Acute Care Briefing Paper. Produced by NEQOS and Mott Macdonald, 340 pages, file size 5.2MB.
- End of Life Care Briefing Paper. Produced by NEQOS and Mott Macdonald, 76 pages, file size 0.9MB.
- Long Term Conditions Briefing Paper. Produced by NEQOS and Mott Macdonald, 104 pages, file size 2.5MB.
- Planned Care Briefing Paper. Produced by NEQOS and Mott Macdonald, 519 pages, file size 12.6MB.

# Appendix 2: Acute Services Quality Legacy Project Board Members

| | |
|---|---|
| Yasmin Chaudhry | CEO, NHS County Durham and Darlington (Joint Chair) |
| Chris Willis | CEO, NHS Tees - Up to 1/12/2012 (Joint Chair) |
| Cameron Ward | Director, Durham, Darlington & Tees Area Team, NHS Commissioning Board, CEO NHS Tees – From 1/12/2012 |
| Sue Jacques | CEO, County Durham and Darlington NHS FT |
| Alan Foster | CEO, North Tees & Hartlepool NHS FT |
| Tricia Hart | CEO, South Tees Hospitals NHS FT |
| Amanda Hume | Chief Officer, South Tees CCG |
| Dr Henry Waters | CCG Chair, South Tees CCG |
| Ali Wilson | Chief Officer, Hartlepool and Stockton on Tees CCG |
| Dr Boleslaw Posmyk | Chair, Hartlepool and Stockton on Tees CCG |
| Nicola Bailey | Chief Operating Officer, North Durham CCG |
| Neil O'Brien | Chief Clinical Officer, North Durham CCG |
| Martin Phillips | Chief Officer, Darlington CCG |
| Andrea Jones | Chair, Darlington CCG |
| Vicky Pleydell | Clinical Chief Officer, Hambleton, Richmondshire & Whitby CCG |
| Debbie Newton | Chief Operating & Finance Officer, Hambleton, Richmondshire & Whitby CCG |
| Stewart Findlay | Chief Clinical Officer, Durham Dales, Easington and Sedgefield CCG |
| Mike Taylor | Chief Operating & Finance Officer, Durham Dales, Easington and Sedgefield CCG |
| Gill Rollings | CEO Middlesbrough Council |
| Rachael Shimmin | Corporate Director, Children & Adults Services Durham County Council |
| Rosemary Granger | Project Director |

(CCG – Clinical Commissioning Group
CEO – Chief Executive Officer)

# Securing Quality in Health Services

This briefing has been issued on behalf of the following:

Darlington Clinical Commissioning Group
Hartlepool and Stockton-on-Tees Clinical Commissioning Group
Durham Dales, Easington and Sedgefield Clinical Commissioning Group
North Durham Clinical Commissioning Group
South Tees Clinical Commissioning Group

## Introduction

Both commissioners and providers of acute services face a similar set of challenges over the next five to ten years. Our population will be older, with more long-term conditions being treated by a state funded NHS that is ultimately tied to the performance of the national economy. These services will also be operating as part of a wider system with social care which itself faces significant challenges related to national financial constraints.

While our local hospital trusts consistently deliver high quality services, meet national performance targets related to waiting times and cleanliness, and operate efficiently within their means, we know we can do better.

The purpose of this briefing is to inform stakeholders about a significant project that is underway across County Durham and Tees Valley to support and enhance the commissioning of sustainable, high quality acute hospital services.

The **securing quality in health services project** was initiated by primary care trusts and has now become the responsibility of the five clinical commissioning groups, working together with the local hospital Foundation Trusts in County Durham and the Tees Valley. We are also in discussion with Hambleton, Richmondshire and Whitby CCG as this piece of work could have an impact upon their plans.

## What is the project about?

The project was designed to first reach consensus on the key clinical quality standards that should be commissioned in acute hospitals and then to work towards their achievement. It has focused on the following clinical areas:

- acute paediatrics and maternity services
- acute care
- end of life care

- long term conditions

The project looked specifically at the following aspects:

1. a clinical quality assessment that considered national best practices, barriers and enablers
2. an economic assessment, taking into account the local financial environment
3. a workforce assessment that identified any constraints in relation to the achievement of agreed quality standards.

**Key findings**

There is growing evidence that patient outcomes could be improved by increasing the number of hours when senior doctors are available in hospital wards to make decisions about the assessment and treatment of patients.

There is also a need to reduce the time taken to assess, diagnosis and treat acutely ill patients and a number of the clinical quality standards agreed during the project would address this.

Taking into account the number of people currently training to work as health professionals in the region, and the age profile of existing staff, we are likely to experience staff shortages in the medium to long term unless we take action.

**Next steps**

Clinical staff have helped us to identify what the best possible care should look like in our hospitals and how we should go about delivering this, given increasing demand for services and the likely financial and workforce challenges ahead.

We recently commissioned an external feasibility study which will consider the implications of implementing the new standards across the Durham and Tees Valley region. This work will also take into consideration two important pieces of work underway in acute services in the area, ie the major consultation on maternity and children's services due to start in the Hambleton, Richmondshire and Whitby area in the near future and the ongoing work at North Tees and Hartlepool FoundationTrust to build a new hospital at Wynyard.

The feasibility study is due to conclude by the end of the summer.

The outcome of the feasibility study will help to inform CCGs as they develop their commissioning plans and contracting intentions for the 2014/15 financial year and onwards and ensure that the focus on sustainable, high-quality care remains the key driver for all organisations commissioning or providing secondary care for the patients of County Durham, Darlington and Tees.

We are approaching local Health and Wellbeing Boards and other stakeholders to ensure that they are aware of this project and its potential implications.

Should recommendations arising from the study involve any changes to existing services, we will put in place appropriate plans to engage with and seek the views of patients, carers and the public.

If you would like any more information about this project please contact:

Rosemary Granger
Project Director
NHS Darlington Clinical Commissioning Group Dr Piper House King Street
Darlington
DL3 6JL
rosemary.granger@nhs.net
Tel: 07837893214 or 01325 746 212

If you would like to read the full project report, you can find it online at http://www.darlingtonccg.nhs.uk/county-durham-and-tees-valley-acute-services-quality-legacy-project/

5.2

Appendix 3

# Acute Services Quality Legacy Project

**Clinical Advisory Group outputs - agreed clinical standards for:**

*Maternity*
*Paediatrics*
*Neonatology*
*Acute medicine*
*Acute general surgery*
*Intensive Care Medicine*

This workbook contains the sets of clinical standards that have been agreed by the Clinical Advisory Groups as part of the Durham and Tees Valley Acute Services Quality Legacy Project Phase 1 (June - October 2012) and updates during Phase 2 (January 2013)

**February 2013**

# Clinical Quality Standards: Agreed set of maternity standards

| Standard | | | Source(s) | Commentary |
|---|---|---|---|---|
| **Access to antenatal services** | **1** | Antenatal care should be provided in a variety of local settings and at times that take account of the demands of the woman's working life and family. | RCOG 2008 | Original standard agreed with no amendments |
| | **2** | All women should be offered a comprehensive, high-quality antenatal screening and diagnostic service, based on the current recommendations of the National Screening Committee, and designed to detect maternal or fetal problems at an early stage. | RCOG 2008 | Original standard agreed with no amendments |
| | **3** | All maternity care providers should ensure that each pregnant woman has two visits early in pregnancy with a midwife who can advise her on her options for care on the basis of an in-depth knowledge of local services. | RCOG 2008 | Original standard agreed with no amendments |
| | **4** | For women with an uncomplicated pregnancy, the number of scheduled antenatal appointments should be planned in accordance NICE Guideline 62 (2008) – uncomplicated nulliparous women: 10 appointments; uncomplicated parous women: 7 appointments. | RCOG 2008 | Original standard agreed with no amendments |
| **Access to EPU** | **5** | Women should be able to access promptly adequately equipped Early Pregnancy Assessment Units. | RCOG 2008 | Original standard agreed with no amendments |
| | **6** | Larger obstetrics units (>3500) should provide 23hr EPAUs on weekdays and extended hours at weekends that provide scanning and assessment. | Local agreement | Locally developed standards (CAG 1) |
| **Networks** | **7** | Commissioners and providers must develop maternity and neonatal care networks. | RCOG 2008; RCOG 2011 | Original standard agreed with no amendments |
| | **8** | All obstetric units should have direct access to special care baby unit facilities to manage babies requiring ventilation and have a defined rapid access route to neonatal intensive care. | RCOG 2008 plus local amendment | The original standard here referred to Level II and III maternity units which was not felt to be a useful classification - the fundamental concept was that direct access required to manage ventilated babies with robust supporting transfer protocols. This locally amended standard was felt to retain and enhance the spirit of the original wording, but makes clearer the requirements to be able to achieve it. |
| **Postnatal examinations** | **9** | All new-born infants should have a complete clinical examination within 72 hours of birth. | RCOG 2008 | Original standard agreed with no amendments |
| **Throughput** | **10** | No less than 2500 births per year for a consultant led unit. | RCOG 2007, RCOG 2011 (implied) | Original standard agreed with no amendments |
| **Support services** | **11** | Every consultant led unit should have on site haematology, blood transfusion and ITU. | Local agreement | Locally developed standards (CAG 1) |
| **Theatre capacity** | **12** | Access to second theatre must be available within 20 minutes 24/7. | Local agreement | Locally developed standards (CAG 1) |
| **Midwife Led Unit (MLUs)** | **13** | MLUs should have a throughput of at least 300 births a year to ensure quality. | Local agreement | Locally developed standards (CAG 1) |
| | **14** | Free-standing Midwifery Units must have robust admission criteria and transfer protocols; obstetric units should have Alongside Midwifery Units co-located with them. | Local agreement | This locally developed standard was suggested at CAG 1 and amended at subgroup meeting. |
| **Staffing: obstetrics** | **15** | Established prospective consultant obstetrician presence on each labour ward:<br>> All centres should have a minimum of 40 hours consultant presence<br>> Centres with 2500-4000 births should have 60 hour consultant presence<br>> Centres with 4000-5000 births should have 98 hour consultant presence<br>> Centres with >5000 births should have 168 hour consultant presence | RCOG 2007, RCOG 2008, CNST 2012 | These standards are related - standard 15 is a phased version of standard 16 (the original requirement recommended by RCOG).<br><br>It was agreed at CAG 2 that the RCOG 2005 recommendation was the agreed minimum requirement. |
| | **16** | Established prospective consultant obstetrician presence on each labour ward:<br>> By 2014 units with between 2500-4000 births should have 98 hour consultant presence and units of 4000 births + should have 168 hour presence<br>> In recognition of the differing needs of units with less than 4000 deliveries, not all units will require 168-hour presence to ensure the necessary quality and safety standards. | RCOG 2005 | |

# Clinical Quality Standards: Agreed set of maternity standards

| Standard | | | Source(s) | Commentary |
|---|---|---|---|---|
| | **17** | A consultant obstetrician should be available within 30 minutes outside the hours of consultant presence. | RCOG 2008 | Original standard agreed with no amendments |
| | **18** | Patients on the labour ward should have four board/team reviews between 8am and 10pm. | RCOG 2008 plus local amendment | This standard updates the original RCOG standard which stipulates the number of physical ward rounds required during times when consultants are not present on the labour ward. This broader standard is more coherent with the minimum requirement for consultant presence. |
| | **19** | There should be a minimum of 10 WTE on medical staff rotas at each level. | Local agreement | Locally developed standards (CAG 1) |
| | **20** | There should be consultant attendance at vaginal breach, vaginal twins, C-section at fully dilated. | Local agreement | Locally developed standards (CAG 1) |
| **Staffing: midwifery** | **21** | Each woman should receive one-to-one midwifery care during the second stage of labour by a trained midwife or trainee midwife under supervision; the first stage of established labour should be overseen by an appropriately trained professional under the care of a midwife. Admission to the labour ward should be limited to women who are in established labour. | RCOG 2008 + local agreement | This standard updates the original requirement for 1:1 midwifery care during the whole of established labour. It was felt that the original requirement was unduly restrictive on the models of care being developed (e.g. using other suitable staff groups for the first stage of labour) which were thought to be equally effective. It was acknowledged that this is a weakening of the original position.<br>There was consensus that the standard should not be weakened for stage two labour. (updated at CAG1 and subgroup meeting) |
| | **22** | To deliver 1:1 care during established labour by an appropriately trained professional under the supervision of a midwife, staffing levels for all midwifery, nursing and support staff for each care setting should be calculated based upon the results of a Birth-rate Plus assessment which is not more than 3 years out of date; as a minimum, the CQC recommended ratio should be adhered to, changing from time to time as the CQC revises its position.<br><br>Currently, the calculation should be based upon:<br>> Home and birth centre: 1:28 Midwives:births , 6:1 midwife:MCA<br>> Obstetrics units: 1:28 Midwives:births, 4:1 midwife:MCA | RCOG 2007, RCOG 2008, CNST 2012 CQC, + local amendment | This standard was updated as more recent requirements than documented in RCOG 2008 are available from the CQC; in addition, Birthplace Plus assessments are suggested to have more currency than the ROCG recommendations and it was felt that the more onerous of the CQC requirement and a (recent) Birth-rate Plus assessment would be a more useful benchmark. |
| | **23** | There should be an identified midwifery team leader on every shift located on the labour ward. | Local agreement | Locally developed standards (CAG 1) |
| **Staffing: anaesthetics** | **24** | Consultant obstetric units require a 24-hour anaesthesia and analgesia service that is dedicated to the unit (i.e. not redirected to other care) with consultant supervision, including:<br>minimum 10 PA/40 hours consultant presence<br>specialist anaesthetic services (may require additional on-call consultant if no standalone obstetric anaesthetic rota) ,<br>adult high-dependency and access to intensive care, haematology blood transfusion and other district general hospital support services and an integrated obstetric and neonatal care service. | RCOG 2007, RCOG 2008, CNST 2012 | Original standard agreed with no amendments |
| | **25** | A duty anaesthetist of appropriate competency and dedicated only to the labour ward must be immediately available, 24 hours a day, 7 days a week. This anaesthetist will normally have had more than 1 year of experience in anaesthesia and must have been assessed as being competent to undertake such duties. The duty anaesthetist must have access to prompt advice and assistance from a designated consultant anaesthetist whenever required. | RCOG 2007, RCOG 2008, CNST 2012 | Original standard agreed with no amendments - there was a suggestion that this could be tiered depending on the size of the unit, but the spirit of the standard is to be maintained. |
| | **26** | Extra anaesthetic cover during periods of heavy workload in addition to the supervising consultant anaesthetist and the duty anaesthetist is required in busier units (more than 5000 births/year, an epidural rate over 35% and a caesarean section rate over 25%, plus tertiary referral centres with a high proportion of high-risk cases). | RCOG 2007, RCOG 2008, CNST 2012 | Original standard agreed with no amendments |
| | **27** | For any obstetric unit there should be a separate consultant anaesthetist for each formal elective caesarean section list. | RCOG 2007, CNST 2012 | Original standard agreed with no amendments |

# Clinical Quality Standards: Agreed set of maternity standards

| Standard | | | Source(s) | Commentary |
|---|---|---|---|---|
| | **28** | Labour wards should be able to care for Critical care Level 2 (non-ventilated) patients*. | Local agreement | Locally developed standards (CAG 1) - NB. wording amended for greater clarity |
| **Staffing: paediatrics** | **29** | There must be 24-hour availability in obstetric units within 30 minutes of a consultant paediatrician (or equivalent staff and associate specialist grade) trained and assessed as competent in neonatal advanced life support. | RCOG 2007, RCOG 2008, CNST 2012 | Original standard agreed with no amendments - at CAG 2 it was agreed that this must be underpinned by the 24/7 availability of paediatric life support competent clinicians. |
| | **30** | 24-hour paediatric middle grade cover should be present at vaginal breach, vaginal twins, C-section at fully dilated. | Local agreement | Locally developed standards (CAG 1) |

# Clinical Quality Standards: Agreed set of Paediatrics standards

| Standard | | | Source(s) | Comments |
|---|---|---|---|---|
| **Staffing: paediatricians** | **1** | All SSPAUs (Short Stay Paediatric Assessment Units) have access to a paediatric consultant (or equivalent) opinion throughout all the hours they are open. | RCPHP 2011 | |
| | **2** | A paediatric consultant (or equivalent) is present in the hospital during times of peak activity. | RCPHP 2011 | |
| | **3** | Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a paediatrician on the middle grade or consultant rota within four hours of admission. | RCPHP 2011 | |
| | **4** | Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician (or equivalent staff, speciality and associate specialist grade doctor who is trained and assessed as competent in acute paediatric care) within the first 24 hours. | RCPHP 2011 | |
| | **5** | All general paediatric inpatient units adopt an attending consultant (or equivalent) system, most often in the form of the 'consultant of the week' system. | RCPHP 2011 | |
| | **6** | All general acute paediatric rotas are made up of at least ten WTEs, all of whom are WTD compliant. | RCPHP 2011 | Local clinical leads believe it may be possible with eight and still be EWTD compliant (agreed a CAG 1). |
| | **7** | At least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent). | RCPHP 2011 | |
| | **8** | Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians. | RCPHP 2011 | |
| | **9** | All children and young people, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary, for children and young people under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report. | RCPHP 2011 | |
| | **10** | PICU should have dedicated 24-hr cover by a consultant paediatric intensivist with appropriate training, and additional 24-hr consultant paediatric anaesthetist cover if the intensivist is not an anaesthetist. | PICU 2012 | The main PICU centre for the North East is at Newcastle's Royal Victoria Infirmary - there is insufficient throughput to support another but other requirements (e.g. Major Trauma Centres) mean PICU-type facilities are required in other centres. Local clinical leads considered it acceptable that while the PICU standards presented were valid, they were not strictly applicable to the facilities at STFT (agreed at CAG 1) |
| | **11** | Consultants should not be rostered for any other clinical commitment when covering the PICU during daytime hours. During daytime hours the consultant in charge of the PICU should spend the majority of his or her time on the PICU and must always be immediately available on the PICU. | PICU 2012 | |
| | **12** | No individual consultant paediatrician or anaesthetist practicing PIC should do so for less than 2 DCC PAs per week. | PICU 2012 | |
| | **13** | PICU should provide training for 1st year ICTPICM registrars, and the necessary requirements to equip nursing staff with specific training in paediatric intensive care. | PICU 2012 | |

# Clinical Quality Standards: Agreed set of Paediatrics standards

| Standard | | | Source(s) | Comments |
|---|---|---|---|---|
| **Staffing: Nursing** | **14** | All nurses who provide care to children and young people should have a specific qualification in the nursing of children and young people. | RCN 2011 | As an absolute minimum (agreed at CAG 1). |
| | **15** | A minimum of two qualified (registered) children's nurses should be on duty 24 hours-a-day in all children's wards and departments. | RCN 2011 | As an absolute minimum (agreed at CAG 1). |
| | **16** | Each children's ward/department nursing establishment should have a minimum of 1 WTE (whole time equivalent) Band 7 and 2 WTE Band 6 qualified children's nurses. | RCN 2011 | As an absolute minimum (agreed at CAG 1). |
| | **17** | Paediatric short stay assessment units and inpatient units should apply a dependency model that is validated by commissioners.<br>As a planning guide:<br>- Short stay paediatric assessment units (SSPAUs) should plan on a nurse:patient ratio of 1:7.<br>- Inpatient paediatric units should plan on a nurse:patient ratio of 1:4.<br><br>However, this should not mean that high need patients such as those requiring a tracheostomy should have care provided on a 1: 3 ratio or if a unit is capable of providing CPAP a ratio of 1:2.<br><br>***Note:*** *Its expected that for the ratio to move to a 1:3 as common place community nurse teams would need to take on more complex cases, thus increasing the case-mix complexity of patients admitted to hospital.* | RCN 2011 plus local amendment | Local clinical leads felt the standards as set out in the RCN 2011 guidance is:<br>(a) Financially unsustainable.<br>(b) Okay as a standard if inpatient units only have the patients in that should be in - many that are in could be elsewhere and do not need this standard of care.<br>Agreement was reached that a standard based on a dependency model - based on children's age, condition, whether mum is there etc. should be defined (agreed at CAG2).<br><br>The clinicians discussed nursing ratios again at CAG 2, in particular the number of registered nurses to HCAs, and agreed that a ratio for registered nurses to patients should be agreed and that this would be different in SSPAU compared to inpatient units. These were agreed to be 1:7 and 1:4 respectively (agreed at CAG 2). |
| | **18** | A Band 7 nurse must be part of the total nursing establishment on every PICU shift. If the PICU has more than 12 beds, they should be supported by 2 Band 6 nurses per shift. | PICU 2012 | PICU notes as above |
| | **19** | All senior PICU nurses (Band 6-8) should have a specific qualification in PIC nursing, with over 90% of PICU nurses being Children's Branch trained and at least 75% with a specific qualification in PIC nursing. | PICU 2012 | |
| | **20** | PICU nurses should be trained in retrieval. | PICU 2012 | |
| **Paediatric surgery** | **21** | General Paediatric Surgery in DGHs should be undertaken by surgeons who had undertaken a minimum duration of 6 months GPS training in a recognised post, at year 4 or higher of the then Higher Surgical Training programme in a centre undertaking at least 1 operating list exclusively for children once every two weeks.<br><br>Exceptions to this are those individuals that have already been working but due to length of service won't meet this requirement. | Joint Statement on General Paediatric Surgery provision in District General Hospitals on behalf of the Association of Paediatric Anaesthetists, the Association of Surgeons for Great Britain and Ireland, the British Association of Paediatric Surgeons, the Royal College of Paediatrics and Child Health and the Senate of Surgery for Great Britain and Ireland. **August 2006** | Needs a grandfather clause for those that have already been working but due to length of service won't meet this requirement |
| **Paediatric anaesthesia** | **22** | Paediatric anaesthetist groups should undertake at least 100, ideally greater than 200, paediatric anaesthetic procedures per year. | Auroy Y, Ecoffey C, Messiah A, Rouvier B (1997) Relationship between complications of paediatric anaesthesia and volume of paediatric anaesthetics. Anesth Analg 84:228–236 | |
| | **23** | On each hospital site there should be 24 hour cover by a consultant anaesthetist with paediatric interest who is able to attend within 30 minutes and does not have responsibilities to other hospital sites. | WEST MIDLANDS STRATEGIC COMMISSIONING GROUP<br>Standards for the Care of Critically Ill & Critically Injured Children in the West Midlands Version 3 July 2009 | Should this be one with "paediatric interest"? |
| | **24** | Anaesthetists with no regular paediatric commitment but who have to provide out-of-hours cover for emergency surgery or stabilisation of children prior to transfer should maintain skills in paediatric resuscitation and an appropriate level of CPD in paediatric anaesthesia to meet the requirements of the job. | RCS 2011 | |

# Clinical Quality Standards: Agreed set of Paediatrics standards

| Standard | | | Source(s) | Comments |
|---|---|---|---|---|
| | **25** | Children should be anaesthetised by consultants who have regular and relevant paediatric practice sufficient to maintain core competencies. Children may also be anaesthetised by staff or Associate specialist (SAS) anaesthetists or specialty doctors (SDs), provided they fulfil the same criteria and there is a nominated supervising consultant anaesthetist. When trainees anaesthetise children, they should be supervised by a consultant with appropriate experience. | Guidance on the provision of Paediatric Anaesthesia Services (ROA 2010) | Concern that this will shut smaller units, but agreed |
| | **26** | *It was agreed that a minimum number of lists per week should be set for paediatric anaesthetists.* | Local suggestion | This standard has been discussed further, however a consensus still has not been reached by the paediatric anaesthetists. |
| | **27** | *It was agreed that a minimum number of cases per annum should be set for paediatric anaesthetists.* | Local suggestion | This standard has been discussed further, however a consensus still has not been reached by the paediatric anaesthetists. |
| | **28** | Anaesthetists should have a minimum of 6 months Paediatric anaesthesia in care of the poorly child and paediatric surgery, as part of their specialty training.<br><br>Exceptions to this are those individuals that have already been working but due to length of service won't meet this requirement. | Local suggestion | |
| **Referrals** | **29** | Every child or young person with an acute medical problem who is referred for a paediatric opinion is seen by, or has the case discussed with, a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner. | RCPHP 2011 | |
| **PICU dependencies** | **30** | PICU must have access to the following paediatric subspecialties as per the critical interdependencies framework (see p.10): ENT (including airway management), specialised paediatric surgery, specialised paediatric anaesthesia, clinical haematology, respiratory medicine, cardiology, neurosurgery, metabolic medicine, neurology, major trauma, nephrology, immunological disorders, infectious diseases, urology, gastroenterology. | PICU 2012 | PICU notes as above |
| | **31** | PICU must have 24-hr access to radiology, including CT and MRI scanners, with 24-hr reporting available by consultant radiologists and neuroradiologists. | PICU 2012 | |
| | **32** | There should be technical staff available at all times (24-hr) to the PICU, to service and troubleshoot electronic equipment and other technical services. | PICU 2012 | |

**Suggestions for strengthening paediatric surgery and anaesthesia - still to be agreed**

| Standard | Source(s) | Comments |
|---|---|---|

# Clinical Quality Standards: Agreed set of Paediatrics standards

| Standard | | | Source(s) | Comments |
|---|---|---|---|---|
| **Paediatric surgery** | **A** | All branches of surgery in children should be undertaken by individuals appropriately trained to undertake this work.<br>They will need to demonstrate:<br>a) appropriate caseload of children to maintain skills. This will be at least 50 general surgery cases per year - made up from elective and emergency care - of children under about 8-12 years of age. An exception may be made for older children with conditions common in adult practice (e.g.: acute appendicitis, facial lacerations or simple fracture management).<br>b) On-going paediatric CPD as part of the 5 year revalidation cycle.<br><br>**Note: This should not impact existing arrangements under the current configuration where all children's major trauma, and emergencies for under 5 year olds go to James Cook or Newcastle.** | | |
| **Paediatric anaesthesia** | **B** | All anaesthesia in children should be undertaken by individuals appropriately trained to undertake this work.<br>They will need to demonstrate:<br>a) appropriate caseload of children to maintain skills. This will be at least 50 cases per year - made up from all specialties, and elective and emergency care - of children under about 8-12 years of age (achieved sporadically or through one designated children's list per fortnight typically of 2 cases). An exception may be made for older children with conditions common in adult practice (e.g.: facial lacerations or simple fracture management).<br>b) Ongoing paediatric CPD as part of the 5 year revalidation cycle.<br><br>**Note: This should not impact existing arrangements under the current configuration where all children's major trauma, and emergencies for under 5 year olds go to James Cook or Newcastle.** | | |
| | **C** | Named paediatric anaesthetist groups should undertake at least 100, ideally greater than 200, paediatric anaesthetic procedures per year. | | |
| | **D** | On each hospital site there should be 24 hour cover by a consultant anaesthetist covering children in A&E and the paediatric inpatient ward who is able to attend within 30 minutes and does not have responsibilities to other hospital sites. | | |
| | **E** | Anaesthetists with no regular paediatric commitment but who have to provide out-of-hours cover for emergency surgery or stabilisation of children prior to transfer should maintain skills in paediatric resuscitation and an appropriate level of CPD (i.e. APLS) in paediatric anaesthesia to meet requirements of the job. | | |
| **Environment** | **F** | Children must be managed in a suitable environment with physical separation from adults. | | |

## Clinical Quality Standards: Agreed set of Neonatology standards

| Standard | | | | | Source | Comments |
|---|---|---|---|---|---|---|
| **Medical staffing** | | **SCBU** | **NHDU / Local Neonatal Unit** | **NICU** | | |
| **Tier 1** | **1** | At least 8 wte on rota | At least 8 wte on rota | At least 8 wte on rota | Toolkit for High Quality Neonatal Services (2009) | |
| ANNPs<br>GP Trainees<br>Foundation Year Doctors<br>Trust doctors<br>ST1-3 trainees** | | 24/7 | 24/7 | 24/7 | | |
| Source | | General paediatrics rota | General paediatrics rota | Dedicated neonatal rota | | |
| *Note:* | | *When a NICU is co-located with a SCBU and NHDU, the NICU staff will also oversee the other units. Similarly when a NHDU is co-located with a SCBU, the NHDU staff will cover both units* | | | | |
| Tier 2 | **2** | At least 8 wte on rota | At least 8 wte on rota | At least 8 wte on rota | Toolkit for High Quality Neonatal Services (2009) | ST3 doctors need minimum competencies defining |
| ANNPs<br>Trust doctors<br>ST trainees - ST 3* and above<br>SSASG<br>Consultants | | 24/7 | 24/7 | 24/7 | | |
| Source | | General paediatrics rota | General paediatrics rota and resident paediatric / neonatal consultants | Dedicated neonatal rota | | |
| *Note:* | | *When a NICU is co-located with a SCBU and NHDU, the NICU staff will also oversee the other units. Similarly when a NHDU is co-located with a SCBU, the NHDU staff will cover both units* | | | | |
| Tier 3 | **3** | At least 8 wte on rota | At least 8 wte on rota | At least 8 wte on rota | Toolkit for High Quality Neonatal Services (2009) | |
| Consultants | | 14-16/7 | 14-16/7 | 14-16/7 | | |
| Source | | General paediatrics (on-call) rota. | General paediatrics (on-call rota) with a minimum of 1 consultant with a designated lead interest in neonatology plus neonatologists | Dedicated neonatal rota | | |
| *Note:* | | *When a NICU is co-located with a SCBU and NHDU, the NICU staff will also oversee the other units. Similarly when a NHDU is co-located with a SCBU, the NHDU staff will cover both units* | | | | |
| **Nursing** | | **SCBU** | **NHDU / Local Neonatal Unit** | **NICU** | | |
| NMC registered | **4** | 70% | 80% | 80% | Toolkit for High Quality Neonatal Services (2009) | |
| NMC registered also QIS | **5** | 70% | 70% | 70% | | |
| Nurse:baby ratio | **6** | 1:4<br>By either a registered nurse or non-registered staff working under the supervision of a registered nurse (QIS) | 1:2<br>Cared for by staff who have completed accredited training in specialised neonatal care or who, while undertaking this training, are working under supervision of a registered nurse (QIS). | 1:1<br>Cared for by staff who have completed accredited training in specialised neonatal care or who, while undertaking this training, are working under supervision of a registered nurse (QIS). | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | Neonatal nursing establishments in units should be calculated against commissioned activity with an uplift of 25% to accommodate expected leave (annual, sick, maternity, paternity, mandatory training and continuous professional development (CPD)), based on an 80% occupancy level. | | | | |
| Minimum number of registered nurses on duty at all times | **7** | 2 | 2 | 2 | | |
| Nurse coordinator | **8** | | | Additional 1 | | |
| **Other** | | | | | | |
| Target cot occupancy | **9** | 80% | 80% | 80% | Toolkit for High Quality Neonatal Services (2009) | |
| Minimum number of cots to ensure high quality** | **10** | - | - | 8 | Local | This should be defined with Obstetrics and then determined by the neonatologists |
| Cots per 1000 births** | **11** | - | - | TBC | Local | This should be defined with Obstetrics and then determined by the neonatologists |
| Transport | **12** | Clear pathways need to be in place not only for the care of babies, but also for the transfer of parents between sites taking account of non-coterminous boundaries between hospital/LA/transport boundaries. | | | Local | |
| Community neonatal nursing support | **13** | Community nursing clinics need to be in place to facilitate the early discharge of patients form hospital, including e.g. paediatric home oxygen services. | | | Local | |
| Outcome data at 32 weeks and 24 months | **14** | Minimum outcome data at 32 weeks and 24 months must be collected | | | Local | |

**NOTES:**
* ST3 doctors need minimum competencies defining
** This should be defined with Obstetrics

# Agreed set of standards for acute medicine

| Standard | | | Sources | Commentary |
|---|---|---|---|---|
| **Consultant-delivered care: core standards** | 1 | **All emergency admissions to be seen and assessed by a relevant consultant** (those who are designated by the organisation and capable of making an appropriate decision) within:<br>**in hours:** 4 hours of the decision to admit within the trust<br>**out of hours:** 12 hours of the decision to admit within the trust, or within 14 hours of the time of arrival at hospital. | • NCEPOD (2007) Emergency admissions: A journey in the right direction?<br>• RCP (2007) The right person in the right setting – first time<br>• RCS (2011) Emergency Surgery Standards for unscheduled care<br>+ local amendment | This standard has been amended to make key terms (relevant consultant, definition of DTA) more specific, and has been strengthened to include the requirement to see patients within four hours during in hours.<br><br>It was also agreed that **health system standards** around aligning time limits between decisions to refer/admit by community teams/GPs and assessment were important.<br><br>**Note: It has been suggested that when it comes to measuring delivery of this standard the '12 hours of the decision to admit within the trust' may need to be removed, leaving the '14 hours of the time of arrival at hospital' target.** |
| | 2 | A clear **multi-disciplinary assessment** (required composition to be defined in local protocols) to be undertaken and a **clear case management plan** (to include differential diagnosis, investigations, escalation of care, treatment and expected date of discharge) to be in place within **4 hours in hours** and within **12 out of hours**, or within **14 hours of the time of arrival at hospital out of hours**. | • RCP (2007) The right person in the right setting – first time<br>+ local amendment | This standard has been amended to make key terms (multi-disciplinary assessment, case management plan) more specific, and has been strengthened to make the time limits consistent with standard 1. |
| | 3 | All patients admitted acutely are to be assessed using a validated early warning system (National Early Warning Score (RCP 2012)), with clear escalation processes followed for patients who reach trigger criteria as defined in local protocols. Consultant involvement for patients considered 'high risk' is to be within one hour.<br><br>Additionally, all pregnant women must be assessed using Modified Obstetrics Early Warning System (MOEWS), which must therefore involve obstetric support. | • RCS (2011) Emergency Surgery Standards for unscheduled care<br>• NICE (2007) Acutely ill patients in hospital<br>+ local amendment | This standard has been amended to specify the EWS to be used, and to require the escalation protocols to be followed to be defined in local protocols. This is on the basis that not all triggers necessitate consultant involvement - there will be too much local detail to put in a commissioning standard, however it was agreed that this detail should be defined in a local protocol.<br><br>**NEWS ref:**<br>*http://www.rcplondon.ac.uk/resources/national-early-warning-score-news*<br><br>**MOEWS ref:**<br>*http://www.oaa-anaes.ac.uk/content.asp?ContentID=356* |
| | 4 | When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments. | • NCEPOD (2007) Emergency admissions: A journey in the right direction?<br>• RCP (2007) The right person in the right setting – first time<br>• RCS (2011) Emergency Surgery Standards for unscheduled care | Accepted with no amendments |

# Agreed set of standards for acute medicine

| Standard | | | Sources | Commentary |
|---|---|---|---|---|
| | 5 | In order to meet the demands for consultant delivered care, senior decision making and leadership on the acute medical unit to cover extended day working, **for a minimum of 12 hours (e.g. 8am-8pm)**, seven days a week. | • RCP (2007) The right person in the right setting – first time<br>+ local amendment | This standard has been amended to be more specific about the definition of the extended day.<br><br>There was discussion about the whether the extended day should be longer (8am-10pm, or even 8am-12am), to align better with demand - primary care in particular are thought to be designed to trigger admissions at midnight. Moving to 14 or 16 hour minimum was regarded as being impracticable at the current time, but could be a future ambition, especially if demand continues to rise; it was felt that this is a national issue and would need discussion in a wider forum.<br><br>There was further discussion about the need to enhance the community infrastructure and interfaces to enable seven day discharging. For the health system, the additional cost of consultant cover may be mitigated by reductions in length of stay. |
| | 6 | All patients on acute medical units to be seen by a consultant **on a morning ward round followed by relevant and targeted patient reviews.** | • RCP (2007) The right person in the right setting – first time<br>+ local amendment | This standard was amended from the original which specified 2 ward rounds per day, to a morning round, followed by targeted interventions as required. This terminology was preferred to the "consistent sweep of all patients" approach, which was seen to prevent the necessarily inconsistent attention required to meet patients' clinical needs. |
| | 7 | All hospitals admitting medical emergencies to have access to all key diagnostic services (CT, MRI, Ultrasound and Plain Radiology) in a timely manner 24 hours a day, seven days a week to support clinical decision making:<br>· **Critical – imaging and reporting within 1 hour of request**<br>· **Non-critical - imaging and reporting within 12hr of request** | • RCP (2007) The right person in the right setting – first time<br>• RCS (2011) Emergency Surgery Standards for unscheduled care<br>• NICE (2008) Metastatic spinal cord compression<br>+ local amendment | This standard was amended to remove the distinction between urgent and non-urgent - all of these are non-critical and should be completed within 12 hours of request.<br><br>It was felt that the significant challenge here was in changing working practices, most significantly for radiographers. |
| | 8 | All hospitals admitting medical and surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week:<br>· Critical patients – 1 hour<br>· Non-critical patients – 12 hours | • RCS (2011) Emergency Surgery Standards for unscheduled care | This standard requires further discussion with the interventional radiology team, and needs cross reference with the major trauma centre recommendation:<br><br>*At Major Trauma centres interventional radiology capability will attend within 60 minutes24 hours a day. Interventional suites should be ideally co-located with operating rooms and/or resuscitation areas.* ***(NHS Clinical Advisory Group on Trauma 2010)***<br><br>***Note: Interventional radiology is recognised to be a regional challenge and the standard (targets) need to be agreed with regional leads.*** |
| **Consultant-delivered care: core standards** | 9 | Rotas to be constructed, **with adequate time for hand over to ensure that all relevant clinical information is transferred between individuals and teams,** to maximise continuity of care for all patients in an acute medical and surgical environment.<br><br>A single consultant is to be identified as the responsible individual for a patient at all times during their stay in the acute medical unit, with this responsibility being transferred at each handover between consultants.<br><br>Subsequent transfer or discharge must be based on clinical need. | • RCP (2007) The right person in the right setting – first time<br>+ local amendment | This standard was strengthened by making more specific the need for adequate handover.<br><br>The **single consultant clause** here means one person at one time with clear handovers. |

# Agreed set of standards for acute medicine

| Standard | | | Sources | Commentary |
|---|---|---|---|---|
| | 10 | A unitary document to be in place, issued at the point of entry (including A&E), which is used by all healthcare professionals and all specialties throughout the emergency pathway. | • RCP (2007) The right person in the right setting – first time | This standard was amended to make clear that the A&E card is to be included in the unitary document. |
| | 11 | Patients admitted for unscheduled care to be nursed and managed in an acute medical unit, **specialty areas which are relevant to the patients' needs,** or critical care environment. | • RCP (2007) The right person in the right setting – first time<br>+ local amendment | This standard was amended to include "specialty areas which are relevant to the patients' needs" to allow for direct admissions to wards if this is appropriate.<br><br>It was felt that there should be a very small or no tolerance for non-compliance with this standard - however, from a practical point of view, there could be phasing of the threshold; careful thought needs to be given to KPI for this standard as one or another method might create perverse incentives. A suggested KPI was:<br>***The Provider must report quarterly the percentage of patients admitted and managed on wards which are not appropriate to their clinical need; generally this will be medical patients on surgical wards or vice versa, threshold of 5%.*** |
| | 12 | Patients to be discharged to their named GP with a complete discharge summary sent within 24 hours. | • NCEPOD (2007) Emergency admissions: A journey in the right direction?<br>• RCP (2007) The right person in the right setting – first time<br>+ Local amendment | The original standard regarding the need for an expected date of discharge now overlaps with standard 2, which is more demanding due to the time limits for putting the care management plan in place. This section of the standard has been deleted on that basis.<br><br>The clause regarding discharge to GP has been strengthened to bring it in line with requirements for discharge summaries (already contained in the acute contract).<br><br>The original clause about social services ("*A policy is to be in place to access social services seven days per week*") has been removed as it is not within the gift of acute trusts to mandate social services provision - this is regarded as extremely important however, and should be a priority for commissioners. |
| | 13 | All referrals to intensive care to be made with the involvement of a consultant both in the referring and receiving teams. | • NCEPOD (2005) An acute problem<br>+ local amendment | This standard has been amended as it was agreed that it was appropriate for senior doctors to make referrals to intensive care, and that waiting for a consultant may delay necessary transfers - the requirement for consultant involvement (which may be in person, or by telephone, for example) was felt to adequately capture the spirit of the original wording. |
| | 14 | Responsibility is with individuals to ensure that there is a handover of patient information to each successive carer within every team structure - a structured process is to be in place for any such handover.<br><br>Changes in treatment plans are to be communicated to nursing and therapy staff as soon as possible if they are not involved in the handover discussions. | • RCP (2007) The right person in the right setting – first time<br>+ local amendment | This standard was amended to emphasise the point of the structured process as a means of transferring information between individuals and teams - the requirement for twice daily handovers was considered obsolete as there may be more handovers than this each day and that *any* handover should be compliant with this standard. |
| **Patient experience** | 15 | Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets. | | Accepted with no amendments |
| | 16 | Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on board agenda and findings are disseminated. | | Accepted with no amendments |

# Agreed set of standards for acute medicine

| Standard | | | Sources | Commentary |
|---|---|---|---|---|
| | 17 | Patients should always be admitted or transferred to the most appropriate ward for their clinical needs. | local agreement | Patient boarding was agreed to be extremely bad practice and this standard was intended to emphasise the need to minimise transfers that aren't clinically necessary (it was acknowledged that determining which transfers are and aren't necessary may be difficult) - this is monitored through standard 11. |
| **Key services** | 18 | All acute medical units to have provision for ambulatory emergency care, **seven days a week and have access to therapy services within a similar timeframe.** Patients treated in these facilities must receive care which is compliant with standards 1 (on admission consultant assessments), 2 (multi-disciplinary assessment and management plans) and 3 (Early warning system). | • RCP (2007) The right person in the right setting – first time<br>+ local amendment | This standard has been strengthened to require therapies to be available to AEC facilities, and to require AEC facilities to be subject to the same standards and any emergency admission as described in standards 1 - 3.<br><br>It was felt that the diagnostics standards (7 and 8) were not relevant for AEC facilities. |
| | 19 | Prompt screening of all complex needs inpatients to take place by a multi-professional team which has same-day access to pharmacy and therapy services, including physiotherapy and occupational therapy, seven days a week with an overnight rota for respiratory physiotherapy. | • RCS (2011) Emergency Surgery Standards for unscheduled care<br>+ local amendment | This standard was strengthened so that *same-day* access to the services listed is required. |
| | 20 | Single call access for mental health referrals to be available 24 hours a day, seven days a week with a maximum adequate clinical response time of 30 minutes. | • AoMRC (2008) Managing urgent mental health needs in the acute trust<br>+ local amendment | This standard was strengthened to require the originally stipulated response to be an adequate clinical response. Acute trusts manage their own SLAs with the mental health trust, so this was seen to be a useful lever for ensuring that MH services are appropriately responsive. |
| | 21 | Hospitals admitting emergency patients to have access to comprehensive 24 hour **upper GI** services that has a formal consultant rota 24 hours a day, seven days a week. | • British Society of Gastroenterology<br>+ local amendment | This standard has been amended to specify that it is an upper GI (rather than just endoscopy) services which is available 24/7. |
| | 22 | All hospitals dealing with complex acute medicine to have onsite access level 1, 2 and 3 critical care services. | Clinical Quality Indicators for Acute Medical Unit , society for acute medicine October 2011<br>+ local amendment | This standard was simplified as the new wording was felt to reflect the spirit of the original without needing to specify e.g. whether "monitored" (as in the original wording) meant 'directly monitored' or telemetry - these are both encompassed by the level 1 requirement and is less ambiguous. |
| **Training** | 23 | Training to be delivered in a supportive environment with appropriate consultant supervision | • RCS (2011) Emergency Surgery Standards for unscheduled care<br>• Temple (2010) Time for training? A Review of the impact of the European Working Time Directive on the quality of training<br>+ local amendment | This standard was amended to remove the word 'graded' - this was felt to be already covered by the term 'appropriate'. |

# Agreed set of Acute General Surgery standards

| Standard | | | Source(s) | Commentary |
|---|---|---|---|---|
| Consultant-delivered care: **core standards** | 1 | All emergency surgical admissions to be seen and assessed by a relevant consultant with 12 hours of admission to a ward or assessment unit under a surgical team. Suggested reliability target of 90% . | • NCEPOD (2007) Emergency admissions: A journey in the right direction?<br>• RCP (2007) The right person in the right setting – first time<br>• RCS (2011) Emergency Surgery Standards for unscheduled care<br>+ local agreement | Amended from original standards which measured the time from DTA or arrival at hospital - it was felt that due to the commitments of surgeons on call (e.g. being in theatre) this was a more realistic, but still challenging, standard. |
| | 2 | A clear multi-disciplinary assessment to be undertaken within 12 hours and a treatment or management plan to be in place within 24 hours (for complex needs patients see 23 and 24).For the majority of surgical patients, a surgical and nursing assessment is sufficient to satisfy this requirement. | • RCP (2007) The right person in the right setting – first time<br>+ local agreement | The original standard was amended to clarify the nature of MDT assessment for the majority of non-elective surgical patients.<br><br>**Note: Timing of second ward round noted as critical – i.e. more 5pm than 8pm to be effective.** |
| | 3 | All patients admitted acutely to be continually assessed using a validated early warning system (EWS). Consultant involvement is required for patients who reach trigger criteria, with 'Consultant involvement' to be clearly defined in trust protocols. Consultant involvement for patients considered 'high risk' to be within one hour. | • RCS (2011) Emergency Surgery Standards for unscheduled care<br>• NICE (2007) Acutely ill patients in hospital<br>+ Local agreement | The original standard was amended only to include the clause stipulating that consultant involvement should be clearly defined in trust protocols. |
| | 4 | When on-take, a consultant and their team are to be complete freed from any other clinical duties or elective commitments. | • NCEPOD (2007) Emergency admissions: A journey in the right direction?<br>• RCP (2007) The right person in the right setting – first time<br>• RCS (2011) Emergency Surgery Standards for unscheduled care | original standard agreed without amendments |
| | 5 | In order to meet the demands for consultant delivered care, senior decision making and leadership on the acute surgical unit to cover extended day working, seven days a week, amounting to a minimum of 70 hours per week. | • RCP (2007) The right person in the right setting – first time<br>+ local agreement | The original standard here was worded in terms of extended cover - the surgeons felt that due to the nature of surgical work (e.g. operating in the middle of the night) suggesting a minimum number of hours for the week (which amounts to 10hours per day in any case) would have a comparable effect but would be more relevant for acute surgery. |
| | 6 | All patients on acute medical and surgical units to be seen and reviewed by a consultant during twice daily ward rounds, including all acutely ill patients directly transferred, or others who deteriorate. | • RCP (2007) The right person in the right setting – first time | original standard agreed without amendments |
| Consultant-delivered care: **core standards** | 7 | All hospitals admitting medical and surgical emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making:<br>· Critical – imaging and reporting within 1 hour<br>· Urgent – imaging and reporting within 12 hours<br>· All non-urgent – within 24 hours | • RCP (2007) The right person in the right setting – first time<br>• RCS (2011) Emergency Surgery Standards for unscheduled care<br>• NICE (2008) Metastatic spinal cord compression | original standard agreed without amendments |
| | 8 | All hospitals admitting medical and surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week:<br>· Critical patients – 1 hour<br>· Non-critical patients – 12 hours | • RCS (2011) Emergency Surgery Standards for unscheduled care | original standard agreed without amendments |

# Agreed set of Acute General Surgery standards

| Standard | | | Source(s) | Commentary |
|---|---|---|---|---|
| Consultant-delivered care: **admissions, ward rounds and theatre** | 9 | Rotas to be constructed to maximise continuity of care for all patients in an acute medical and surgical environment. A single consultant is to retain responsibility for a single patient on the acute medical/surgical unit. Subsequent transfer or discharge must be based on clinical need. | • RCP (2007) The right person in the right setting – first time | original standard agreed without amendments<br><br>**Note: In discussion, operational issues around systems with trace-ability and the importance of safe and effective handovers were emphasised.** |
| | 10 | A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals and all specialties throughout the emergency pathway. | • RCP (2007) The right person in the right setting – first time | original standard agreed without amendments |
| | 11 | Patients admitted for unscheduled care to be nursed and managed in an acute medical/surgical unit, a specialty ward relevant to the patient's clinical need, or critical care environment. | • RCP (2007) The right person in the right setting – first time<br>+ local agreement | The original standard here only referred to acute medical/surgical units and critical care - it was felt that it was often appropriate to manage surgical patient most appropriately on a surgical ward - the additional clause was therefore added to allow for this as long as the admitting ward was appropriate to the patient's needs. |
| | 12 | All admitted patients to have discharge planning and an estimated discharge date as part of their management plan as soon as possible and no later than 24 hours post-admission.<br><br>A policy is to be in place to access social services seven days per week. Patients to be discharged to their named GP. | • NCEPOD (2007) Emergency admissions: A journey in the right direction?<br>• RCP (2007) The right person in the right setting – first time | original standard agreed without amendments |
| | 13 | All hospitals admitting emergency general surgery patients to have access to a fully staffed emergency theatre immediately available and a consultant on site within 30 minutes at any time of the day or night. | • NCEPOD (1997) Who operates when?<br>• ASGBI (2010)<br>• RCS (2011) Emergency Surgery Standards for unscheduled care | original standard agreed without amendments |
| Consultant-delivered care: **admissions, ward rounds and theatre** | 14 | All patients admitted as emergencies are discussed with the responsible consultant if immediate surgery is being considered. For each surgical patient, a consultant takes an active decision in delegating responsibility for an emergency surgical procedure to appropriately trained junior or speciality surgeons. This decision is recorded in the notes and available for audit. | • RCS (2011) Emergency Surgery Standards for unscheduled care | original standard agreed without amendments |
| | 15 | All patients considered as 'high risk' to have their operation carried out under the direct supervision of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care. High risk is defined as where the risk of mortality is greater than 10%. | • RCS (2011) Emergency Surgery Standards for unscheduled care | original standard agreed with amendment to define "high risk" |
| | 16 | All patients undergoing emergency surgery to be discussed with consultant anaesthetist. Where the severity assessment score is ASA3 and above, anaesthesia is to be provided by a consultant anaesthetist. | | original standard agreed without amendments |

# Agreed set of Acute General Surgery standards

| Standard | | | Source(s) | Commentary |
|---|---|---|---|---|
| | 17 | The majority of emergency general surgery to be done on planned emergency lists on the day that the surgery was originally planned. The date, time and decision maker should be documented clearly in the patient's notes and any delays to emergency surgery and the reasons why recorded. Any operations that are carried out at night (00:00 to 07:59) are to meet NCEPOD classifications and be under the direct supervision of a consultant surgeon. | • NCEPOD (2004) The NCEPOD classification of Intervention<br>NCEPOD 2007 | original standard agreed - the surgeons felt that it was appropriate to specify the definition of night time hours as being after midnight.<br>amended to include **NCEPOD 2007 definition of 'night' p24**<br>*For the purposes of the data overview, day was taken to be from 08:00 to 17:59, evening from 18:00 to 23:59, and night from 00:00 to 07:59. Figure 4 shows the times of admissions within this categorisation. Unsurprisingly, the majority of admissions were during the day.* |
| | 18 | All referrals to intensive care to be made from a consultant to consultant | • NCEPOD (2005) An acute problem | original standard agreed without amendments |
| | 19 | A structured process to be in place for the medical handover of patients twice a day. These arrangements to also be in place for the handover of patients at each change of responsible consultant/medical team. Changes in treatment plans are to be communicated to nursing and therapy staff as soon as possible if they are not involved in the handover discussions. | • RCP (2007) The right person in the right setting – first time | original standard agreed without amendments |
| Patient experience | 20 | Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets. | | original standard agreed without amendments |
| | 21 | Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on board agenda and findings are disseminated. | | original standard agreed without amendments |
| Key services | 22 | All acute medical and surgical units to have provision for ambulatory emergency care. | • RCP (2007) The right person in the right setting – first time | original standard agreed without amendments |
| | 23 | Prompt screening of all complex needs inpatients to take place by a multi-professional team which has access to pharmacy and therapy services, including physiotherapy and occupational therapy, seven days a week within an overnight rota for respiratory physiotherapy. | • RCS (2011) Emergency Surgery Standards for unscheduled care | original standard agreed without amendments |
| | 24 | Single call access for mental health referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes. | • AoMRC (2008) Managing urgent mental health needs in the acute trust | original standard agreed without amendments |
| | 25 | Hospitals admitting emergency patients to have access to comprehensive 24 hour endoscopy services that has a formal consultant rota 24 hours a day, seven days a week. | • British Society of Gastroenterology | original standard agreed without amendments |
| Training | 26 | Training to be delivered in a supportive environment with appropriate, graded consultant supervision | • RCS (2011) Emergency Surgery Standards for unscheduled care<br>• Temple (2010) Time for training? A Review of the impact of the European Working Time Directive on the quality of training | original standard agreed without amendments |
| **Cell size** | 27 | There should be a minimum 8 cell rota for all acute sites. | Joint Royal College of Anaesthetists & Royal College of Surgeons of England 2009 project | original standard agreed without amendments |

# Agreed set of standards for Intensive Care Medicine

| Standard | | | Sources | Commentary |
|---|---|---|---|---|
| **Outcome monitoring** | 1 | All trusts must participate in ICNARC and achieve good clinical outcomes as compared to comparable units. | DH 2002 | SMR not greater than 1.1 |
| | 2 | All trusts must achieve the following minimum quality indicators targets:<br>Unit acquired MRSA: <1%<br>Unit acquired C.Diff: <2%<br>Out of Hours ward discharges < 5% Early discharges <5% Delayed discharges <10% Early readmissions < 3% Post ITU deaths <10% | Local agreement based on national ICNARC quality data | Delayed discharges for this purpose meaning delayed beyond midnight of the day deemed ready for discharge by the Intensivist as per Jane Eddlestone do document 2012. Promotes efficiency of resource utilisation as well as quality care freeing beds for timely admission of next sick patient. ICNaRC reports require informed interpretation |
| | 3 | Non clinical transfers out of hospital should be a rare event and out of network an SUI. | | Requires robust internal escalation policies and flexible nurse staffing to escalate to cope with excess internal demand rather than exposing critically ill patients to risks of transfer |
| **Staffing: consultants** | 4 | All Critical Care services must have 24/7 access to an immediately available doctor @ ST3 or above with advanced airway skills (or equivalent, e.g. Advanced Critical Care Practitioners) with no other duties (theatre for example). | ICS 2007 | |
| | 5 | All consultants participating the Critical Care rota must do daytime sessions in Critical Care, 2 is considered minimum. | ICS 2007 | |
| | 6 | New consultant appointments to critical care rotas should have CCT in Critical Care and FFICM exam. | ICS 2007 | Single or joint CCT but now UK critical care has FFICM exam as exit exam |
| | 7 | All critical care units should have consultant sessions and ward rounds in evenings and weekends. Standard 15 PAs for each 8 level 3 beds as national recommendation. | ICS 2007 | National recommendation ICS |
| | 8 | Each Critical Care Unit should have a named consultant 24 hours per day with no other clinical duties with 2 ward rounds as a minimum, 3 desirable, e.g.0900, 1600 and 2000. | ICS 2007 | |
| | 9 | Each admission to critical care should be reviewed by a consultant within 12 hours of admission. | ICS 2007 | |
| | 10 | Each Critical Care Unit should have a named Director with sufficient time for administration of the unit. A minimum of 1 session is recommended for each 8 level 3 beds and a whole time director whose job is directed to patient care and management is recommended for units with greater than 20 level 3 beds. | ICS 2007 | National recommendation ICS |
| | 11 | Each patient admitted to critical care should have a named parent specialty consultant whose team or nominated team visits daily until discharge from critical care | | Facilitates both quality of care from input and handover to ward level as well as facilitating timely discharge and efficient utilisation of beds |
| | 12 | All referrals to critical care should involve discussion with the referring parent consultant | | Facilitates appropriate admissions and use of scarce resource |
| | 13 | Level 3 Units should deliver renal support in dialysis or CVVH | Adding Insult to injury NCPOD 2009 | |

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| **Staffing: nursing** | 14 | Every patient in an Critical Care must have immediate access to a registered nurse with a post registration qualification in this specific speciality. | BACCN 2009 | |
| | 15 | Level 3 (ventilated or CVVH) patients should have a minimum of one nurse to one patient. | BACCN 2009 | |
| | 16 | Level 2 patients should have a minimum of one nurse to two patients. | BACCN 2009 | |
| | 17 | Larger units (>6 beds) and or geographically diverse units require a clinical co-ordinator who is a senior critical care qualified nurse who is not allocated a patient on the clinical shift. | BACCN 2009 | |
| **Occupancy** | 18 | Intensive Care Units should maintain mean occupancy levels of <70% for units of 8 beds or fewer and <80% for larger units. | ICS | <80% for larger units is a local suggestion, national recommendation is actually<65%% |
| | 19 | A Level 3 bed should be available for a new admission requiring it within one hour of the need arising in 90% of cases. | local agreement | Aspirational for patient care |
| | 20 | There should be <10% delayed discharges to the wards, where delay is defined as delayed after midday on the day following them deemed suitable for ward transfer by the consultant. | local agreement based on Jane meddlesome work with oh on mixed sex critical care | NB. this definition of delay is aligned to work that was conducted in 2011 in liaison with the DH in relation to the definition of delayed discharge for the purposes of fines incurred for mixed-sex accommodation breaches.<br>**It is noted that not all units work to this definition** |
| | 21 | Patient transfers between networked ICUs should be only undertaken on the basis of clinical need, and should be agreed between the referring and accepting intensive care consultant. Transfers outside the network should be avoided. | DH 2002 | ?Bed pressure transfers should be recorded as a critical incident? |
| | 22 | All Critical Care Units should perform a RCA on unplanned readmissions or early discharges from critical Care areas within a 48 hour period. | ICNARC 2009 quality indicator | |
| **Ward escalation** | 23 | The National Early Warning Score (NEWS) should be a standard measured for patient safety for every patient. Clear pathways of referral must be in place (defined in local protocols) for patients who reach trigger criteria. | RCP 2012;<br>NCEPOD Time to Intervene NICE CH50 | http://www.rcplondon.ac.uk/resources/national-early-warning-scorenews); |
| | 24 | There should be an acute response team to call, in some smaller hospitals this may be an acute medical response team. In larger hospitals it is recommended that a form of Critical Care Outreach is adopted. | National Outreach Forum: Operational Standards and Competencies for Critical Care Outreach Services, 2012;<br>DH 2002 | NICE CG50 which does not actually state outreach but demands all of the functions of an outreach team - what you call it does not really matter. |
| | 25 | All trusts should implement the NICE Rehabilitation after Critical Illness (NICE 2009) guidelines, including follow up clinics and 7 day rehab. | NICE 2009 | http://www.nice.org.uk/nicemedia/live/12137/43526/43526.pdf |
| **Other** | 26 | All trusts must comply with the Network evidence based guidelines which should be in place in each unit for management of common critical care conditions e.g. sepsis management as per surviving sepsis guidelines and North East SHA sepsis standards. | local agreement | |

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| | 27 | The structure of Intensive Care Units should follow HBN 57 and CCUs V4 for all new builds or refurbishment. | ICS 2007 & DoH CCUs planning v 4 | http://www.sykehusplan.org/data/critical_care_20040629170135.pdf |
| | 28 | All sites admitting emergencies should have the ability to increase their Level 2 and Level 3 capacity to accommodate periods of exceptional need dependant upon local and regional ACCEP levels. | local agreement | Each Trust requires a clear locally agreed escalation policy which requires flexible utilisation of nursing staff to increase staffing level sin times of need |

| North East End of Life Care Network Priorities |
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| Promote the north east good death charter. |
| Identify resources to support individuals at end of life |
| Effective use of palliative care registers in supporting personalised care planning |
| Develop access to 24/7 support for those with end of life needs, ensuring that patient choice and wishes are respected. |

| Resources |
|---|
| North East End of Life Clinical Network |
| National End of Life Care Programme |
| National End of Life Strategy |
| End of Life Strategy - Quality Markers |
| NICE Quality Standards -End of life care for adults |
| North East Charter - 'A good death' |
| End of Life Care Profiles |

| NICE Quality Standards | | | Quality statement | Specification | Guidance | Resources | Social Care |
|---|---|---|---|---|---|---|---|
| **Identification and assessment** | 1 | Identification | People approaching the end of life are identified in a timely way | Acute Trust clinicians adopt one of the available tools for the timely identification of people approaching the end of life and inform GP colleagues. Discharge letters to include this information. | Guide to identifying patients | | |
| | 2 | Communication and information | People approaching the end of life and their families and carers are communicated with, and offered information, in an accessible and sensitive way in response to their needs and preferences. | Hospitals to provide information to people approaching the end of life, and their families and carers, including:<br>• information about treatment and care options, medication and what to expect at each stage of the journey towards the end of life<br>• who they can contact at any time of day or night to obtain advice, support or services<br>• practical advice and details of other relevant services such as benefits support<br>• details of relevant local and national self-help and support groups. | Examples of patient information | North East EOL Network Information | |
| | 3 | Assessment, care planning and review | People approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, with the opportunity to discuss, develop and review a personalised care plan for current and future support and treatment. | Assessments should encompass all aspects of end of life care, taking into account the preferences of the person approaching the end of life, and their families and carers, with respect to:<br>• written and other forms of information<br>• face-to-face communication<br>• control of physical symptoms<br>• psychological support<br>• social support<br>• spiritual support<br>• organ and tissue donation.<br><br>Personalised care plans may or may not include advance statements or advance decisions to refuse treatment depending on the person's preferences.<br><br>Trusts should adopt the Deciding Right framework which is a regional approach to making decisions in advance as advanced care planning no longer exists. | Assessment guidance | Deciding Right | |
| **Holistic support** | 4 | Holistic support - psychological and physical | People approaching the end of life have their physical and specific psychological needs safely, effectively and appropriately met at any time of day or night, including access to medicines and equipment. | Hospital Trusts will provide as a minimum a 24/7 care service that includes:<br>• nursing services (defined as visiting, rapid response services and provision of one-to-one care at home, including overnight)<br>• access to pharmacy services<br>• access to equipment and adaptations<br>• specialist palliative care advice for generalists on symptom and side-effect management. | Northern Cancer Network EOL Guidelines | | |
| | 5 | Holistic support - social, practical and emotional | People approaching the end of life are offered timely personalised support for their social, practical and emotional needs, which is appropriate to their preferences, and maximises independence and social participation for as long as possible. | Hospital Trust will have access to social services 7 days a week to advise on the social, practica and emotional needs of patients at the end of life. | Social care at the end of life | | Social support should include, but is not limited to:<br>• Assistance to obtain financial support, including information about 'special rules' or equivalent, and access to individuals such as welfare rights and benefits advisers who can provide information and assistance in completing applications.<br>• Support with legal and practical affairs such as wills and funeral arrangements.<br>• Practical support and advice, including personal and domestic care.<br>• Support, advice and therapy to maintain independent living, including home adaptations and the provision of equipment.<br>• Services to assess the needs and protect the rights of vulnerable adults or children of a family member approaching the end of life, and to support people approaching the end of life in caring for vulnerable adults or children.<br>• Respite and day care/therapy in social and health care settings.<br>• Care home placements. |

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| | 6 | Holistic support - spiritual and religious | People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences. | Hospital Trusts will provide a chaplaincy service meeting the religious and spiritual needs of patients and staff:<br>• Every 35 beds = 1 unit of chaplaincy-spiritual care<br>• Every 500 WTE staff = 1 unit of chaplaincy-spiritual care.<br>Each unit of chaplaincy-spiritual care is deemed to last for 3.5 hours. These units are intended to cover the general responsibilities of the healthcare chaplain – additional units are required for specific responsibilities. (DH Guidance) | Guidance on spiritual and religious support | | |
| | 7 | Holistic support - families and carers | Families and carers of people approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, and holistic support appropriate to their current needs and preferences. | Hospital Trust will have access to social services 7 days a week to advise on the social, practica and emotional needs of families and carers of patients at the end of life. | | | A comprehensive assessment is likely to be multidisciplinary and may require the input of both health and social care professionals, as well as other appropriate support services. A comprehensive assessment is one that is coordinated effectively in order to avoid duplication. |
| **Access to services** | 8 | Coordinated care | People approaching the end of life receive consistent care that is coordinated effectively across all relevant settings and services at any time of day or night, and delivered by practitioners who are aware of the person's current medical condition, care plan and preferences. | Hospital Trusts and Commissioners will develop an Electronic Palliative Care Co-ordination Register ( EPACC) - IT based system to coordinate care through access to electronic patients records:<br>- Standardise documentation<br>- Adopt a functional IT platform<br>- Adopt an agreed electronic summary care record built upon a common core minimum dataset<br>- Establish an information governance framework | | | |
| | 9 | Urgent care | People approaching the end of life who experience a crisis at any time of day or night receive prompt, safe and effective urgent care appropriate to their needs and preferences. | Community services should aim to achieve a response time of 1 hour following a call for urgent care.<br><br>Trusts will provide specialist palliative care advice 7 days a week and access to specialist palliative inpatient care (see quality statements 4, 10 and 16). | | | |
| | 10 | Specialist palliative care | People approaching the end of life who may benefit from specialist palliative care, are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night. | Specialist palliative care inpatient facilities should be responsive to emergency need and able to admit people approaching the end of life at any time of day or night.<br>Palliative care services should ensure provision to:<br>• Visit and assess people approaching the end of life face-to-face in any setting between 09.00 and 17.00, 7 days a week (provision for bed-side consultations outside these hours is high-quality care).<br>• Provide specialist palliative care advice at any time of day or night, which may include telephone advice. | | | |
| **Care in the last days of life** | 11 | Care in the last days of life | People in the last days of life are identified in a timely way and have their care coordinated and delivered in accordance with their personalised care plan, including rapid access to holistic support, equipment and administration of medication. | The Liverpool Care Pathway will be used in all care setting for planning, coordinating and delivering safe and effective care in the last days of life. This includes using all allied documents in specialist areas.<br><br>Trusts need to have a mechanism at board level to discuss the results of VOICES, which is the survey sent nationally to bereaved relatives asking about experience of end of life and an action plan to improve the quality of care based on feedback. | | | |
| **Care after death** | 12 | Care after death - care of the body | The body of a person who has died is cared for in a culturally sensitive and dignified manner. | Hospitals should have in place procedures to ensure that GP practices are informed of a death on the same day as the death occurs, or the following working day if the death occurs out of hours. This will include information written on the Medical Certificate of Cause of Death and whether the coroner has been notified. | Guidance about care after death | | |
| | 13 | Care after death - verification and certification | Families and carers of people who have died receive timely verification and certification of the death. | All hospital staff should be able to direct people to the bereavement service, with the location of bereavement services included on any map or written information about hospital services.<br><br>Hospitals should aim to provide a dedicated office with private waiting facilities that are | | | |

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| Care after death | 14 | Bereavement support | People closely affected by a death are communicated with in a sensitive way and are offered immediate and on going bereavement, emotional and spiritual support appropriate to their needs and preferences. | Hospital Trusts and commissioners will adopt the VOICES survey and include the findings in organisational reports on the quality of care. | Standards for bereavement support | VOICES survey | |
| **Workforce** | 15 | Workforce - training | Health and social care workers have the knowledge, skills and attitudes necessary to be competent to provide high-quality care and support for people approaching the end of life and their families and carers. | All staff should have easy access to e-learning modules and other training opportunities that includes communication skills (including issues around loss, grief and bereavement), spiritual care, assessment and care planning, advance care planning, and symptom management as they apply to end of life care. Also training related to the Liverpool Care Pathway for the dying patient (LCP) or equivalent integrated care pathway.<br><br>Specialist palliative care services to act as an educational resource for training generalist palliative care in the community<br><br>Medical and district/community nursing out-of-hours workers should be competent in providing general palliative care, including symptom management, the use of syringe drivers, assessment of need, communication skills and providing support both to the patient and to carers in relation to 'do not attempt cardiopulmonary resuscitation' orders (also 'do not attempt resuscitation' orders), and advance decisions. | Competences Framework | Current Learning in Palliative Care (CLIP) | |
| | 16 | Workforce planning | Generalist and specialist services providing care for people approaching the end of life and their families and carers have a multidisciplinary workforce sufficient in number and skill mix to provide high-quality care and support. | Trusts and Commissioners to adopt the Royal College of Physicians recommendations for Specialist Palliative Care of between 1.56 and 2.00 whole-time equivalent (WTE) consultants in palliative medicine per 250,000 population. | RCP Palliative Care Medicine | | |

# HEALTH AND WELL BEING BOARD

**5th August 2013**

**Report of:** Chair – Cllr Carl Richardson

**Subject:** Feedback from Chairs of Health and Well Being Boards Regional Meeting

## 1. TYPE OF DECISION/APPLICABLE CATEGORY

NON KEY

## 2. PURPOSE OF REPORT

2.1 The purpose of this report is to provide feedback to the Board from the regional meeting of the Chairs of Health and Well Being Boards.

## 3. BACKGROUND

3.1 The meeting of the chairs of Health and Well Being Board is an opportunity for the chairs across the North East to discuss common issues affecting health and well being boards.

3.2 This meeting is supported by the Association of North East Councils (ANEC).

## 4. ITEMS DISCUSSED AT MEETING ON 17th JUNE 2013

4.1 The following items were discussed:

- Update from Cameron Ward from NHS England
- Update from Dr Roberta Marshall – Public Health England
- Integration of health and social care through pioneer programme – Wendy Balmain from NHS England

4.2 Due to time constraints the following items were deferred:

- Investment in tobacco by pension funds – FRESH
- Minimum unit price for alcohol –BALANCE
- Better health at work
- Health and well being strategies and synergies

## 5. RECOMMENDATIONS

5.1 Members of the Board are note the content of the report.

## 6. REASONS FOR RECOMMENDATIONS

6.1 To ensure the Board receives feedback from the regional meeting that the chairman of the board attends on behalf of the Hartlepool Health and Well Being Board.

## 7. CONTACT OFFICER

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