AUDIT AND GOVERNANCE COMMITTEE AGENDA

HARTLEPOOL BOROUGH COUNCIL

Thursday 28 July 2016

at 10.00 am

in the Council Chamber, Civic Centre, Hartlepool

MEMBERS: AUDIT AND GOVERNANCE COMMITTEE

Councillors S Akers-Belcher, Belcher, Cook, Hamilton, Harrison, Martin-Wells and Tennant.

Standards Co-opted Members; Mr Norman Rollo and Ms Clare Wilson.

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

   3.1 Minutes of the meeting held on 14 July 2016 *(to follow).*

4. **AUDIT ITEMS**

   No items.

5. **STANDARDS ITEMS**

   No items.

6. **STATUTORY SCRUTINY ITEMS**

6.1 Assisted Reproduction Unit (ARU) Consultation – Results – *Scrutiny Manager and Hartlepool and Stockton-on-Tees Clinical Commissioning Group*

6.2 Scoping Report – Access to Transport for People with a Disability – *Scrutiny Manager (to follow)*

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

7.1 To receive the Minutes of the meeting held on 29 April 2016.

8. **MINUTES FROM THE RECENT MEETING OF THE FINANCE AND POLICY COMMITTEE RELATING TO PUBLIC HEALTH**

No items.

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

No items.

10. **MINUTES FROM THE RECENT MEETING OF SAFER HARTLEPOOL PARTNERSHIP**

10.1 To receive the Minutes of the meeting held on 11 March 2016.

11. **REGIONAL HEALTH SCRUTINY UPDATE**

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

ITEMS FOR INFORMATION

Date of next meeting – Thursday 1 September 2016 at 10.00 am in the Civic Centre, Hartlepool.

AUDIT AND GOVERNANCE COMMITTEE

MINUTES AND DECISION RECORD

14 July 2016

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

Present:

Councillor: Ray Martin-Wells (In the Chair).

Councillors: Sandra Belcher, Rob Cook, Brenda Harrison and John Tennant.

In accordance with Council Procedure Rule 5.2 (ii), Councillor Richardson was in attendance as substitute for Councillor Lesley Hamilton.

Independent Persons:
Norman Rollo and Clare Wilson.

Also Present:Cath Andrew, Mazars

Officers: Chris Little, Chief Finance Officer
Noel Adamson, Head of Audit and Governance
Sandra Shears, Head of Finance (Corporate)
Alastair Rae, Public Relations Officer
Joan Stevens, Scrutiny Manager
Angela Armstrong, Principal Democratic Services Officer

14. Apologies for Absence

Apologies for absence were received from Councillors Stephen Akers-Belcher and Lesley Hamilton.

15. Declarations of Interest

None.

16. Minutes of the meeting held on 30 June 2016

Confirmed.

17. Presentation – Internal Audit and Mazars - Training

(*Chief Finance Officer and Mazars Representative*)

The representative from Mazars provided the Committee with a

comprehensive presentation which examined the role and responsibilities of the Council's external auditor which reflected the special accountability attached to public money and the conduct of public business. It was noted that the framework for external audit was undergoing a major change and was now governed by the Local Audit and Accountability Act 2014. Further detail was provided on the Council's audit approach and reporting including the arrangements in place to ensure the Council's processes were secure, economic, efficient and effective in the use of resources. The Chair requested that copies of both presentations be circulated to Members for their information.

In response to a request for clarification, the Chief Finance Officer confirmed that Mazars had been appointed as the Council's external auditor through a competitive national procurement exercise. These arrangements had produced significant savings for all Councils with the remit of the external auditor being more focussed on traditional audit work.

The Head of Audit and Governance provided the Committee with a presentation which outlined the role of Internal Audit the aim of which was to provide an independent assurance regarding the arrangements for managing risk and maintaining an effective control environment. This included statutory and professional requirements. The presentation provided further detail on the remit and responsibilities of Audit Committees including good practice characteristics as provided by CIPFA. The key activities of the Committee for 2016/17 were outlined in the report.

Recommended

(i) The presentations were noted.
(ii) That copies of both presentations be circulated to Members of the Committee for their information.

18. The 2015/16 Financial Report (including the 2015/16 Statement of Accounts) (*Chief Finance Officer)*

The Chief Finance Officer reported on the arrangements for approving the Council's Financial Report for 2015/16 (which included the Statement of Accounts) and provided a copy of the 2015/16 unaudited Financial Report for the Committee's information. Local Authorities were required to produce an annual statement of accounts by 30 June with a further requirement that elected Members approve the final audited accounts by 30 September.

It was noted that from 2017/18 changes to the Accounts and Audit Regulations would require Local Authorities to prepare their draft Financial Report by 30 May and then publish audited accounts by 31 July. In view of this more challenging deadline, procedures for preparing the accounts had been reviewed and testing during the preparation of the 2015/16 accounts. This had enabled the draft accounts to be published on the Council's website on 17 June. The basis for the preparation of the accounts was

outlined in the report.

The Chief Finance Officer concluded that the final outturn for 2015/16 was £0.091m higher than forecast and a strategy for using these one-off resources would be developed as part of the 2017/18 budget process.

A Member sought clarification on the business rates safety net grant reserve referred to in the report. The Chief Finance Officer referred to the significant impact the reduction in the rateable value of Hartlepool Power Station and the resulting loss if income. It was noted that there was a safety net provided by the Government for the cumulative impact from 2010, however the ongoing impact from 2015/16 did not trigger this safety net. This change had been reflected within the Statement of Accounts and did not impact on the current Medium Term Financial Strategy.

In response to a question, the Chief Finance Officer indicated that the Collection Fund was a separate account which included business rates and council tax income along with the Police and Fire Authorities pre-cepts.

Recommended

(i) The report was noted.
(ii) It was noted that the pre-audit accounts would be subject to independent audit by Mazars and details of any material amendments would be reported to the Audit and Governance Committee in September.
(iii) It was noted that there was an opportunity to raise questions and/or seek clarification of information included in the pre-audit Statement of Accounts in the period up to 22 September 2016 when the audited Statement of Accounts would be presented to the Audit and Governance Committee for final approval.

19. Internal Audit Plan 2016/17 Update (*Head of Audit and Governance*)

The Head of Audit and Governance reported on the progress made to date completing the internal audit plan for 2016/17. Details of the audits completed and receiving a satisfactory assurance level were included within the report. However, it was noted that the audits undertaken on Economic Development ERDF Grant had been categorised as ‘no assurance’ and Inspiration Nursery Stock Control had a ‘limited’ assurance level. The Head of Audit and Governance reassured Members that the necessary changes had been made to mitigate against any future risks in both these areas.

In response to a request for clarification from the Chair, the Head of Audit and Governance indicated further information on the discrepancies discovered between stock records and stock held at Inspirations Nursery would be circulated to Members of the Committee.

Recommended

(i) That the report was noted.
(ii) That further information on the discrepancies discovered between stock records and stock held at Inspirations Nursery be circulated to Members of the Committee.

20. Letter to those Charged with Governance – Compliance with Laws and Regulations/Fraud (*Chief Finance Officer*)

The Head of Audit and Governance informed Members of the proposal to reply to the letter received from the Director of Engagement Lead of the Council's external auditor Mazars, to those charged with governance regarding compliance with laws and regulations and fraud. Attached to the report at Appendix A was a letter to Mazars from the Chair of the Committee detailing how the Committee had complied with the requirements of International Standards for Auditing.

The representative from Mazars suggested it would be useful to circulate the original request for declarations for year ending 31 March 2016 to all Members of the Committee.

Recommended

(i) The contents of the letter to Mazars outlining how the activities of the Committee complied with the requirements of International Standards for Auditing was approved and thereupon signed by the Chair.
(ii) That the original request for declarations for year ending 31 March 2016 be circulated to all Members of the Committee.

21. Review of Minimum Revenue Provision (MRP) Policy for 2017/17 (*Chief Finance Officer*)

The report provided detailed information on the proposal reported to the Finance and Policy Committee on 20 June 2016 as part of the Medium Term Financial Strategy report to revise the Minimum Revenue Provision (MRP) policy for 2017/18 before submission to full Council. It was noted that the existing MRP policy had been in place for eight years and to provide adequate time to consider a revised MRP policy, the report had been considered by the Finance and Policy Committee and was submitted to this Committee for detailed scrutiny before being referred to full Council.

The Chair clarified that the policy change would provide a guarantee the Capital Financing Requirement (CFR) would be fully repaid within 50 years along with a recurring annual saving of £2m over a 12 year period.

Recommended

The report and recommendations approved by the Finance and Policy Committee on 20 June 2016 were endorsed for submission to Council.

22. Proposed Closure of Assisted Reproduction Unit (ARU) – Update

The Chair provided a comprehensive update on the current position in relation to the proposed closure of the Assisted Reproduction Unit (ARU) at the University Hospital of Hartlepool. It was highlighted that the consultation currently being undertaken by Hartlepool and Stockton on Tees Clinical Commissioning Group (CCG) was coming to an end very shortly. The Clinical Senate had examined the proposals in detail and had stated that North Tees and Hartlepool NHS Foundation Trust (the Trust) had no desire to continue to operate the ARU from the University Hospital of Hartlepool. Whilst the Chair acknowledged that the Trust had indicated that they would allow any future provider of the service to utilise the Unit and equipment within the Hospital, the actions of the Trust in the lead up to that decision were condemned in the strongest terms as they had shown this Committee and the people of Hartlepool utter contempt and distrust. In conclusion, the Chair provided an assurance that the Committee would provide its support to the ongoing provision of the service through an alternative provider to ensure the best outcomes for the patients utilising that service were achieved and with this in mind were aware of several options for the future operation of this service. Members endorsed the Chair's comments reiterating that they felt the way the Trust had handled the proposed closure of the ARU, including the affect this had on the current staff within the Unit was an absolute disgrace. Members were informed that discussions were ongoing with the CCG to seek reassurances that the ongoing treatment would continue.

The Scrutiny Manager highlighted that Members could play an active role in the ongoing work being undertaken on a regional basis around the Better Health Programme and the development of services for the future. It was noted that the Chair of this Committee was the Vice Chair of the regional committee examining the Better Health Programme and would continue to represent the needs and wishes of Hartlepool residents through that programme.

A Member expressed his disappointment at the apparent lack of accountability of the Trust as it should be accountable to the people of Hartlepool.

Recommended

The update on the proposed closure of the ARU was noted.

23. Selection of Potential Topics for Inclusion within the 2016/17 Statutory Scrutiny Work Programme (*Scrutiny Manager*)

Members' consideration was requested of a number of potential work programme items which related to the statutory scrutiny functions of health and crime and disorder. In addition the Committee had a rolling health scrutiny work programme which Members were asked to consider. In addition to the report, a referral had been received from the Adult Services Committee in relation to Access to Transport for People with a Disability which would need to be examined and the outcome and reported back to the Committee no later than 10 weeks.

A discussion ensued and it was suggested that the high mortality rates at the North Tees and Hartlepool Foundation Trust (the Trust) be investigated alongside the Shared Diagnostics and Use of Theatres. It was noted that whilst there were no specific crime and disorder issues identified for investigation, the Committee would continue to receive regular performance reports from the Safer Hartlepool Partnership. The Scrutiny Manager indicated that the consideration of the above items would ensure there was capacity for additional scrutiny through Councillor referrals where required.

Recommended

(1) The following investigations were agreed to be included within the 2016/17 Work Programme:
- Statutory Health Scrutiny – High Mortality Rates at North Tees and Hartlepool Foundation Trust alongside Shared Diagnostics – Use of Theatres;
- Statutory Crime and Disorder – No specific areas to scrutinise but would continue to receive the performance reports of the Safer Hartlepool Partnership.

(2) That the items contained within the rolling programme be maintained.

24. Regional Health Scrutiny Update

The Scrutiny Manager indicated that the next meeting of the regional Committee to examine the Better Health Programme was on 21 July, would be held in Durham and was open to the public. The Chair commented that through membership of the North East Joint Health Scrutiny Committee, the regional Committee looking at the Better Health Programme and the Tees Valley Joint Health Scrutiny Committee, Hartlepool residents' interest were well represented across the region.

25. Any Other Items which the Chairman Considers are Urgent

None.

The meeting concluded at 11.20 am

CHAIR

AUDIT AND GOVERNANCE COMMITTEE

28 July 2016

Report of: Scrutiny Manager

Subject: ASSISTED REPRODUCTION UNIT CONSULTATION - RESULTS

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1. PURPOSE OF REPORT

1.1 To introduce representatives from NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group who will be in attendance at today's meeting to discuss the results of the Assisted Reproduction Unit (ARU) consultation.

2. BACKGROUND INFORMATION

2.1 NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group have been consulting with local residents, patients and members of the public on three different options for the future location of assisted reproduction services. A 6 week public consultation was held and closed on 15 July 2016. Representatives will be present at today's meeting to discuss the results of the consultation with the Committee. A further detailed supplementary report will be circulated prior to the meeting.

2.2 An independent clinical review of the ARU at the University Hospital of Hartlepool was undertaken on the 7 June 2016 by the Northern England Clinical Senate and the report is attached at **Appendix A** for Member's information.

3. RECOMMENDATIONS

3.1 The Audit and Governance Committee is requested to consider the results of the consultation and formulate a response.

BACKGROUND PAPERS

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

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APPENDIX A

6.1

Northern England Clinical Senate

Review of Assisted Reproduction Unit at University Hospital of Hartlepool

June 2016

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1. Introduction and Background

In early January, 2016, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG) approached the Northern England Clinical Senate to ask the Senate to undertake a clinical review of the Assisted Reproduction Unit (ARU) at the University Hospital of Hartlepool (UHH). This request followed an apparent decision by the provider of the service, North Tees and Hartlepool NHS Foundation Trust (NTHFT), to cease providing the service themselves, leading to negative publicity in the local press.

The Associate Director for the Northern England Clinical Networks and Senate subsequently attended a meeting of the Health Scrutiny Joint Committee and the Audit and Governance Committee in Hartlepool on 15th March 2016 and gave details of how such a review might be undertaken and the likely timescales which would be involved.

Agreement was reached to convene a panel of independent clinical experts to undertake the review on behalf of the Clinical Senate; it was considered important to go outside the Northern England boundaries for this expertise to ensure absolute independence. The three clinical members of the panel were

Member	Role
Mrs Jane Blower (Chair)	Consultant Embryologist, Leicester Fertility Centre, Leicester Royal Infirmary and HFEA Person Responsible
Prof Daniel Brison	Consultant Embryologist, Department of Reproductive Medicine, Central Manchester University Hospitals NHS Foundation Trust, St. Mary's Hospital, Manchester.
Dr Cheryl Fitzgerald	Consultant in Reproductive Medicine, Central Manchester University Hospitals NHS Foundation Trust, St. Mary's Hospital, Manchester.

Biographies for the panel members are included as Appendix A.

The panel was supported managerially by Roy McLachlan, Associate Director of Clinical Networks and Senate and by two members of his support team, Michelle Wren and Denise Preston. Terms of Reference for the review were agreed with the CCG; an extract is given in section 2 below and the full Terms of Reference are given as Appendix B.

The date for the review was established as Tuesday, 7th June 2016 and it was agreed it would take place at University Hospital Hartlepool (UHH) so that an opportunity could be taken to visit the ARU during the course of the day. The date of the visit was also scheduled to fit in with the planned public consultation on the future options for provision of the service. It was hoped that this report would be available during week commencing 20th June, 2016 so that its contents could be considered alongside the formal consultation document.

2. Terms of Reference

An extract from the Terms of Reference is given below, summarising the main issues to be considered by the review panel.

Undertake a critical review and clinical analysis of the proposed service change in relation to the Assisted Reproduction Unit (ARU) provided by North Tees and Hartlepool Foundation Trust (NTHFT) to;

- *Review clinical safety of current service delivery and workforce which takes account of the work undertaken by NTHFT in identifying the mitigating clinical risk.*
- *Review proposed future service model to ensure the commissioning of a sustainable future service including, efficiency, workforce, clinical safety, patient experience, current and future demand.*
- *Provide assurance of the option proposed or provide recommendations that will result in the commissioning of safe services for local people which has sustainability.*

The full Terms of Reference are given as Appendix B to this report.
The following timeline was established for the production of this report

- First draft available to CCG for accuracy check in early week commencing 13th June 2016
- Final version available week commencing 20th June 2016

It was recognised by all concerned that this timeline was much tighter than usually expected for a Clinical Senate report.

3. Methodology

A range of documentation was made available to the Senate Review Team by the CCG in advance of the review visit and was presented via email over a period of weeks. A list of documents provided is detailed in Appendix C.

Some further information from North Tees and Hartlepool Foundation Trust was presented at the request of members of the review team.

The agenda for the day was designed carefully to allow 90 minutes each with representatives of the following organisations

- North Tees and Hartlepool NHS Foundation Trust
- NHS Hartlepool and Stockton-on-Tees CCG
- Local Authorities – Hartlepool, Stockton, Middlesbrough, Redcar and Cleveland and Durham.

Time was also built in to visit the ARU which gave the review panel an opportunity to talk to staff. The panel noted the absence of the Person Responsible and made enquiries as to his availability.

During the early afternoon of the visit, arrangements were made for the Person Responsible, Mr Hany Mostafa, to meet with the panel as he had been in Newcastle on a professional appointment during the morning. The panel met with Mr Mostafa for half an hour after meeting representatives from the Local Authorities.

The planned agenda for the day is included as Appendix D and a list of attendees for each session as Appendix E.

The review panel had several opportunities to deliberate on discussions throughout the day and had a final session to discuss the possible contents of this report before the end of the visit.

4. What the panel heard

The following sections outline the key messages heard in each of the sessions outlined in the methodology section.

4.1 North Tees and Hartlepool NHS Foundation Trust

The key issues highlighted to the panel by the Trust were:

- that the ARU is a small unit which has encountered difficulties in recruiting into Embryology posts
- that by the end of 2015 the Trust had serious concerns over the viability of continuing with the service safely and did not wish to compromise their ability to offer high quality services to patients
- that the CCG and Local Authorities had been made aware of the difficulties during the course of 2014 and 2015.

4.2 Hartlepool and Stockton-on-Tees CCG

The key issues highlighted to the panel by the CCG were:

- the CCG did not initiate the proposed changes to the ARU but wanted their residents to have access to a sustainable good quality service which was also economically viable
- that the CCG was representing other CCG's whose residents used the service at UHH
- the CCG welcomed advice from the independent panel on the options set out in the public consultation document.

4.3 Local Authorities

The key issues highlighted to the panel by the representations of the Local Authorities were:

- that there was a strong disappointment with the Trust for not engaging with the local Audit and Governance Group or the Health Scrutiny Joint Committee
- that on behalf of local residents they wanted to keep as many services as possible provided at UHH but there was a feeling that the Trust wanted increasingly to centralise services at Stockton
- that the Trust had not exhausted all possible recruitment routes to get their Embryology posts filled.

4.4 Person Responsible

The key issues highlighted to the panel by the Person Responsible (PR) were:

- that the ARU at UHH was a mature service with good standing and a strong regional position that had encountered difficulties in recruiting to vacant Embryologist posts
- that there had been a trend for merging of smaller units but not a move to close them completely
- that issues identified in the HFEA inspection had been satisfactorily addressed.

Overall the panel were impressed by the desire of all the people they met to be able to offer a sustainable safe service for patients.

5. Findings of the panel

It is intended to give only a summary of the findings of the review panel against each of the three main elements of the Terms of Reference as set out below.

5.1 Clinical Safety

The main factor given by NTHFT behind the cessation of (and intention to close) ARU services in Hartlepool was the inability to fill the staffing establishment for the unit. Based on the accounts and evidence provided regarding the recent workforce issues it was clear that:

- there had been difficulties with recruitment to Embryology posts over an extended period,
- succession planning around the retirement of long term staff had not proved successful
- the ARU did not train its own embryologists (which improves a unit's ability to recruit and retain staff)
- there has been recent instances of long/medium term sickness amongst medical and nursing staff within the ARU
- there had been a sudden departure of a substantive consultant appointment after only 3 months in post.

The approach to recruitment adopted by NTHFT had not managed to address these workforce shortages despite short-term measures being adopted. For example, a flexi-retired member of staff was retained and then supplemented with locum arrangements, some of which cost £750 per day. The equivalent per annum rate of this arrangement is £200,000 per year, an amount which is not financially sustainable in the medium- to long- term.

The Trust was, therefore, by the end of 2015, running at 25% Embryologist capacity against establishment for the unit (i.e. funding in place for 2.5 wte but with only 0.6 wte available). This situation was exacerbated by the absence of 1 Associate Specialist due to long-term sickness and one nurse on long term sickness a reduction in available nursing workforce of 25%.

Panel Findings

Based on the assessment of this workforce situation, the Expert Panel feel that the ARU could not provide a clinically safe environment for patients and that on balance NTHFT were right in giving serious consideration to no longer providing the service in the short-term. Given the unsuccessful attempts to address the workforce issues,

the Expert Panel also feel that the CCG are right in considering a range of options for a sustainable service for the medium- to long-term.

5.2 Proposed Future Service Models

The session with the CCG gave an opportunity to consider jointly the options set out in the consultation document. Colleagues from the CCG were keen to hear the panel's views on the advantages, risks and/challenges of each option with a view as to how the CCG ensured a sustainable future service to meet patient's needs.

Hartlepool currently provides (on average) 250 cycles per year undertaken on the basis of patients choosing to select Hartlepool ARU as their unit of choice (from the range of reproduction units across the North East / England). The facilities provided in the UHH ARU are also generally excellent although there is a likely requirement for modification to the current laboratory space which would require additional investment (a consideration that would need to be taken into account when making a final decision on future models).

The Expert Panel suggested that for a licenced fertility provision to be clinically and sustainable and financially viable, clinics usually need to deal with between 400 and 500 IVF cycles a year.

Based on the necessity for a range of clinical skills i.e. Nurse Specialists, embryologists, consultants, to be available each day within an ARU, the number of cycles overseen by a unit in a year is highly correlated to its ability to recruit the appropriate workforce and be financially viable.

The CCG had identified three main options for new service models which the Expert Panel were asked to comment on. These are:

- Option 1: A comprehensive assisted reproductive service including HFEA Licensed and unlicensed provision remains at Hartlepool delivered by an alternative provider.
- Option 2: Unlicensed assisted reproductive services continue to be delivered at Hartlepool and patients requiring licenced provision go to an alternative site e.g. James Cook University Hospital, Queen Elizabeth University Hospital, Gateshead and Newcastle Fertility Centre at the Centre for Life.
- Option 3: A comprehensive assisted reproductive service including HFEA Licensed and unlicensed provision will no longer be available at Hartlepool but will be delivered at other sites in the region

5.2.1 Option 1

Service Option 1
A comprehensive assisted reproductive service including HFEA Licensed and unlicensed provision remains at Hartlepool delivered by an alternative provider.
Risks
• The CCG is unable to secure and commission an alternative provider to deliver at Hartlepool site.
Benefits

• Existing provision will be maintained and patients will not see any changes. • Patients will receive all treatment in Hartlepool.
Patients Potentially Impacted
0 (nil)

Advantages identified by the Expert Panel:

- Maintains a local service, for both licensed and unlicensed treatments
- Provides stability for current staff and patients
- Potentially sustainable from a service perspective (but only if greater numbers of patients chose to utilise Hartlepool for their treatment and current workforce challenges overcome)

Risks/challenges identified by the Expert Panel:

- The service sustainability does not necessarily mean financial viability (which would in all probability be dependent on the ARU undertaking fee paying and private work).
- This option would in all likelihood be very expensive for a new provider to take on as it would need to replicate a full range of staffing and laboratory services over multiple sites, reducing potential economies of scale.
- Would require increased staffing levels to sustain a future service which has so far proved difficult to attract and retain.

5.2.2 Option 2

Service Option 2
Unlicensed assisted reproductive services continue to be delivered at Hartlepool and patients requiring licenced provision choose to go to an alternative site e.g. James Cook University Hospital, Queen Elizabeth University Hospital, Gateshead and Newcastle Fertility Centre at the Centre for Life.
Risks
• Patient experience, as patients may not be aware when starting unlicensed treatments that they may not be able to receive all of their treatments from the one site if they progress to licensed treatments. • Ensuring referrers are aware of the changes before referring. • Capacity assessment required for other providers to ensure that they have the capacity to manage additional patients.
Benefits
• Assisted reproductive services for the majority of patients will continue to be provided at Hartlepool site.
Patients Potentially Impacted
116 *(Based on the average number of cycles of 1.2 per patient and 2015/16 activity)*

Advantages identified by the panel:

- Keeps a limited local service (likely to be about 20% of referrals would undergo treatment locally with the remaining 80% either not undergoing treatment or being referred to a tertiary unit for assisted conception).

Risks/challenges identified by the panel:

- Patients under the care of two providers with potentially poorer patient experience (e.g. patients needing to change pathways for licensed treatments)
- Duplication of investigations unless a robust single pathway is developed
- Travel to other hospital sites for 80% of patients
- With this option it was noted that stored gametes and embryos would need to be transferred to another provider site. This has risks in terms of transporting embryos in tanks of liquid or vapour phase nitrogen and also in maintaining administrative records of patients consent to storage, expiring deadlines for storage and systems for contacting patients.

The Expert Panel feel that the fewer service providers involved in delivering the different elements of the overall fertility service (with an ideal of one - but mindful of procurement restrictions), the stronger the clinical governance and clearer the care pathway would be within a larger, overall service utilising more streamlined processes.

5.2.3 Option 3

Service Option 3
A comprehensive assisted reproductive service including HFEA Licensed and unlicensed provision will no longer be available at Hartlepool but will be delivered at other sites in the region.
Risks
• Patients already referred to the service will need to be transferred to another provider. • Capacity assessment required for other providers to ensure that they have the capacity to manage additional patients.
Benefits
• Service will be commissioned from a smaller number of providers which can attract clinical staff due to the specialist nature of the provision. • Increased volumes of activity at other sites will improve the financial viability of services ensuring continues delivery of services in the future.
Patients Potentially Impacted
A maximum of 600 of which 116 relate to licensed provision.

Advantages identified by the panel:

- May make other nearby units more sustainable in the medium- to long-term thereby securing viability.

- May enable seven-day working in nearby units.

Risks/challenges identified by the panel:

- This would be a loss of local service and therefore, consideration of this option should include the views of the public over the degree of willingness to travel and how far, to access a new service.
- With this option it was noted that stored gametes and embryos would need to be transferred to another provider site.

Overall, the Expert Panel were not able to identify any other alternative options.

6. Summary

Throughout the review, the Expert Panel was struck by the strength of feeling of local councillors and others for keeping services local and of commissioners and providers of ensuring services were of a high level of quality and sustainable into the future.

The main findings of the Expert Panel are that:

- The Trust was right to consider the clinical safety of the ARU to be compromised in December 2015.
- There are benefits and risks associated with each of the options identified by the CCG as the sustainable model for the future.
- Generally larger units seeing more NHS funded cycles (or supplementing NHS funded cycles with privately funded work) find it easier to recruit and retain staff in a clinically sustainable and financially viable service. They are also more likely to attract other national funding (e.g. for the development of a training scheme locally for embryologists, such as those which exist in Newcastle, Manchester and other centres throughout the UK)
- Adopting a more nuanced form of recruitment (e.g. use of specialist media) may have a greater chance of identifying new members of staff to any future service.
- Whilst being mindful of procurement regulations and the wishes of neighbouring commissioners and providers, there may be benefit in looking for greater collaboration with neighbouring ARUs within the options for new service models

On behalf of the Northern England Clinical Senate the Expert Panel would like to thank everyone who contributed to the discussions.

Biographies

Jane Blower
Consultant Embryologist and Human Fertilisation and Embryology Authority (HFEA) Person Responsible Leicester Fertility Centre University Hospitals of Leicester NHS Trust

Jane graduated from Nottingham University with the first UK Masters in Assisted Reproductive Technology. In her substantive role as a consultant embryologist she is responsible for directing and managing the scientific service for the diagnosis, management and treatment of infertility patients at the Leicester Fertility Centre. She is also the HFEA Person Responsible; she was part of the original team who opened the Leicester Fertility Centre in 1989. Jane is a founder member of the Association of Clinical Embryologists (ACE) and sat on the ACE Executive committee for 6 years. Jane is a member of the quality Improvement group for the IQIPS Improving Quality in Physiological Services accreditation programme at the Royal college of Physicians and has a strong belief in the role of accreditation to improve the quality of diagnostic services. She was a member of the NICE evidence update review on fertility group and is a Health & Care Professions Council (HCPC) partner. She is also a scientific advisor to the HFEA and a member of the East Midlands Clinical Senate Assembly. In October 2010 Jane was appointed as Scientific Director to the NHS East Midlands as a part time secondment, offering scientific advice to the Strategic Health Authority (SHA), and subsequently Healthcare Science workforce advisor to Health Education East Midlands, whilst providing leadership, strategic direction, and influence for healthcare sciences and scientists across the region.
Jane undertakes a part time role providing scientific advice to the East Midlands Academic Health Science Network (EMAHSN) and supporting their affiliated projects, including the Medical Research Council (MRC) nodes.
In April 2014 Jane was seconded to a national role as Deputy CSO for 12 months, and subsequently as Clinical Associate with the CSO team. In this role she worked closely with the Chief Scientific Officer (CSO) and senior colleagues at NHS England and continues to be actively involved in the CSO work programme supporting accreditation of scientific and diagnostic services focusing on leadership, quality, and innovation and commissioning of diagnostics as well as the delivery of seven day scientific services. Her research interests include male factor infertility.

Professor Daniel R Brison
PhD, FRCPath

Professor of Clinical Embryology and Stem Cell biology; Scientific Director of the Department of Reproductive Medicine, Co-Director NW Embryonic Stem Cell Centre. Department of Reproductive Medicine, St Mary's Hospital, Central Manchester and Manchester University Hospitals NHS Foundation Trust.

Professor Daniel Brison is a Consultant Embryologist at St Mary’s Hospital, Manchester and Person Responsible to the HFEA for licenses in embryo research and embryonic stem cells. He is a member of the HFEA's Scientific and Clinical Advances Advisory Committee, the UK Association of Clinical Embryologists Scientific Advisory Committee, Clinical lead for the UK national MSc in Reproductive

Sciences and an examiner for the Royal College of Pathologists. His clinical and research interests include: improving the effectiveness and safety of clinical assisted reproductive technologies (ART), the characterization of early human development at the molecular level, the regulation of pluripotency in embryos and embryonic stem cells and the derivation and use of clinical grade embryonic stem cells for the treatment of disease, and the impact of environmental factors and ART on embryonic and child health.

Cheryl T. Fitzgerald M.B. Ch.B., M.R.C.O.G., M.D.
Consultant in Reproductive Medicine
Old St Mary's Hospital, Manchester

Cheryl graduated from The University of Manchester in 1986. Her current role is full time NHS Consultant in Reproductive Medicine, and she has a commitment to the general gynaecology on-call rota and the Termination of Pregnancy service.

From 2006 – 2010 was the person responsible to HFEA. 2010 – 2014 saw her as Clinical Lead for IVF and ICSI. Cheryl is the clinical lead for the fertility preservation service and is also the Associate Dean of Undergraduate studies for St Mary's hospital, and, Clinical Lead for the Gynaecology Quality Improvement Programme

Cheryl has been actively involved in the production of several clinical publications – peer reviewed.

Appendix B

Northern England
Clinical Senate

SENATE CLINICAL REVIEW

TERMS OF REFERENCE

Title: Assisted Reproduction Unit, University Hospital of Hartlepool

Sponsoring Organisation: Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG)

Clinical Senate: Northern

NHS England regional or area team: NHS Cumbria and the North East

Terms of reference agreed by:

Roy McLachlan

on behalf Northern England Clinical Senate and

(Name)

on behalf of Hartlepool and Stockton-on-Tees CCG

Date: 7 June 2016

Senate Clinical Review Team Members

Chair: Mrs Jane Blower, Consultant Embryologist & HFEA Person Responsible.

Professor Daniel Brison, Consultant Embryologist, Department of Reproductive Medicine, Central Manchester University Hospitals NHS Foundation Trust, St Mary's Hospital, Manchester.

Dr Cheryl Fitzgerald, Consultant in Reproductive Medicine, Central Manchester Foundation Trust.

Scope of the Review

To undertake a critical review and clinical analysis of the proposed service change in relation to the Assisted Reproductive Unit (ARU) provided by North Tees and Hartlepool Foundation Trust to;

- Review clinical safety of current service delivery and workforce which takes account of the work undertaken by NTHFT in identifying the mitigating clinical risk.
- Review proposed future service model to ensure the commissioning of a sustainable future service including; efficacy, workforce, clinical safety, patient experience, current and future demand.
- Provide assurance of the options proposed or provide recommendations that will result in the commissioning of safe services for local people which has sustainability.

Timeline

June 2016.

Reporting Arrangements

The clinical review team will report to the clinical senate council which will agree the report and be accountable for the advice contained in the final report. Clinical senate council will submit the report to the sponsoring organisation and this clinical advice will be considered as part of the NHS England assurance process for service change proposals.

Methodology

The review team will look over the information provided by the CCG (This can be circulated via secure email) then the review team will come together for a one day face to face meeting to discuss the information received as a group and meet with teams from North Tees and Hartlepool NHS Foundation Trust, Hartlepool Borough Council, and Hartlepool and Stock-on-Tees CCG to clinically test out the proposal. The timeframe would be for CCG information to be circulated in May 2016 with the face to face meeting on Tuesday 7 June 2016.

Report

A draft clinical senate assurance report will be circulated within five working days from the face to face meeting by the review team to the sponsoring organisation for factual accuracy.

Comments/correction must be received within five working days.

The final report will be submitted to the sponsoring organisation during week commencing 20 June 2016 and will be endorsed at the Northern England Senate Council meeting in July 2016.

Communication and Media Handling

The arrangements for any publication and dissemination of the clinical senate assurance report and associated information will be decided by the sponsoring organisation.

Resources

The Northern England Clinical Senate will provide administrative support to the review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

Accountability and Governance

The clinical review team is part of the Northern England Clinical Senate accountability and governance structure.

The Northern England Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

Functions, Responsibilities and Roles

The **sponsoring organisation** will

i. provide the clinical review panel with the agreed information pack, including the formal consultation document. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process.

Clinical Senate Council and the sponsoring organisation will

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical Senate Council will

i. appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
ii. endorse the terms of reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the team and
v. submit the final report to the sponsoring organisation

Clinical Review team will

i. undertake its review in line with the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the

report. The team will subsequently submit final draft of the report to the Clinical Senate Council.

iv. keep accurate notes of meetings.

Clinical Review team members will undertake to

i. commit fully to the review and attend all briefings, meetings, interviews, panels etc. that are part of the review (as defined in methodology).

ii. contribute fully to the process and review report

iii. ensure that the report accurately represents the consensus of opinion of the clinical review team

iv. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

END

Appendix C

Documentation provided by CCG in advance of review panel meeting

- Human Fertilisation Embryology Authority - Executive Licensing Panel minutes – Interim Inspection Report
- Terms of Reference
- ARU paper to Audit and Governance Committee January 2016
- Letter to Secretary of State 15 April 2016
- CCG Letter to Audit and Governance Committee 19 April 2016
- Notes from Hartlepool ARU Teleconference 27 April 2016
- Unison Report
- Contract Information – there is not a separate specification for this service there is only a reference to the service in women and children's overarching specification
- Activity Levels
- Engagement and Consultation document
- Timeline

Hartlepool ARU Meeting
Agenda

Date:	Tuesday 7 June 2016	**Time:**	08:30 – 16:00
Location:	University Hospital of Hartlepool, Holdforth Road, Hartlepool TS24 9AH Board Room		
Chair:	Mrs Jane Blower		
Panel Members:	Professor Daniel Brison, Dr Cheryl Fitzgerald, Roy McLachlan		

Time:		
08:30	Panel Meet	
09:15	Visit to ARU	
09:45	Panel Reconvene	
10:00	Meeting with North Tees and Hartlepool NHS Foundation Trust	Chief Operating Officer & Deputy Chief Executive – Julie Gillon Medical Director – David Emerton or Deepak Dwarakanath Clinical Director – Elaine Gouk Associate Director – Lynne Kirby General Manager – Jane Barker HR Business Partner – Catherine Connor
11:30	Break	
11:45	Meeting with Hartlepool and Stockton on Tees CCG – Working Lunch	Ali Wilson – Chief Officer (TBC) Karen Hawkins – Associate Director Commissioning Carl Parker – Clinical Lead IHC Paul Pagni – GP Lead Trish Hirst – Senior Contract Manager
13:15	Break	
13:30	Meeting with Local Authorities	***Hartlepool*** Joan Stevens – Scrutiny Officer Ray Martin Wells – Chair, Audit and Governance Committee ***Stockton-on-Tees*** Peter Kelly – Director Public Health Jim Beal – Councillor (Chair, Health & Wellbeing) ***Middlesbrough*** Julie McGee – Councillor Julie McGee@middlesbrough.gov.uk

		Terry Lawton - Terence Lawton@middlesbrough.gov.uk ***Redcar and Cleveland*** Ray Goddard - Ray.goddard@redcar-cleveland.gov.uk Anne Watts - Anne.watts@redcar-cleveland.gov.uk ***Durham and Darlington*** TBC
15:00	Panel Review and Report Writing	
16:00	Close	

Appendix E

Attendees at each session

Panel Meeting

8.30am	Jane Blower Cheryl Fitzgerald Daniel Brison Roy McLachlan Karen Hawkins (part)	Michelle Wren Denise Preston

Visit to ARU

09.15am	Jane Blower Cheryl Fitzgerald Daniel Brison Roy McLachlan Karen Hawkins	Michelle Wren 4 x ARU staff Jane Barker Lynne Kirby

Meeting with North Tees and Hartlepool NHS Foundation Trust

10.00am	Jane Blower Cheryl Fitzgerald Daniel Brison Roy McLachlan Michelle Wren Denise Preston	Julie Gillon David Emerton, Medical Director Catherine Connor Elaine Gouk Lynne Kirby Jane Barker Lisa Johnson

Meeting with Hartlepool and Stockton on Tees CCG

11.45am	Jane Blower Cheryl Fitzgerald Daniel Brison Roy McLachlan Michelle Wren Denise Preston	Ali Wilson Karen Hawkins Carl Parker Paul Pagni Trish Hirst

Meeting with Local Authorities
Hartlepool

13.30pm	Jane Blower Cheryl Fitzgerald Daniel Brison Roy McLachlan Michelle Wren Denise Preston	Joan Stevens Ray Martin Wells Cllr Rob Cook Dr Menabawey (declared an interest, founded and help fund service and delivered 1st IVF Baby)

Redcar and Cleveland

13.30pm	Jane Blower Cheryl Fitzgerald Daniel Brison Roy McLachlan Michelle Wren Denise Preston	Ray Goddard Anne Watts

Partners in improving local health

North of England Commissioning Support

Equality Impact Assessment

Original report June 2016
Updated report 20 Jul 2016

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Introduction - Equality Impact Assessment

An Equality Impact Assessment (EIA) is a process of analysing a new or existing service, policy or process. The aim is to identify what is the (likely) effect of implementation for different groups within the community (including patients, public and staff).

We need to:

- ✓ Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- ✓ Advance equality of opportunity between people who share a protected characteristic and those who do not
- ✓ Foster good relations between people who share a protected characteristic and those who do not

This is the law. In simple terms it means thinking about how some people might be excluded from what we are offering.

The way in which we organise things, or the assumptions we make, may mean that they cannot join in or if they do, it will not really work for them.

It's good practice to think of all reasons why people may be excluded, not just the ones covered by the law. Think about people who may be suffering from socio-economic deprivation or the challenges facing carers for example.

This will not only ensure legal compliance, but also help to ensure that services best support the healthcare needs of the local population.

Think of it as simply providing great customer service to everyone.

As a manager or someone who is involved in a service, policy, or process development, you are required to complete an Equality Impact Assessment using this toolkit.

Policy	A written statement of intent describing the broad approach or course of action the Trust is taking with a particular service or issue.
Service	A system or organisation that provides for a public need.
Process	Any of a group of related actions contributing to a larger action.

STEP 1 - EVIDENCE GATHERING

Name of person completing EIA:	Sarah Fountain
Title of service/policy/proces:	Assisted Reproduction Unit (ARU) – University Hospital of Hartlepool
Existing: ☐ **New/proposed:** ☐ **Changed:** ✓	
What are the intended outcomes of this policy/service/process? Include outline of objectives and aims	

The Assisted Reproductive Unit (ARU) at the University Hospital of Hartlepool (UHH) carries out non licensed and licensed fertility treatments. The service began in the early 1990's before moving in 2008.

The CCG's currently commission ARU services from South Tees NHS Foundation Trust and North Tees and Hartlepool NHS Foundation Trust. The existing provider North Tees and Hartlepool NHS Foundation Trust have informed the CCG they are unable to continue to deliver safe and clinically effective assisted conception services (IVF and IUI) under their HFEA (Human Fertilisation and Embryology Authority) Licence in the future.

The Human Fertilisation and Embryology Authority (HFEA) is the UK's independent regulator of the fertility sector. The HFEA licenses centres providing in vitro fertilisation (IVF) and other fertility treatments and those carrying out human embryo research.

Licensed centres usually receive a licence to operate for up to four years and must, by law, be inspected every two years. The full inspection prior to a licence being granted or renewed assesses a centre's compliance with the law and the HFEA's Code of Practice (CoP) and Standard Licence Conditions (SLC). (http://guide.hfea.gov.uk/guide/ShowPDF.aspx?ID=5939&merge=1)

Case for Change

The ARU has been identified by the HFEA as a small centre. It provides services to NHS patients and undertakes an average of 250 cycles of licenced fertility treatments per year with approximately 180 patients. Licenced fertility treatment that the unit provides are those treatments regulated by the HFEA and require the specialised skills of an embryologist. Without an embryologist, the licensed

treatments cannot be carried out.

The unit has been subject to continuous review due to the small number of staff working on the unit, specifically the number of embryologists. There are currently difficulties around recruiting and retaining specialist staff in such a small unit due to the lack of opportunities to develop skills, undertake research and develop expertise.

There is also a clinical risk and sporadic locum cover is neither financially or clinically viable, the clinical turnover of embryologists does not provide a stable and safe environment to patients.

For these reasons, a review of the sustainability of the unit is currently underway.

Intended Outcomes/ Options

At this stage, there are three potential options for the future of this service, these are:

Option1: A comprehensive assisted reproductive service to include HEFA Licensed and unlicensed provision remains at Hartlepool delivered by an alternative provider.

Option 2: Unlicensed assisted reproductive services continue to be delivered at Hartlepool and patients requiring licenced provision choose to have this provided at an alternative site e.g. South Tees, Newcastle, Gateshead.

Option 3: Assisted reproductive services are no longer provided in Hartlepool but will be available at other sites in the region.

There is the potential that some protected groups may be negatively affected by only one or two of the options, therefore this EIA will take into consideration the impact of all protected groups in relations Option 1, 2 and 3 separately.

Aims

The Aims of this review are to ensure that patients are treated in a safe environment with the availability of specialist staff for licensed fertility treatments. The review will ensure that the proposed changes are both financially and clinically viable and sustainable for the future.

Objectives

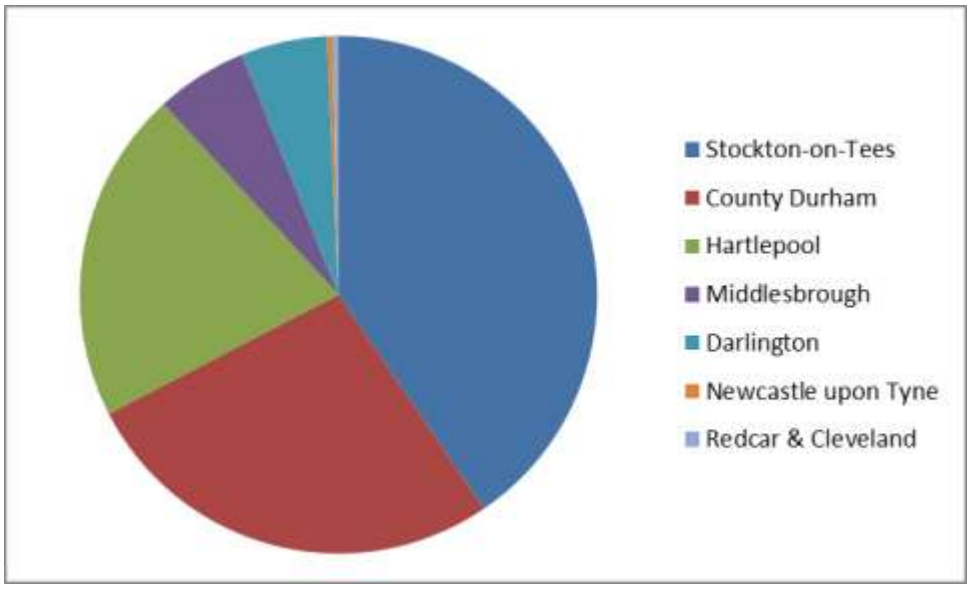
North of England Commissioning Support (NECS) are supporting Hartlepool and Stockton CCG (HaST) to actively engage the populations covered by HaST, Darlington, DDES and South Tees CCG's. The following factors have been taken into consideration to ensure a clinically effective service and meet the above aim:

- HFEA Licence Requirements

- Continuity in provision for patients
- Travel times to alternative provision
- Alternative provision by other providers and their ability to increase capacity should this be required.

Within this EIA, impact has been assessed on a number of factors including service usage data, and where this is not available, actions have been identified and local population data has been used.

The chart below shows a breakdown of the residencies of those using the ARU from 2015 to 2016. As there is currently minimal service level data available, this EIA has used local data where possible to assess the impact of the protected groups in relation to their representation within the local population. As the majority of people using the service are living in the Stockton-on-Tees, Hartlepool and County Durham area, the data is mainly focused around this population.



We recognise that there are people outside of these areas using the service, however the numbers are significantly low and therefore we cannot use their local population data to conclude impact as this is likely to distort the figures.

Who will be affected by this policy/service /process? (please tick)

✓ **Consultants** ✓ **Nurses** ✓ **Doctors** ✓ **Staff members** ✓ **Patients** ✓ **Public** ☐ **Other**
If other please state:
What is your source of feedback/existing evidence? (please tick)
✓ **National Reports** ☐ **Internal Audits** ☐ **Patient Surveys** ☐ **Staff Surveys** ✓ **Complaints/Incidents** ✓ **Focus Groups** ✓ **Stakeholder groups** ☐**Previous EIAs** ✓ **Other**
If other please state: Public Surveys, service inpatient/day case data and local data.

Evidence	What does it tell me? (about the existing service/policy/process? Is there anything suggest there may be challenges when designing something new?)
National Reports	North Tees and Hartlepool NHS Foundation Trust have informed Hartlepool and Stockton CCG that they are unable to continue to deliver safe and clinically effective assisted reproduction services in the future. National reports suggest that there were 175 patients treated between July 2013 and June 2014 (http://guide.hfea.gov.uk/guide/HeadlineData.aspx?code=31&s=l&&rate=i&rate_sub=FSO). However, this does not reflect the number of cycles provided to patients. In the 12 months to 31 July 2015, the centre provided 275 cycles of treatment (excluding partner intrauterine insemination). In relation to activity levels this is a small centre.(http://guide.hfea.gov.uk/guide/ShowPDF.aspx?ID=5939&merge=1) Risks and challenges have been identified within the 3 possible options for the future of the service. These are outlined below: **Option 1** • The CCG is unable to secure and commission an alternative provider to deliver at the Hartlepool Site **Option 2** • Patients may not be aware when starting unlicensed treatments that they may not be able to receive all of their treatments from the one site if they progress to licenced treatment. • Referrers need to be aware of the changes before referring • Capacity assessment required for other providers to ensure they have the capacity to manage additional

	patients **Option 3** • Patients already referred to the service will need to be transferred to another provider • Capacity assessment require for other providers to ensure that they have the capacity to manage additional patients.
Patient Surveys	The consultation attracted 1,220 responses from the NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group, NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group and NHS South Tees Clinical Commissioning Group population. The response breakdown is as follows: Paper survey = 900 Online survey = 320 The paper returns include survey forms extracted from the main consultation document and a two-page survey form used by focus groups and in street surveys. Online returns are typically generated by e-communications from the CCG, links from the consultation website, media activity and social media posts.
Staff Surveys	Due to the small number of staff employed within the unit, it is not possible to produce and analyse a data around staff engagement.
Complaints	In November 2015, an unannounced interim inspection from the HFEA noted one critical, one major and one other

and Incidents	area of non-compliance. The panel noted that the Person Responsible (PR) has committed to fully implementing all of the inspectorate's recommendations within the prescribed timescales. (http://guide.hfea.gov.uk/guide/ShowPDF.aspx?ID=5939&merge=1)
Results of consultations with different stakeholder groups – staff/local community groups	Respondents were asked to rank each of the three options first, second or third. The majority of respondents (58%) ranked Option 1 as their first choice. Option 2 was ranked their top selection by 23% and Option 3 by 22%. Option 1 received the highest number of respondents – 1037 compared to 991 for Option 2 and 989 for Option 3. Option 1 consisted of: • A comprehensive assisted reproductive service including HFEA Licensed and unlicensed provision remains at Hartlepool delivered by an alternative provider. The risk of this option was: • The CCG may be unable to secure and commission an alternative provider to deliver at University Hospital of Hartlepool site. The benefits of this option were: • Assuming an alternative provider can be secured, the existing provision would be maintained and patients would not see any changes. • Patients would receive all treatment in Hartlepool. • There would be no (nil) patients potentially impacted. Although the majority stated their preference is for keeping a comprehensive assisted reproductive service in Hartlepool, over 70% stated if they were or are a patient, they would be prepared

to travel to an alternative site in the northeast for assisted reproductive treatment.

39% stated a car journey time of within 20 minutes (up to 1 hour by public transport) was reasonable. 39% stated a car journey within 45 minutes (over 1 hour by public transport) was reasonable and only 22% stated a car journey over 45 minutes (over 1 hour by public transport) was reasonable.

The breakdown of support can be shown as follows.

	Ranked 1st	Ranked 2nd	Ranked 3rd	
Option 1	58%	19%	23%	
Option 2	23%	63%	14%	
Option 3	22%	17%	61%	

Option 1 was ranked the highest of the three options. 58% (of 1,037 respondents) ranking this option as the first preferred choice, with just 19% ranking this option second and another 23% ranking this option third.

Option 2 was ranked second highest of the three options. 23% (of 991 respondents) ranking this option as the first preferred choice, with 63% ranking this option second and 14% ranking this option third.

Option 3 was ranked lowest of the three options. 22% (of 989 respondents) ranking this option as the first preferred choice, with 17% ranking this option second and 61% ranking this option third.

The number of respondents in this question varies and is lower than the total number of respondents because not all paper surveys were completed in full.

Focus Groups	Focus groups were held with the aim to target the protected groups outlined in the Equality Act 2010. 19 Focus groups sessions were held around Easington area and Teesside over the consultation period. 137 adults were involved in the discussions that generally followed a structured format of facilitators outlining the background, asking if attendees knew anyone affected by ARU services and asking what was important when undergoing treatment. The feedback from attendees was scribed for analysis.
Other evidence (please describe)	As part of the consultation around the proposed changes, individuals and organisations have been given the opportunity to respond to the Public Consultation document. An online survey has been produced and is available to complete via the following link http://www.hartlepoolandstocktonccg.nhs.uk/get-involved/consultations/ . A paper version is also available upon request. An email address and postal address has also been provided within the consultation document. The online survey collects monitoring information around gender, age, ethnic group, pregnancy/maternity, disability, carers, sexuality and gender reassignment. This monitoring information will be reflected throughout this report under the respective section in relation to each protected characteristic. **Equality and Diversity Annual Report (Appendix 1)** The Trust have published their Equality and Diversity Annual Report which shows how the trust maintains its commitment to the practices of equality, diversity and human rights by embedding and maintaining this within all aspects of service provision and employment.

Equality Delivery System (EDS)

The trust are using NHS England's EDS framework in order to strengthen their compliance with the Equality Act 2010. They have identified four objectives which are as follows:

- To engage with patients, local community and stakeholders, in line with the requirements of EDS2, to ensure effective provision of services.
- To enable staff to work alongside patients and carers to determine realistic, reasonable adjustments to deliver safe, effective care to people with literacy problems, learning difficulties and dementia.
- To develop a robust system to capture data of employees from all key characteristics to enable effective monitoring of equality.
- To explore and reduce discrimination experienced by staff as identified via the staff survey through the development of proactive measures and support mechanisms to be implemented Trust wide.

Clinical senate report

The Clinical Senate were asked undertake a critical review and clinical analysis of the proposed service change in relation to the Assisted Reproduction Unit (ARU) provided by North Tees and Hartlepool Foundation Trust (NTHFT) to;

- Review clinical safety of current service delivery and workforce which takes account of the work undertaken by NTHFT in identifying the mitigating clinical risk.
- Review proposed future service model to ensure the commissioning of a sustainable future service including, efficiency, workforce, clinical safety, patient experience, current and future demand.
- Provide assurance of the option proposed or provide recommendations that will result in the commissioning of safe services for local people which has sustainability.

The following timeline was established for the production of this report

- First draft available to CCG for accuracy check in early week commencing 13th June 2016
- Final version available week commencing 20th June 2016 It

	was recognised by all concerned that this timeline was much tighter than usually expected for a Clinical Senate report. The full report can be found at the following web address: http://www.hartlepoolandstocktonccg.nhs.uk/get-involved/have-your-say-2/fertility-services-public-consultation/

STEP 2 - IMPACT ASSESSMENT

What impact will the new policy/system/process have on the following: (Please refer to the 'EIA Impact Questions to Ask' document for reference)

Age A person belonging to a particular age

The ARU Service at UHH provides services to all regardless of their age, based on clinical need. The service is currently open to people who meet the criteria of the value based North East Clinical Commissioning Policy for Invitro Fertilisation (IVF) and Intra Cytlopasmic sperm injection (ICSI). This will continue to be open to people who continue to meet the above criteria if the changes set out in option 1,2 or 3 go ahead.

The service does not make assumptions against people because of their age, and information that is provided gives positive messages to all age groups, it is available in a variety of formats to reach different ages such as written, verbal and online information.

Service & Local data

The data in Table 1 shows those admitted to the ARU unit for a procedure as either a day case or inpatient, the age range of those admitted is between 20 and 49 years old . There has been a reduction in the amount inpatients using service, from 386 in 13/14 to 229 in 15/16. Between 2013 and 2015, the average age of those using the service remained the same (30-34), however in the last year (15/16) this has reduced to those aged 25 to 29.

Table 1 (SUS Data)

	Age 20 to 24	Age 25 to 29	Age 30 to 34	Age 35 to 39	Age 40 to 44	Age 45 to 49	Total
13/14	16	100	139	103	27	1	386
%	4%	26%	36%	27%	7%	0%	100%
14/15	9	89	120	101	23	3	345
%	3%	26%	35%	29%	7%	1%	100%
15/16	8	96	53	57	15	0	229
%	3%	42%	23%	25%	7%	0%	100%
Total	33	285	312	261	65	4	960

Table 2 shows an age breakdown of the population of Hartlepool, Stockton and

County Durham, these areas being where the majority of patients using the service reside. Those using the service are between the age of 20 and 49 (Table 1) and therefore the local population data between this range has been analysed.
Of those aged between 20 and 49, the highest age range of those living in the Hartlepool, Stockton on Tees and Durham areas are those aged 45 to 49.

Table 2 (Census, 2011)

Hartlepool							
Age	Age 20 to 24	Age 25 to 29	Age 30 to 34	Age 35 to 39	Age 40 to 44	Age 45 to 49	Total
Population	5955	5622	5033	5373	6463	7267	35713
%	17%	16%	14%	15%	18%	20%	100%
Stockton							
Age	Age 20 to 24	Age 25 to 29	Age 30 to 34	Age 35 to 39	Age 40 to 44	Age 45 to 49	Total
Population	12,651	12,602	11,445	12,003	12,602	14,644	75,947
%	17%	17%	15%	16%	17%	19%	100%
Durham							
Age	Age 20 to 24	Age 25 to 29	Age 30 to 34	Age 35 to 39	Age 40 to 44	Age 45 to 49	Total
Population	35155	30628	28133	30498	37519	39537	201470
%	17%	15%	14%	15%	19%	20%	100%

There is no direct correlation between those using the service compared to their population representation. There is a significanlty low number of people between the ages of 45 and 49 using the service in comparison to their representation within the population, however this is likely to be due to the nature of service and the main users being young people wishing to start families.

Staff

The trust does collect and publish data in relation to age and this is available in the Equality and Diversity Annual Report (Appendix 1), this EIA is focussing on the ARU and due to the small numbers of staff within the unit we are unable to publish the

data due to the risk that it may become identifiable.

We do know that the proposed changes set out in 2 of the options could possibly provide more opportunties for development, likely to have a positive impact on staff of all ages.

All staff within the ARU Unit currently undertake Mandatory Equality and Diversity Training which covers this protected group and ensures staff are fully aware of the impacts and difficulties facing younger and older people both when accessing services and within the workplace.

The Trust have an Equality and Diversity Steering group which is made up of representatives across the trust, there are two people named as leads for Age (younger and older people) and they play a vital role in ensuring that equality, diversity and inclusion are incorporated within everyday working practices in relation to age.

Engagement

The following table is a guide to the representation by age group. It shows consultation responses versus census data for County Durham Unitary Authority (UA), Hartlepool UA, Middlesbrough UA, Redcar and Cleveland UA, Stockton-on-Tees UA. Note: County Durham Unitary Authority. Operative since 1 April 2009, it is the same area covered by the former districts of Chester-le-Street, Derwentside, Durham, Easington, Sedgefield, Teesdale and Wear Valley.

From this table it is clear the age groups 20-44 are over represented in proportion to total population.

	Age band	**Age band**	**Age band**	**Age band**	**Age band**	**Age band**	**Age band**
	20 – 24	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75 over**
Total population 1,070,469	7%	12%	13%	15%	13%	9%	8%
Consultation responses stating age – 1,040	11%	27%	27%	14%	10%	6%	4%

Source: Census 2011. Please note total population varies to population figures quoted by CCGs earlier in this document.

Impact – Option 1, 2 and 3

The service is currently open to people of all ages, and regardless of which option is chosen, this will still be the case, although due to the nature of the service, there is a specific age group which make up the majority of service users.

The majority of people who used the service last year are those between the ages of 25 and 29, this has been taken into consideration throughout the engagement around the 3 options of what the service may look like in the future.

The engagement has involved many different methods in order to gather the views and opinions of those from all age groups, including social media, written (postal), online and paper surveys.

We do not believe that there will be anything from any age category that would discourage a service user from this protected group. However, we are aware of the need to focus on the age bracket of all of those using the service from the age of 20 – 47, paying particular attention to those highest users between the ages of 25 and 34. **Conclusion:** No negative impact for any of the three options, however action identified to ensure full support of those aged between 25 and 34.

Disability A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities

The Trust are fully aware that not all disabilities are visible, and that any communications with the public around the ARU at UHH need to be available in various formats taking into consideration the communication needs of people with various disabilities, ensuring information is easy to read and understand.

Service and Local Data

Currently, it is not a mandatory requirement that the trust collect data around who is using the service in relation to disability within the ARU, therefore local data has been used to assess the impact of the proposed changes in relation to this protected group. Again, this data includes Hartlepool, Stockton and County Durham as these are where the majority of service users reside.

Table 3 has been taken from the 2011 Census and shows that there are more people who believe that their day-to-day activities are limited a lot in Hartlepool and County Durham, however the figures are very similar across the 3 areas.

There is a fairly significant number (23%) of people who consider themselves as to having their day to day activities limited by some degree, and this needs to be taken into consideration for all of the 3 proposed options to prevent this group from being negatively affected by the changes.

Table 3 (Census 2011)

Variable	Hartlepool	%	Stockton-on-Tees	%	County Durham	%	Total	Total %
Day-to-Day Activities Limited a Lot	11,137	12%	17,677	9%	62,875	12%	91,689	12%
Day-to-Day Activities Limited a Little	10,178	11%	18,731	10%	58,411	11%	87,320	11%
Day-to-Day Activities Not Limited	70,713	77%	155,202	81%	391,956	76%	617,871	78%
Whole population	92,028	100%	191,610	100%	513,242	100%	796,880	100%

Staff

It is not possible to publish data in relation to Disability around the staff currently employed on the ARU due to the small numbers working on the Unit, however, the Trust have reported on disability within their Equality and Diversity Annual Report which can be seen in Appendix 1.

The Equality and Diversity Mandatory training provides training around disability, ensuring staff treat people with a physical or mental health condition, learning disability or sensory impairment with respect and dignity.

Within the Equality and Diversity Working Group, there are three named disability leads for Physical, Sensory and Learning Disability groups that have a role in working towards promoting issues or negative impacts or experiences that these groups face through the access of services and also within the workforce.

If data was available in relation disability around those using the ARU service, this would further the analysis on the impact of this protected group. We have therefore reflected our recommendations below and within the action plan.

Engagement

Respondents were asked *'Do you consider yourself to have a long*

standing illness or disability?'

- 14% answered 'Yes'
- 84% answered 'No'
- 1% preferred not to say

Impact

Option 1

Patients are not likely to see any real changes when using the service and therefore it is unlikely that anyone from this protected group will be impacted. The "alternative" provider will need impact assess any changes made to the service in the future to ensure that this protected group do not receive any unfair disadvantage. The service is currently physically accessible to people with mobility problems and wheelchair users. **Conclusion**: No negative impact.

Option 2

This option means that those requiring licenced provision of services will need to go to an alternative site for this treatment. As services are already provided in these sites, we would assume that these have already been impact assessed and that services that are provided are fully accessible, information is available in a variety of formats and interpreters can be arranged if necessary. The service should already be physically accessible to those with mobility problems and wheelchair users.

With this option, there is a risk to patient experience which could impact this group more so than others. Referrers need to be fully aware of the changes and the patients should be fully supported through the transition, further support may need to be provided to those with learning difficulties. The trust will also need to consider transport links to and from the new provider. **Conclusion:** Negative impact, mitigated within the action plan.

Option 3

If this is the chosen option, all patients will be referred to another site within the region. All risks outlined in Option 2 also apply to this option, the trust need to consider supporting patients with a disability through this process, ensuring transport is appropriate and patients are fully supported the transition of services to prevent negative experiences or unintended consequences. **Conclusion:** Negative impact, mitigated within the action plan.

Gender reassignment (including transgender) Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self perception.

A transgender person is someone who proposes to, starts or has completed a process to change his or her gender. Currently, data in this area is not routinely collected either at a service level and national data is limited.

Staff

The Equality and Diversity Mandatory training undertaken by all staff ensures that they are fully aware of the potential negative impacts this group may experience both within the workforce and for patients when accessing services.

At present the trust are not able to report on this equality strand as these details are not captured on the standard documents / application forms that are used to gather personal details. However, any member of staff is undergoing gender reassignment is supported both by their manager and HR through their transition and the various issues that may arise in relation to that process within the workplace.

Within the Trusts Equality and Diversity working group, there is a named lead for Gender Reassignment who has a role in working with staff to ensure they are fully aware of the negative experience this group may face both within the workplace and also when accessing services.

Engagement

Respondents were asked *'Have you undergone gender reassignment?'*

- Less than 1% answered 'Yes'
- 97% answered 'No'
- 3% preferred not to say

Impact – Option 1,2 and 3

From the available evidence, we have not identified any negative impact for this group. However, within the next Census we understand that this data will be collected and would advise the trust to ensure that when available this is taken into consideration when changes are made to any services. We would also recommend working towards collecting this at a service usage level, however understand that this is one of the objectives identified as part of the EDS2. **Conclusion:** No negative impact identified.

Marriage and civil partnership Marriage is defined as a union of a man and a woman (or, in some jurisdictions, two people of the same sex) as partners in a relationship. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters

Although the Trust do collect data in this area at a service level, it is not a mandatory field and therefore sparsely populated. The Census data in Table 4 shows the

population breakdown of those living in the 3 areas. The majority of people are living in a couple or married. This group are significant and need to be fully considered in any changes, as the majority of people using this service are like to be in a couple or married and wishing to start a family.

Table 4 (Census 2011)

Variable	County Durham	%	Stockton-on-Tees	%	Hartlepool	%	Total	Total %
All Usual Residents Aged 16 and Over in Households	412,617	100%	150,859	100%	73,296	100%	636,772	100%
Living in a Couple; Married	195,198	47%	71,075	47%	32,264	44%	298,537	47%
Living in a Couple; Cohabiting	46,333	11%	18,307	12%	8,924	12%	73,564	12%
Living in a Couple; In a Registered Same-Sex Civil Partnership or Cohabiting (Same-Sex)	2,704	1%	1,167	1%	427	1%	4,298	1%
Not Living in a Couple; Single (Never Married or Never Registered a Same-Sex Civil Partnership)	97,195	24%	36,116	24%	18,753	26%	152,064	24%
Not Living in a Couple; Married or in a Registered Same-Sex Civil Partnership	3,540	1%	1,436	1%	599	1%	5,575	1%
Not Living in a Couple; Separated (but Still ... or Still Legally in a Same-Sex Civil Partnership)	8,597	2%	3,136	2%	1,494	2%	13,227	2%
Not Living in a Couple; Divorced or Formerly ... Civil Partnership which is Now Legally Dissolved	29,133	7%	9,964	7%	5,428	7%	44,525	7%

Not Living in a Couple; Widowed or Surviving Partner from a Same-Sex Civil Partnership	29,917	7%	9,658	6%	5,407	7%	44,982	7%

It is likely that people from this protected group will see an impact upon any changes to this service regardless of their status, it must not be assumed that those who are "Not living in a couple" would not want to access the service. The ARU treats all patients regardless of their status, and this will continue to be the case when the changes set out in either option 1, 2 or 3 are made.

Staff

The Equality and Diversity Mandatory training provided to all staff ensures that they are aware of civil partnerships rights and competent in applying them. It ensures that staff are aware that patients and also the workforce should not be treat any differently because of their status. Within the Equality and Diversity Working group, there is a named lead for Marriage and Civil Partnership who has a role to ensure that staff foster good relations between people who are and are not of this protected group.

Engagement

Those who are married or in a civil partnership have been consulted through the use of focus groups and surveys.

Impact – Option 1, 2 and 3.

Although it is likely that the majority of service users will have this characteristic, we believe that they are likely to see a positive impact and improvement when using services. This group will need to be fully supported through the transition of services if options 2 or 3 are chosen. If option 1 is chosen, this group are not likely to see any significant change when using this service. We have not identified any factors that are likely to negatively impact this group. We have highlighted that this group are likely to be high users of the service and have been consulted with throughout.
Conclusion: No negative impact.

Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.

This protected group is directly related to the service being provided. The consultation has paid particular attention to those of this protected group to understand the needs and wishes of those who are pregnant or who have recently

given birth. This service gives those with a qualifying clinical need the ability to access treatment. There are no aspects that would leave a woman who was pregnant or on maternity leave at a disadvantage.

Although service users are unlikely to be pregnant when using the service, the hospital can provide breastfeeding facilities at the request of the service user.

Staff

The mandatory Equality and Diversity training covers this protected group and ensures that staff are fully aware of the needs of this protected group. Staff have been engaged throughout the consultation period and there are currently no members of staff on maternity leave on the unit.

The Equality and Diversity working group has a named lead for pregnancy and maternity, and their role is to ensure that good relations are fostered across members of staff and with those who are accessing the service.

Engagement

Respondents were asked *'Please tell us if you are pregnant or have a*

child under two years old'

- 20% answered 'Yes'
- 78% answered 'No'
- 2% preferred not to say

Impact – Option 1, 2 and 3

The options aim to improve the services received by patients, and people of this protected group are not likely to be pregnant when initially accessing the service, however some women may have young children already and need facilities for example baby changing and breastfeeding. These are available within the hospital currently, leaving this group not likely to be negatively affected in relation to Option 1.

We trust that the alternative providers in relation to Option 2 and 3 would also have these facilities and that their service has already been impact assessed, however would advise that if any changes are made another EIA is carried out to prevent any unintended negative consequences.

Due to the direct contact staff have with patients who are trying to conceive, they are fully aware of the needs of this protected group and we therefore do not believe that they are likely to experience any negative impact. **Conclusion:** No negative impact

Race It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.

The Trust is aware of the diverse population of which it services and strives to ensure that people from minority ethnic backgrounds are not negative impacted when accessing services. The ARU is currently available to all and the trust have mechanisms in place for this protected group to ensure that people are respected regardless or their ethnicity/race.

Local

The local area has a diverse population, the trust fully understand the need to ensure services are accessible, taking into account cultural issues. The current ARU is accessible to the population regardless of their ethnic background. Information is available in different languages for all service users at their request.

Across the 3 areas, there is a total make up of 97% people who state they are of a white ethnicity. 2.5% of the population are from a Black/ Minority Ethnic background (BME). The trust recognises that these communities may speak different languages and Interpreters can be requested for appointments when and where appropriate though the use of Everyday Language Solutions and staff on the unit are aware of the process around booking this service to ensure that information is understood.

Table 5 (Census 2011)

Ethnicity	Hartlepool	%	Stockton-on-Tees	%	County Durham	%	Total	Total %
All Usual Residents	92,028	100.00%	191,610	100.00%	513,242	100.0%	796,880	100.0%
White	89,899	97.7%	181,299	94.6%	503,769	98.2%	774,967	97.3%
Mixed/ Multiple ethnic groups	550	0.6%	1997	1.0%	3094	0.6%	5,641	0.7%
Asian/Asian British	1304	1.4%	6,632	3.5%	4,856	0.9%	12,792	1.6%
Black/African/Caribbean/Black British	170	0.2%	1133	0.6%	701	0.1%	2,004	0.3%
Other Ethnic Group	105	0.1%	549	0.3%	822	0.2%	1,476	0.2%

Service Usage

The table below shows inpatient/ day cases admitted to the ARU broken down by ethnic group. The majority of inpatients admitted to the ARU at UHH are British; this is expected due the high representation of this group living in the area. Last year, 3% of service users reported that they were from a Pakistani background, this is an increase since 13/14, however is still relative in relation to their representation within

the local community.

Table 6 (SUS Data)

Ethnic Category	13/14	%	14/15	%	15/16	%	Grand Total
Any other Asian background			3	1%			3
Any other White background	2	1%					2
British	384	99%	336	96%	218	95%	938
Indian			1	0%			1
Pakistani			2	1%	7	3%	9
Any other ethnic group			1	0%	4	2%	5
Any other mixed background			2	1%			2
Grand Total	386		345		229		960

We do not believe that the data from any ethnic groups reflects that anyone would see a disadvantage in changes to this service, however the trust need to be mindful that a minority of service users are from a Pakistani origin and service should be tailored to suit the needs of this group when and where appropriate.

Staff

Staff receive mandatory Equality and Diversity Training which includes information about this protected group, ensuring that staff are fully aware of any negative impacts that they may face both in the workplace and when accessing services.

The Equality and Diversity Working Group within the trust has a named Ethnicity Lead who has a role of ensuring good relations are fostered between people who share this characteristic and those who do not.

The trust have published data on the Workforce Race Equality Standard which aims to improve workplace experiences and employment opportunities for Black and Minority Ethnic (BME) people in the NHS, or those who want to work in the NHS, by taking positive action to help address workforce race inequalities.

The trust have demonstrated through the Workforce Race Equality Standard metrics how they are addressing race equality issues in a range of staffing indicators and this information is available within their Equality and Diversity Annual Report (Appendix

1).

Engagement

Respondents were asked *'Please identify which ethnic group you consider yourself to be'*

- 91% answered 'White'
- 3% answered 'Mixed/Multiple ethnic groups'
- 2% answered 'Asian/Asian British'
- 2% answered 'Other ethnic group'
- 1% answered 'Black/African/Caribbean/Black British'

Impact

Option 1
It is unlikely that this protected group would be negatively impact by this option, as patients are unlikely to see any real changes to the service. However, we would suggest that any future changes to the service are fully impact assessed so that there are no unfair disadvantages to this group. **Conclusion:** No negative impact.

Option 2
Service Option 2 proposes to deliver licenced provision at an alternative site, with this option there is a risk that patients may not be aware that they need to have this service delivered at a different site. Information should be clear and provided in alternative languages so that this group do not face an unintended negative impact. The consultation information should be available in a variety of languages to suit the needs of those BME communities. We trust that the alternative site will also have interpretation services available to them, and that when any changes are made they will be impact assessed.
Conclusion: No negative impact, however actions within the action plan identified to mitigate risk (A004)

Option 3
Service option 3 involved the provision of all HFEA services at an alternative site, the risks for this group are outlined in Option 2. Information needs to be clear, and provided in alternative languages where possible. Again, information should be available in a variety of languages and interpretation services should be made available. **Conclusion**: No negative impact, however actions within the action plan identified to mitigate risk (A004).

Religion or belief Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

Religion or Belief is not currently collected on a mandatory basis by the trust, however the ARU is religiously and culturally sensitive to meet the needs of people from various religious backgrounds.

Local data

The 2011 Census provides a local overview of population currently served by the UHH. The majority of the population that the service currently serves report being of a Christian religion. However, it is clear to see that there is a high percentage of Muslims living in the Stockton-on-Tees area. This is significant in relation to the service, as the majority of inpatients/day cases on the Unit are from this area.

Table 7 (Census 2011)

Religion/Belief	Hartlepool	%	Stockton-on-Tees	%	County Durham	%	Total	Total %
All Usual Residents	92,028	100.00%	191,610	100.00%	513,242	100.00%	796,880	100.00%
Christian	64,349	69.92%	130,723	68.22%	369,715	72.04%	564,787	70.87%
Buddhist	152	0.17%	388	0.20%	1,001	0.20%	1,541	0.19%
Hindu	168	0.18%	675	0.35%	607	0.12%	1,450	0.18%
Jewish	9	0.01%	94	0.05%	208	0.04%	311	0.04%
Muslim	689	0.75%	4,143	2.16%	1,934	0.38%	6,766	0.85%
Sikh	97	0.11%	625	0.33%	609	0.12%	1,331	0.17%
Other Religion	178	0.19%	382	0.20%	1,525	0.30%	2,085	0.26%
No Religion	20,507	22.28%	42,910	22.39%	107,281	20.90%	170,698	21.42%
Religion Not Stated	5,879	6.39%	11,670	6.09%	30,362	5.92%	47,911	6.01%

The trust ensure they meet the needs of people of different religious beliefs, at the University Hospital of Hartlepool there are multi-faith rooms readily available which provide a welcoming area for all, especially those of traditional faith. The rooms are near to the entrance of the chapels for all staff, visitors and patients. There are

ablution facilities, spiritual resources and books for various faith traditions.

Staff

The mandatory Equality and Diversity training ensures that staff are fully aware of the rights of those from differing religions and of differing beliefs. Clinical staff receive training to understand the needs of their patients, such as respecting their beliefs around, for example, being treat by a member of staff of the same gender and respecting the wishes of those who have particular beliefs around blood transfusions, respecting religious holidays (such as Ramandan) and being flexible around meal times.

The Equality and Diversity working group has a named lead who has the role of ensuring staff are aware of the particular needs of those with differing religions.

Engagement

The public have been engaged through the process with the aim of reaching all protected groups through the use of many differing formats.

Impact

Option 1
This option is unlikely to negatively affect anyone from this group as the service will very much remain the same/similar and currently provisions are already in place for this protected group including multi-faith rooms which cater for all religions and a wide variety of food options available to patients. **Conclusion**: No negative impact

Option 2
With this option, patients are unlikely to see any difference unless they are referred for licenced provision which will be delivered at an alternative site. We trust that the service at this site will be fully impact assessed and the same facilities will be available (such as multi-faith rooms and specialist dietary requirements) and therefore it is not likely that this group will face any unintended negative consequences. **Conclusion**: No negative impact.

Option 3
For option 3, all services will be delivered at other sites in the region. We would expect that an impact assessment has already taken place, or will take place as these other sites and that the alternative sites will also have the same facilities as the UHH to ensure this group are not negatively impacted. **Conclusion**: No negative impact.

Sex/Gender A man or a woman.

The majority of people admitted to the ARU for treatment either as an inpatient or a

day case are female, a small minority of patients are men. The trust do consider that when patients are receiving IVF that this can affect both the man and woman. The service treats anyone who clinically qualifies, regardless of their gender.

Local

The table below shows the male/female breakdown of the local population. There is an even male/ female split across all three areas. The ARU service is used significantly more by females however this is due to the nature of the service itself rather than the representation of the male/female split in the area.

Table 8 (Census 2011)

Gender	Hartlepool	%	Stockton-on-Tees	%	County Durham	%	Total	Total %
All Usual Resident	92,028	100%	191,610	100%	513,242	100%	796,880	100%
Males	44,751	49%	94,082	49%	251,280	49%	390,113	49%
Females	47,277	51%	97,528	51%	261,962	51%	406,767	51%

Service Usage

The table below shows a breakdown of those admitted to the ARU by either day case or as an inpatient at UHH by gender. Since 2013, there were a total of 949 female patients and 11 male patients treated at this hospital. The number of females using this service has significantly reduced over the last three years however the male usage remains relatively stable but this could be due to the initial small number of users.

Table 9 (SUS Data)

Gender	13/14	%	14/15	%	15/16	%	Grand Total
Female	383	99.22%	340	98.55%	226	98.69%	949
Male	3	0.78%	5	1.45%	3	1.31%	11
Grand Total	386	100.00%	345	100.00%	229	100.00%	960

A professional and confidential counselling service is available free of charge to all those attending the Assisted Reproduction Unit for fertility procedures

Engagement

The consultation had a high number of female respondents.

	Male	Female
Total population	49%	51%
Consultation responses stating gender	27%	73%

Impact – Option 1, 2 and 3

Females are the highest users of this service, with very little males receiving treatment. This group are likely to be impacted by changes set out in options 2 and 3, however we have not identified anything that would mean this group experiencing an unintended negative consequence. The engagement has taken into account that the majority of users are female and this is reflected throughout the Consultation Report **Conclusion:** No negative impact.

Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes

Data around this protected group is not currently collected nationally, locally or at a service level. The trust Equality and Diversity Policy respects Lesbian, Gay and Bisexual (LGB) people. It ensures that those working within the trust respect and foster good relations between their colleagues and patients and the public who are of this protected group.

The HFEA released a report in 2013 which shows that "The number of IVF treatment cycles involving same-sex female couples has increased by nearly 20% year-on-year, rising from 766 treatments in 2011 to 902 in 2012. The number of donor insemination cycles involving same-sex couples (DI) rose by nearly 15%, from 1,271 in 2011 to 1,458 in 2012 [8]. These amount to a minority of overall treatments undertaken in the period covered." (http://www.hfea.gov.uk/docs/HFEA_Fertility_Trends_and_Figures_2013.pdf). Although this is only a minority, the trust should be fully aware in the increasing demand, ensuring that the staff are up to date with their training to fully understand the needs and rights of this group.

Staff

The Equality and Diversity Mandatory training covers "Making Judgements", which

ensures that staff are trained to not be prejudice when patients or other colleagues disclose their sexual orientation and respect the rights of this group.

The Equality and Diversity Annual Report publishes trust wide data around sexual orientation, however due to the small number of staff working on the unit we cannot publish data around the staff on the Unit.

The Equality and Diversity Working group have a named Sexual Orientation lead who plays a key role in ensuring that good relations are fostered between people who are of this protected group and who are not.

Engagement

Respondents were asked *'How would you describe your sexuality?'*

- 90% answered 'Heterosexual or Straight'
- 5% answered 'Gay or Lesbian'
- 4% answered 'prefer not to say'
- 1% answered 'Bisexual'
- 0.1% answered 'Other'

Impact – Options 1, 2 and 3

There is no evidence to suggest that this group will be negatively effected. Although regardless of which option is chosen, the provider needs to be aware that there is an increasing demand of same sex couples wishing to have IVF and any changes in the future should be impact assessed to ensure that this group have equal access and rights to the service. **Conclusion:** No negative impact.

Carers A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person

The Trust recognise that a large percentage of the population they serve are carers and that they need to take into account the needs of this could when delivering services for people who are providing care and also for those who need a carer with them when accessing service.

Local

A total of 6% of the local population regard themselves as providing 1 – 19 hours of unpaid care a week and 3% provide 50 or more hours. Although we have no service data to show how many of those using the service are carers or need care to access services, the ARU needs to consider this group and how they may have

differing needs to those who are not of this protected group.

Considerations need to be given to patients who may be carers and also those who care for the patients that may be using the service, this means providing a service that is flexible and providing options for appointment times.

Table 10 (Census 2011)

Variable	Hartlepool	%	County Durham	%	Stockton -on-Tees	%	Total	Total %
All Usual Residents (Persons)	92,028	100%	513,242	100%	191,610	100%	796,880	100 %
Provides No Unpaid Care (Persons)	82,104	89%	453,187	88%	171,686	90%	706,977	89%
Provides 1 to 19 Hours Unpaid Care a Week (Persons)	5,325	6%	34,336	7%	11,683	6%	51,344	6%
Provides 20 to 49 Hours Unpaid Care a Week (Persons)	1,555	2%	8,826	2%	2,933	2%	13,314	2%
Provides 50 or More Hours Unpaid Care a Week (Persons)	3,044	3%	16,893	3%	5,308	3%	25,245	3%

Staff

The Equality and Diversity Mandatory training ensures that staff consider those with protected characteristics both within the workforce and with regards to patients when accessing services. They are aware of the need to provide flexibility for this specific group.

Engagement

Respondents were asked *'Are you a carer?'*

- 11% answered 'Yes'
- 87% answered 'No'
- 2% preferred not to say

Impact

Option 1
This option means that it is not likely that any real change will be seen in service provision. Therefore this group are not likely to be negatively affected. We would advice that if the new provider does propose any changes, that these are fully impact assessed. **Conclusion**: No Negative impact.

Option 2 and 3
Patients accessing the service may need to attend with a carer, or the patients themselves may be carers, if either of these two options are chosen, the service needs to consider flexibility around appointment times to suit the needs of this group, however we would trust that the new provider has already impact assessed their service and this group are fully considered in the provision. **Conclusion**: No negative impact identified.

Other identified groups such as deprived socio-economic groups, substance/alcohol abuse and sex workers

Deprivation

The Trust are aware that people from deprived areas often have poorer health, they understand that the population they serve currently has higher deprivation than the national England average. Consideration should be given to those who are living in these areas, such as travel, childcare costs and the level of health education for this group.

Local

The table below shows some key deprivation data for the areas in comparison to the England national average. Unemployment rate is currently higher than the national England average in all three areas, and there are more people claiming jobseekers allowance in Hartlepool and Stockton-on-Tees than the national England average. This needs to be taken into account with any changes to the ARU.

Variable	Stockton (%)	Hartlepool (%)	County Durham (%)	England (%)
Economically Active People Aged 16-64 (Persons, Apr12-Mar13)	78.3	70.2	72	77.3

Employment Rate; Aged 16-64 (Persons, Apr12-Mar13)	69.4	60.9	67.6	71.1
Unemployment Rate; Aged 16-64 (Persons, Apr12-Mar13)	10.5	12.9	9.2	7.8
All People of Working Age Claiming a Key Benefit (Persons, Aug10)	18	25	20	15
Jobseeker's Allowance Claimants (Persons, Aug10)	5	7	4	4
Incapacity Benefits Claimants (Persons, Aug10)	8	11	10	7

Engagement

19 focus groups were held across Tees Valley over the consultation with 137 adults being involved. These were delivered by Healthwatch and voluntary sector organisations that have strong relationships with hard to reach groups in the community.

Impact

Option 1

Patients are not likely to see any significant impact in relation to option 1, the service is to remain in the same location. **Conclusion:** No negative impact

Option 2 and 3

These options outline the proposal for some or all of the current services provided to be delivered elsewhere. This would have a potential negative impact for those living in the most deprived areas. The trust need to consider the cost implications around travel for those living in different geographical areas, in particular those outside the local area. **Conclusion:** Negative impact identified, mitigated within the action plan.

STEP 3 - ENGAGEMENT AND INVOLVEMENT

How have you engaged stakeholders in testing the policy or process proposals including the impact on protected characteristics?

A wide range of stakeholders have been involved throughout the process through many different forms of communication. A full stakeholder map can be seen in appendix 2.

Internal Stakeholders

Staff have been involved and informed throughout the consultation period and weekly meetings have been held with senior managers, staff will be supported through ongoing cultural and organisational changes.

Key clinicians have played a key role in the development of the three options to understand the current issues in providing the service as it stands. They have been kept informed through clinical networks, representative bodies, and individual correspondence and throughout the consultation period.

External Stakeholders

Methods of engagement

In addition to the communications materials described in Section 2, all used to engage with members of the public and stakeholders, a number of additional activities included:

3.1 Stakeholder meetings

To support the consultation the CCG devised and delivered an ongoing engagement programme to ensure dialogue with key stakeholders. This programme included:

Overview and scrutiny committees

Healthwatch

Health and wellbeing boards

Staff engagement – NHS trusts

3.2 Focus groups

19 Focus groups sessions were held around Easington area and Teesside over the consultation period. 137 adults were involved in the discussions that generally followed a structured format of facilitators outlining the background, asking if attendees knew anyone affected by ARU services and asking what was important when undergoing treatment. The feedback from attendees was scribed for analysis. For a breakdown of comments see Section 5.4

3.3 Street surveys

750 street surveys were carried out between 7th and 14th June 2016 in three CCG areas (NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group, NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group and NHS South Tees Clinical Commissioning Group) by a specialist agency.

250 were completed in each of the three areas. A survey worker would explain the changes that were happening, encourage reading of the consultation document (where required), handle questions and facilitate assisted completion of the survey in the presence of the member of public. This enabled robust collection of data.

Verbal feedback can be summarised as:

- Many people didn't know that the services might be changing
- Most felt they would travel as far as needed for the service although they stated transport might be costly
- Some didn't think there was much difference in the options
- Some religious groups were vocal against the service.

Barnard Castle	10th June	Stainton market place and car park
Billingham	8th June	Forum, market square, Crown building
Bishop Auckland	9th June	
Cockfield	10th June	Prospect square
Crook	10th, 11th & 13th June	Hope Street, New Road
Easington	12th June	Low Row
Eston	8th June	Eston Square
Guisborough	7th June	Westgate shops
Hartlepool	7th, 13th & 14th June	The Quays, railway station, Middleton Grange
Loftus	12th June	West Road
Marske	11th June	High Street
Middlesbrough	13th & 14th June	Grange Road, railway station, Hill Street Centre
Middleton-in-Teesdale	8th June	Near Market Place Bakery
Newton Aycliffe	10th June	Beverage Way
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Redcar	7th, 8th & 10th June	Lord Street, Clock Tower, High Street, Esplanade
Saltburn	9th & 12th June	Milton Street
Seaham	7th June	Byron Place
Sedgefield	12th June	Front Street
Spennymoor	9th June	High Street – near leisure centre
Stanhope	10th, 11th & 13th	Market Place, Dales Centre, Bus station

Stockton-on-Tees	7th & 12th June	High Street, Wellington Street, Town Centre
Thornaby	10th June	Pavilion shopping centre
Tow Law	11th & 13th June	High Street
Willington	13th June	High Street near Office
Wolsingham	13th June	Market Place
Yarm	9th & 10th June	High Street

The consultation has been shared to gather the views, experiences and ideas of the public in through the use of an online survey (with the option of a paper service which can be provided by request), social media and also the option to write to the CCG directly.

Please list the stakeholders engaged:

A detailed stakeholder map has been development and this can be viewed in appendix 2. This map includes:

- Providers (NHS Trusts)
- General Public and patients
- Staff
- Voluntary development agencies (HVDA and Catalyst)
- Charity and community groups
- Statutory authorities and regulatory bodies (such as Overview and Scrutiny Committees)
- Internal (such as other CCGs)
- Media (such as local and national radio and TV)
- Government (such as MPs)
- Health partners (such as NHS England)
- Public sector parties (such as NHS England)

STEP 4 - METHODS OF COMMUNICATION

What methods of communication have you used to inform service users of the changes?
✓ Verbal – stakeholder groups/meetings ✓ Verbal - Telephone ✓ Written – Letter ✓ Written – Leaflets/guidance booklets ✓ Email ✓ Internet ✓ Other
If other please state: Focus Groups and Questionnaires

ACCESSIBLE INFORMATION STANDARD

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

Tick to confirm you have you considered an agreed process for:
✓ Sending out correspondence in alternative formats. ✓ Sending out correspondence in alternative languages. ✓ Producing / obtaining information in alternative formats. ✓ Arranging / booking professional communication support. ✓ Booking / arranging longer appointments for patients / service users with communication needs.

If any of the above have not been considered, please state the reason:

STEP 5 - SUMMARY OF POTENTIAL CHALLENGES

Having considered the potential impact on the people accessing the service, policy or process please summarise the areas have been identified as needing action to avoid discrimination.

Potential Challenge	What problems/issues may this cause?
1 Engagement with those from all age groups	The highest users of this service are those between the ages of 25 and 34. If these groups are not engaged throughout the process then confusion may occur if services are relocated.
2 Supporting those who have already been referred into the service	Patient experience may suffer due to this potential challenge, and this may affect those with a disability more than others.
3 Supporting staff members through changes	If staff members are not supported throughout the whole process and kept informed along the journey this may leave them feeling undervalued, unsupported and have a negative impact upon moral
4 Engagement with those who have used the service in the past	Although communications have gone out to a wide variety of the public, it is not likely that they will reach anyone who has used the service in the past. This is due to the small numbers of people currently accessing the service.

5 Data	The trust is not currently collecting data around who is using the service, it is difficult to fully assess the potential negative impact on those using the service without the data to support this.

STEP 6- ACTION PLAN

Ref no.	Potential Challenge / Negative Impact	Protected Group Impacted (Age, Race etc)	Action(s) required	Expected Outcome	Owner	Timescale/ Completion date
A001 (All Options)	Those between the ages of 25 and 34 are high users of the service and are likely to be negatively affected if not engaged thorough throught the proces	Age	Focus groups have been set up to ensure those from all ages are targeted within the engagement, paying particular attention to those between the ages of 25 and 34 years old.	We trust that the engagement will reach out to all age ranges and their views are taken into consideration throughout decision making.	Sarah Murphy	July 2015
A002 (Option 2 and 3)	Supporting those with a disability through the transition of moving to a	Disability	Focus groups have been set up with the aim of reaching out to this protected group.	We trust that the engagement will reach out to some members of the public who have a disability and that their views are taken into consideration	Sarah Murphy	July 2015

	different provider			throughout decision making.		
A003 (Option 1)	Data currently held by trust around who is using the service	All	The trust have an equality objective to work towards improving their data as part of the EDS2 Framework	Increase in data held around the protected groups	Elizabeth Morrell	2016/17
A004 (All options)	Those speaking non-English are not fully aware of the implication of the proposed changes	Race	Consultation documents and information throughout the transition or change to be available in a variety of languages and formats.	We trust that the engagement will reach out to this group and their views are taken into consideration throughout decision making.	Sarah Murphy	July 2017
A005	Consider travel implications for those living in deprived areas	Deprivation				
A006	Supporting staff through the cultural and organisational change	Staff				

Ref no.	Who have you consulted with for a solution? (users, other services, etc)	Person/ People to inform	How will you monitor and review whether the action is effective?
A001	Sarah Murphy	N/A	To be reviewed throughout the consultation process
A002	Sarah Murphy	N/A	To be reviewed throughout the consultation process
A003	Elizabeth Morrell	N/A	This will be measured and followed up using the Equality Delivery System 2.
A004	Sarah Murphy	N/A	To be reviewed throughout the consultation process
A005			
A006	Jane Baker	N/A	Continuously keep staff informed throughout the process offering support where necessary.

SIGN OFF

Completed by:	
Date:	
Signed:	
Presented to: (appropriate committee)	
Publication date:	

1. Please send the completed Equality Analysis with your document to: **necsu.equality@nhs.net**
2. Make arrangements to have the EA added to all relevant documentation for approval at the appropriate Committee
3. Publish Equality Analysis

For further advice or guidance on this form, please contact the NECS Equality Team: necsu.equality@nhs.net

NHS

Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Public consultation report on proposed future arrangements for the Assisted Reproduction Unit in University Hospital of Hartlepool.

Prepared by Proportion Marketing Ltd. on behalf of NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group – July 2016

www.haveasay.org.uk

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2. Communications plan
3. Stakeholder briefing
4. MPs letters
5. Gateshead Health NHS Foundation Trust proposal
6. Focus group transcriptions

1. Executive summary

1.1. Summary

A formal public consultation on proposed future arrangements for the Assisted Reproduction Unit in University Hospital of Hartlepool ran for six weeks from 31st May 2016 to 15th July 2016.

NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG) were responsible for the consultation as, along with NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group, NHS Darlington Clinical Commissioning Group and NHS South Tees Clinical Commissioning Group, they currently commission assisted reproductive services from both South Tees Hospitals NHS Foundation Trust and North Tees and Hartlepool NHS Foundation Trust.

One of the existing providers, North Tees and Hartlepool NHS Foundation Trust has informed the CCGs they are unable to continue to deliver safe and clinically effective assisted conception services (IVF and IUI) under their HFEA (Human Fertilisation and Embryology Authority) Licence in the future from University Hospital of Hartlepool.

The CCGs therefore undertook a formal public consultation on the future service options for assisted reproductive services to inform future commissioning arrangements, specifically the location of where the service will be delivered, who would be delivering the services and what would be provided.

This independent report contains information about the formal public consultation, the communications and engagement activity used to facilitate dialogue with the public and stakeholders, analysis of the feedback and final consultation results.

NHS North of England Commissioning Support (NECS), who supported the consultation on behalf of NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group, NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group, NHS Darlington Clinical Commissioning Group and NHS South Tees Clinical Commissioning Group would like to thank all those who took part in the consultation.

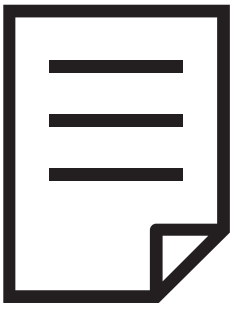
Your input and feedback has proved invaluable, and will help the CCGs to decide where the location of assisted reproductive services will be delivered, who would be delivering the services and what would be provided.

Note: The original consultation document did not include NHS Darlington CCG in the list of commissioning CCGs. The CCG was added after the document was printed.

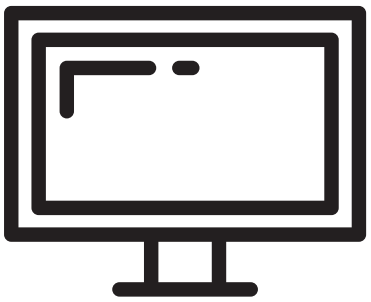
'This consultation has been monitored by the Consultation Institute under its Consultation Quality Assurance Scheme. The Institute is happy to confirm that the exercise has fully met its requirements for good practice.'

1.2. Consultation survey response

The consultation attracted 1,220 responses from the NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group, NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group, NHS Darlington Clinical Commissioning Group and NHS South Tees Clinical Commissioning Group population. The response breakdown is as follows:



Paper survey
= 900



Online survey
= 320

The paper returns include survey forms extracted from the main consultation document and a two-page survey form used by focus groups and in street surveys. There were no spoiled paper returns submitted.

Online returns are typically generated by e-communications from the CCG, links from the consultation website, media activity and social media posts. As a result of a web server crash at the end of the consultation period, the online survey was left open for a further two days until 17th July. There were six responses entered that weekend.

The response is equivalent to 0.104% of a population around 1.176m.

A petition to 'Save the ARU' was started on Twitter (@saveh-poolaru) and at the end of the consultation period it had 29 followers. A change.org petition had 14 supporters.

The CCG has a public sector equality duty, defined by S.149 of the Equality Act 2010, and targeted engagement (focus groups and street surveys) ensured that people from all groups with protected characteristics, defined within the Act, had the opportunity to participate in the consultation.

1.3. Feedback on the consultation proposals

Respondents were asked to rank each of the three options first, second or third.

The majority of respondents (58%) ranked Option 1 as their first choice. Option 2 was ranked their top selection by 23% and Option 3 by 22%.

Option 1 received the highest number of respondents – **1,037** gave an answer compared to **991** for **Option 2** and **989** for **Option 3.**

Option 1 consisted of:

- A comprehensive assisted reproductive service including HFEA Licensed and unlicensed provision remains at Hartlepool delivered by an alternative provider.

The risk of this option was:

- The CCG may be unable to secure and commission an alternative provider to deliver at University Hospital of Hartlepool site.

The benefits of this option were:

- Assuming an alternative provider can be secured, the existing provision would be maintained and patients would not see any changes.
- Patients would receive all treatment in Hartlepool.
- There would be no (nil) patients potentially impacted.

Other risks and benefits were highlighted by the Northern England Clinical Senate Report and these can be found in Appendix 1.

Although the majority stated their preference is for keeping a comprehensive assisted reproductive service in Hartlepool, over 70% of 1,062 answers stated if they were or are a patient, they would be prepared to travel to an alternative site in the northeast for assisted reproductive treatment.

39% of 1,049 answers stated a car journey time of within 20 minutes (up to 1 hour by public transport) was reasonable. 39% stated a car journey within 45 minutes (over 1 hour by public transport) was reasonable and only 22% stated a car journey over 45 minutes (over 1 hour by public transport) was reasonable.

The breakdown of support can be shown as follows.

Provider	Ranked 1st	Ranked 2nd	Ranked 3rd	Total
Option 1	58%	19%	23%	**1,037**
Option 2	23%	63%	14%	**991**
Option 3	22%	17%	61%	**989**

Option 1 was ranked the highest of the three options. 58% (of 1,037 respondents) ranking this option as the first preferred choice, with 19% ranking this option second and another 23% ranking this option third.

58%

Option 2 was ranked second highest of the three options. 23% (of 991 respondents) ranking this option as the first preferred choice, with 63% ranking this option second and 14% ranking this option third.

23%

Option 3 was ranked lowest of the three options. 22% (of 989 respondents) ranking this option as the first preferred choice, with 17% ranking this option second and 61% ranking this option third.

22%

The number of respondents in this question varies and is lower than the total number of respondents because not all paper surveys were completed in full.

Further analysis was undertaken to investigate responses by eliminating records where respondents answered they would not be a service user in the future. This produced a smaller database of 212 responses. Themes in free text followed the main consultation survey responses shown in Section 5. However, there were differences in answers to question 6 on travel. This sub set report is shown as an annex to the main report.

2. Consultation objectives and communications materials

2.1. Consultation objectives and principles

Regular and consistent communications and engagement is crucial in ensuring that the CCG commissions services that are of good quality, value for money and meet the needs of local people.

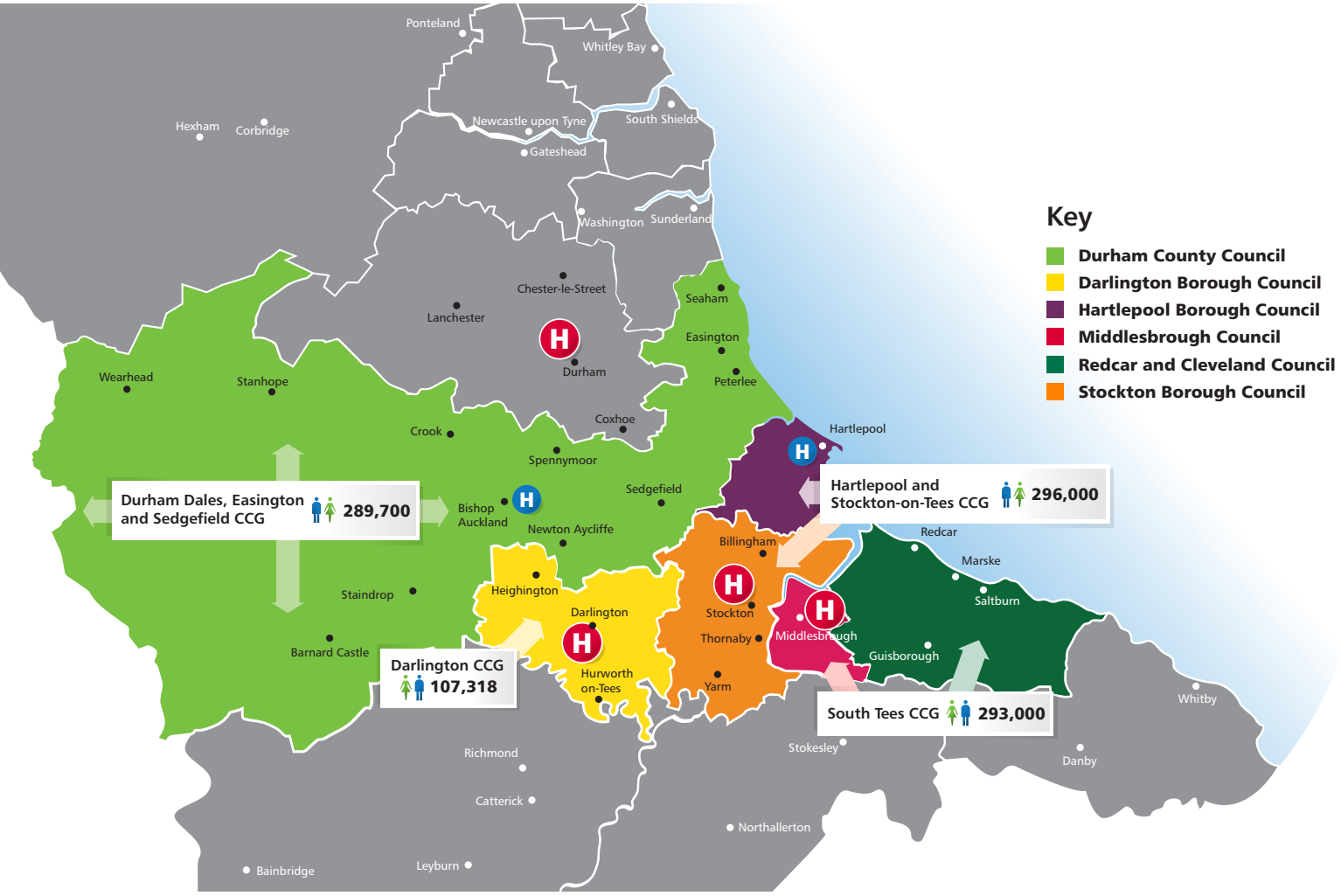
For this urgent care consultation, the communications and engagement objectives were to:

- Effectively engage the local population, partners and other stakeholders
- Give the local population in the four CCG areas, partners and stakeholders the opportunity to consider and comment on the options for assisted reproductive services
- Use the comments and feedback from the local population, partners and stakeholders to inform consideration by the CCG as to where assisted reproductive services should be provided
- Inform CCG commissioning responsibilities in relation to, and the procurement of, assisted reproductive services
- Ensure that the consultation is accessible to local people, patients, partners and key stakeholders, that they are aware of the consultation and have the opportunity to participate fully, should they wish to do so.

Consultation principles include:

- Being open and transparent
- Listening to the feedback from those engaged
- Taking into account differing needs of participants, for example age, gender, sexual orientation etc. within the population.

The overarching principle was to encourage active, two-way dialogue between the CCG and members of the public who feel that they have been able to have their say, and can see how their feedback has influenced where assisted reproductive services will be provided.



The consultation covered NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group, NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group, NHS Darlington Clinical Commissioning Group and NHS South Tees Clinical Commissioning Group.

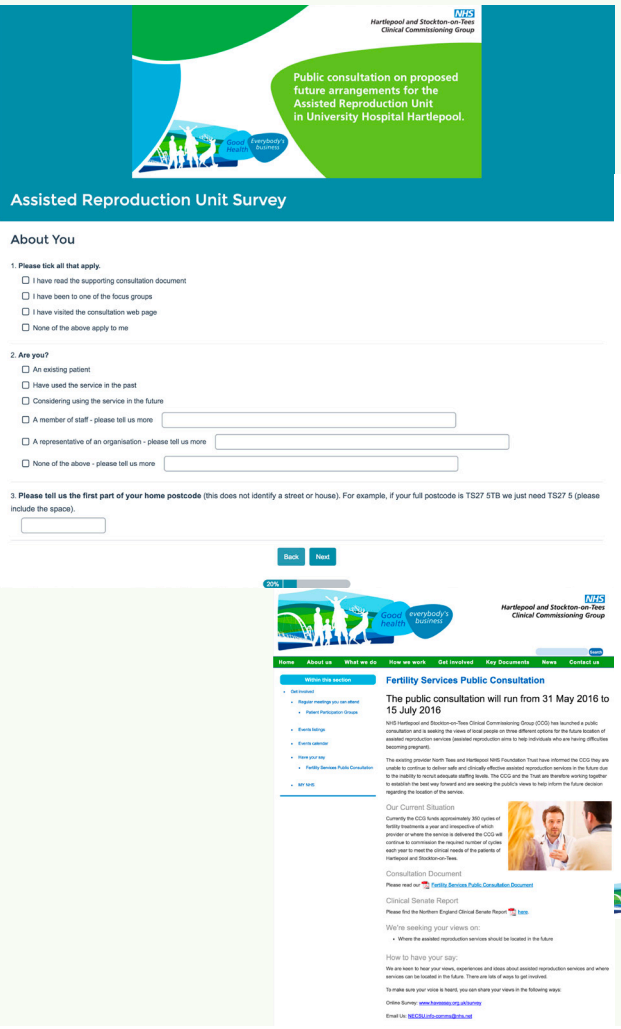
A suite of communications materials was produced to support the consultation.

2.2. Consultation document

An A4 20-page full consultation document featuring a tear out 2-page survey response form. 2,000 copies were printed and 10 copies were mailed to 128 GP surgeries in the consultation geography. The balance was delivered to CCG offices for use in various engagement activities.

2.3. Online survey

This was launched on 31st May and was accessed via a link from the consultation website. It was also promoted via media activity and social media posting.



This map shows the number of NHS commissioned treatment cycles carried out University Hospital of Hartlepool

Number of NHS commissioned treatment cycles carried out at the University Hospital of Hartlepool by patient residence	
Hartlepool	58
Redcar & Cleveland	1
Middlesbrough	16
Stockton-on-Tees	113
Darlington	15
Easington	14
Sedgefield	2
Bishop Auckland	59
Newcastle upon Tyne	1

The CCGs are consulting on the future service options for assisted reproductive services to inform future commissioning arrangements, specifically the location of where the service will be delivered from. It is important to note that upon completion of the consultation process and subsequent decision by the CCG, the CCG may be required to implement interim service arrangements to enable the CCG to comply with The National Health Service (Procurement, Patient Choice and Competition) Regulations 2013.

2.4. Website

The URL www.haveasay.org.uk forwarded visitors to pages within the NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group website. The site featured supporting materials including:

- Assisted Reproductive Services consultation document
- Northern England Clinical Senate Report
- A link to the online survey
- An email link for responses
- A link to the CCG Twitter page

2.5. A3 Poster

A promotional poster publicising consultation dates and the website was mailed with the consultation document to 128 GP surgeries in the consultation geography.
The balance was delivered to CCG offices for use in various engagement activities.

3. Methods of engagement

In addition to the communications materials described in Section 2, additional activities included:

3.1. Stakeholder meetings

To support the consultation the CCG devised and delivered an ongoing engagement programme to ensure dialogue with key stakeholders. This programme included:

- Overview and scrutiny committees
- Healthwatch
- Health and wellbeing boards
- Staff engagement – NHS trusts

A copy of the briefing document is shown in the appendices section.

GPs were part of the ongoing stakeholder engagement process by the Governing Body providing regular briefings.

3.2. Focus groups

19 Focus groups sessions facilitated by voluntary sector partners were held across the Tees Valley over the consultation period. 137 adults were recruited from partner's existing groups, the voluntary sector partners' websites and other promotional materials such as leaflets and posters. They were involved in the discussions that generally followed a structured format of facilitators outlining the background, asking if attendees knew anyone affected by ARU services and asking what was important when undergoing treatment. The feedback from attendees was transcribed for analysis. For a breakdown of comments see Section 5.3

3.3. Digital

Website. There were 1,334 visits to the fertility services web page.

Social media. The twitter page had 138 Followers (up 34 in the selected period) and generated 85 link 'clicks' with a total reach of 31,518. There were 6,200 total impressions (number of times users saw the tweet) on twitter with 136 average daily impressions. 8 tweets were posted during the consultation period.

3.4. Street surveys

750 street surveys were carried out between 7th and 14th June 2016 in three CCG areas (NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group, NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group and NHS South Tees Clinical Commissioning Group) by a specialist agency.

Face-to-face interviews involved the researcher approaching respondents personally, in the street. The researcher would explain the changes that were happening, encourage reading of the consultation document (where required), respond to questions and facilitate assisted completion of the survey in the presence of the member of public.

The researcher asked the respondent the questions in the survey form and noted their responses. This format enabled the researcher to 'sell' the research to a potential respondent. Face-to-face interviewing is a more costly and time-consuming method than a postal survey, however the researcher can select the sample of respondents in order to balance the demographic profile of the sample.

250 were completed in each of the three areas.

Verbal feedback can be summarised as:

- Many people didn't know that the services might be changing
- Most felt they would travel as far as needed for the service although they stated transport might be costly
- Some didn't think there was much difference in the options
- Some religious groups were vocal against the service.

Street survey locations and dates

Barnard Castle	**10th June**	Stainton market place and car park
Billingham	**8th June**	Forum, market square, Crown building
Bishop Auckland	**9th June**	
Cockfield	**10th June**	Prospect square
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Tow Law	**11th & 13th June**	High Street
Willington	**13th June**	High Street near Office
Wolsingham	**13th June**	Market Place
Yarm	**9th & 10th June**	High Street

3.5. Media activity

There were several press releases issued to media throughout the consultation.

This activity resulted in 7 press cuttings during the consultation period.

Evening Gazette	**2nd June**	Public to have say on fertility services
Northern Echo	**2nd June**	Have a say on fertility clinic axe
Northern Echo	**1st July**	NHS Fertility clinic's closure report criticism
Northern Echo	**1st July**	Fertility clinic could stay at town's hospital
Hartlepool Mail	**4th July**	Anger at flawed view of fertility clinic
Northern Echo	**4th July**	Clinic closure criticised by leading councillor
Hartlepool Mail	**4th July**	Anger at flawed view of fertility clinic
Hartlepool Mail	**11th July**	Fertility consultation nears end

A press article appeared in the Hartlepool Mail prior to consultation on 5th April.

Responses to media questions were also published.

BBC Online	**2nd June**	Question on licensed and unlicensed treatment
Hartlepool Mail	**2nd June**	Unions not happy with launch of consultation

3.6. Who we engaged with

NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG)

The CCG represents 38 GP practices across the two boroughs and a population of almost 296,000. It includes the towns of Billingham, Hartlepool, Stockton-on-Tees, Thornaby and Yarm.

NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group

The CCG represents 40 GP practices. It overs a total population of around 289,700 over a large and diverse geographical area, from Wearhead in the west to Seaham in the east and covers towns including Barnard Castle, Bishop Auckland, Newton Aycliffe, Sedgefield, Easington and Peterlee.

NHS South Tees Clinical Commissioning Group

The CCG represents 44 GP practices across an area including Eston, Guisborough, Loftus, Marske, Middlesbrough and Redcar with a population (registered with a GP) of 290,000.

NHS Darlington Clinical Commissioning Group

The CCG represents 11 GP practices across Darlington with a population around 100,000.

4. Analysis and reporting

4.1. Receiving the response

The consultation collected comments from a number of sources:

- Paper surveys (sent to a FREEPOST address)
- Online surveys
- Focus groups
- Street surveys
- Letters/emails from individuals and organisations

Online and postal survey responses were structured to prompt tick-box and free text responses around the main consultation question – the options proposed.

The survey asked; questions about the responder, where they lived (at postcode sector level i.e. TS26 1), what they thought of the proposed changes, opinions on travel, ranking the options presented and if they would be affected by changes. A final section covered questions about the individual and satisfied the CCG's equality duties. These questions were optional to answer.

As there is no prescribed framework for responding via email or letter, comments via these response mechanisms was free text. This meant that comments were recorded, data inputted and coded into themes to prepare them for robust analysis.

4.2. Analysing the response

The online questionnaire contained tick box and free text response options. The tick boxes allowed straightforward quantitative analysis.

As much of the response to the consultation was open, unprompted and free comment from individuals, Proportion Marketing used a robust methodology to count, classify and analyse these comments.

When coding qualitative data, the classification and analysis process has to be as consistent as possible. To minimise inconsistency, Proportion Marketing use one person to interpret all comments and a panel of three to settle ambiguous responses. To make meaningful analysis possible, the response data is organised into key themes made up of individual comments.

This enables analysis and allows for summarising and clearer presentation.

A respondent could make more than one comment and one comment could be counted in more than one theme.

4.3. Explanation of themes

The qualitative data (free text responses in the questionnaire, comments at focus groups) has been recorded in the consultation and allocated into recurring themes.

These themes were established approximately half way through the consultation process after analysing a sample of the initial responses.

Additional themes or a refinement of the current themes formed after this period but by the end of the consultation period the themes were fully established. Each comment is allocated a theme and each theme is then quantified to highlight key issues.

5. Survey results

5.1. Demographic breakdown of responses

The following table is a guide to the representation by postcode.

Some paper responses elected not to show the whole postcode sector and so responses are shown at Royal Mail 'outward' level i.e. TS26.

COUNT	POSTCODE	Post town
5	DH1 DURHAM	Durham
1	DH3 CHESTER LE STREET	Chester-le-Street (east of East Coast Main Line), Great Lumley, Birtley (east of East Coast Main Line)
3	DH4 HOUGHTON LE SPRING	Houghton le Spring (West of A690), Penshaw, Shiney Row
3	DH5 HOUGHTON LE SPRING	Houghton le Spring (East of A690), Hetton-le-Hole
7	DH6 DURHAM	South Hetton, Haswell, Shotton Colliery, Ludworth, Shadforth, Sherburn, Littletown, Kelloe, Coxhoe , Bowburn, Cassop, Pittington, Thornley, Wheatly Hill
5	DH7 DURHAM	Brandon, Lanchester, Esh Winning, Burnhope, Langley Park, Sacriston, Ushaw Moor, Brancepeth
1	DH9 STANLEY	Dipton, Stanley, Annfield Plain
7	DL1 DARLINGTON	Darlington East
8	DL2 DARLINGTON	Staindrop, Gainford & Darlington new estates
12	DL3 DARLINGTON	Darlington West, Faverdale, Coatham Mundeville
3	DL4 SHILDON	Shildon
15	DL5 NEWTON AYCLIFFE	Newton Aycliffe & Heighington
1	DL8 BEDALE, HAWES, LEYBURN	Wensleydale & Bedale
21	DL12 BARNARD CASTLE	Barnard Castle, Bowes & Middleton-in-Teesdale
64	DL13 BISHOP AUCKLAND	Stanhope, Frosterley, Wolsingham & Tow Law
30	DL14 BISHOP AUCKLAND	Bishop Auckland & Evenwood
41	DL15 CROOK	Crook & Willington
12	DL16 SPENNYMOOR	Spennymoor
5	DL17 FERRYHILL	Ferryhill, Chilton, Cornforth & Bishop Middleham
4	LE	Leicester
3	NE	Newcastle
1	NW	London
4	SR1 SUNDERLAND	Sunderland City Centre, East End, Hendon (north of Egerton Street)
1	SR3 SUNDERLAND	Chapelgarth, Doxford Park, Farringdon, Elstob Farm, Essen Way, Gilley Law, Hall Farm, Herrington, Humbledon Hill, Mill Hill, Moorside, Plains Farm, Ryhope, Silksworth, Springwell, Thorney Close, Tunstall
3	SR4 SUNDERLAND	Ayres Quay, Barnes, Chester Road, Deptford, Ford Estate, Grindon, Hastings Hill, Hylton Lane Estate, High Barnes, Millfield, Tyne and Wear, Pallion, Ford Estate, Pennywell, South Hylton
1	SR6 SUNDERLAND	Cleadon, Fulwell (east of Metro line), Monkwearmouth (east of Metro line), North Haven, Roker, St Peter's Riverside, Seaburn, Seaburn Dene, South Bents, Whitburn
14	SR7 SEAHAM	Cold Hesledon, Dalton-le-Dale, Dawdon, Deneside, Greenhill, Murton, Northlea, Parkside, Seaham, West Lea
42	SR8 PETERLEE	Easington, Easington Colliery, Horden, Little Thorpe, Peterlee
1	TD	Galashiels

COUNT	POSTCODE	Post town
9	TS1 MIDDLESBROUGH	Middlesbrough Town Centre (Gresham, University, Abingdon,)
5	TS2 MIDDLESBROUGH	Middlehaven, Port Clarence
21	TS3 MIDDLESBROUGH	Brambles Farm, Thorntree, Park End, North Ormesby, Berwick Hills
5	TS4 MIDDLESBROUGH	Grove Hill, Longlands
6	TS5 MIDDLESBROUGH	Acklam, Linthorpe
40	TS6 MIDDLESBROUGH	Eston, Grangetown, Normanby, Teesville, South Bank
14	TS7 MIDDLESBROUGH	Marton, Nunthorpe, Ormesby
11	TS8 MIDDLESBROUGH	Coulby Newham, Marton, Hemlington Stainton, Thornton & Maltby
6	TS9 MIDDLESBROUGH	Great Ayton, Stokesley
66	TS10 REDCAR	Redcar
27	TS11 REDCAR	Marske-by-the-Sea, New Marske
15	TS12 SALTBURN-BY-THE-SEA	Saltburn-by-the-Sea, Skelton-in-Cleveland, Brotton
20	TS13 SALTBURN-BY-THE-SEA	Loftus, Skinningrove, Staithes
19	TS14 GUISBOROUGH	Guisborough
33	TS15 YARM	Yarm, Kirklevington
1	TS16 STOCKTON-ON-TEES	Eaglescliffe, Egglescliffe, Aislaby
47	TS17 STOCKTON-ON-TEES	Thornaby, Ingleby Barwick, Stainton (part)
30	TS18 STOCKTON-ON-TEES	Central, Hartburn, Preston-on-Tees, Grangefield, Oxbridge, Portrack
42	TS19 STOCKTON-ON-TEES	Newtown, Fairfield, Hardwick, Roseworth, Bishopsgarth, Elm Tree Farm
9	TS20 STOCKTON-ON-TEES	Norton, Mount Pleasant
12	TS21 STOCKTON-ON-TEES	Stillington, Bishopton, Redmarshall, Thorpe Thewles, Carlton, Sedgefield, Long Newton
17	TS22 BILLINGHAM	Billingham (West), Wolviston
68	TS23 BILLINGHAM	Billingham (East)
57	TS24 HARTLEPOOL	Hartlepool Town Centre, Hartlepool Marina, Stranton, Belle Vue
85	TS25 HARTLEPOOL	Seaton Carew, Fens Estate, Owton Manor, Greatham
111	TS26 HARTLEPOOL	Middle Warren, Upper Warren, Bishop Cuthbert, Throston, West Park
28	TS27 HARTLEPOOL	Blackhall Rocks, Blackhall Colliery, Castle Eden, Hesleden, High Hesleden, Hutton Henry
9	TS28 WINGATE	Wingate, Station Town
3	TS29 TRIMDON STATION	Trimdon

The following table is a guide to the representation by age group. It shows consultation responses versus census data for County Durham Unitary Authority (UA), Darlington UA, Hartlepool UA, Middlesbrough UA, Redcar and Cleveland UA, Stockton-on-Tees UA. Note: County Durham Unitary Authority. Operative since 1 April 2009, it is the same area covered by the former districts of Chester-le-Street, Derwentside, Durham, Easington, Sedgefield, Teesdale and Wear Valley.

From this table it is clear the age groups 20-44 are over represented in proportion to total population.

	Age band	Age band	Age band	Age band	Age band	Age band	Age band
	20-24	25-34	35-44	45-54	55-64	65-74	75 over
Total population 1,176,033	7%	13%	14%	16%	14%	10%	9%
Consultation responses stating age – 1,040	11%	27%	27%	14%	10%	6%	4%

Source: Census 2011. Please note total population varies to population figures quoted by CCGs earlier in this document.

The consultation also had a high number of female respondents.

	Male	Female
Total population	49%	51%
Consultation responses stating gender	27%	73%

Source: Census 2011

5.2. Survey responses

5.2.1. Response counts

There were a total of 1,220 responses.

Paper survey = 900 Online survey = 320

Please note some tick box questions allowed for more than one answer so numbers may not add up to 100%.

5.2.2. Q1. What respondents read before completing the survey:

- Over 90% reported they had read the 20-page consultation document
- 8% reported attending a focus group
- 9% reported visiting the consultation web page
- 4% reported they had read none of the above.

5.2.3. Q2. Reporting in what capacity respondents were completing the survey:

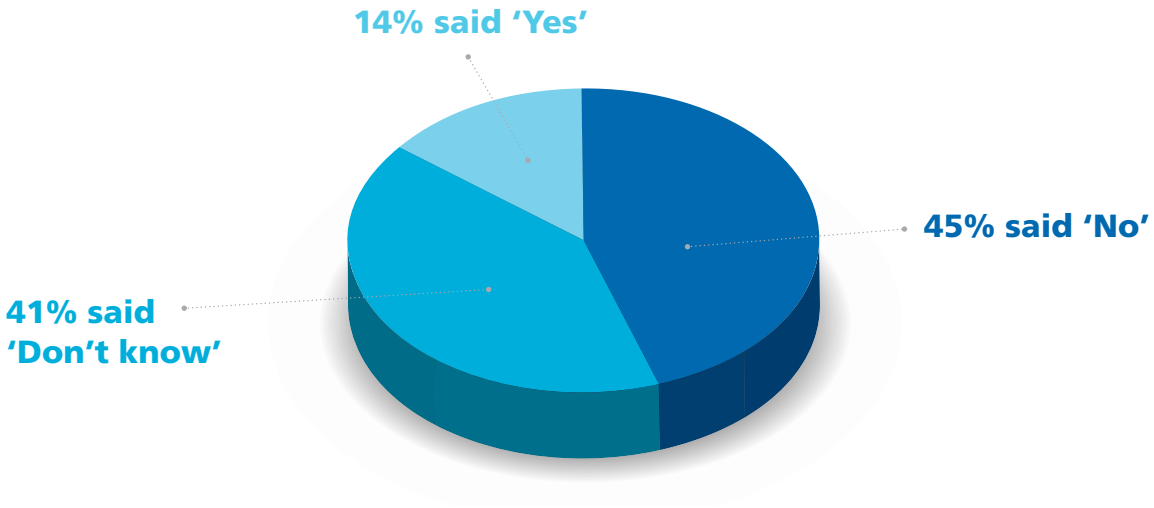
- 11% had used the service in the past
- 9% were considering using the service in the future
- 8% were an existing patient
- 2% represented an organisation
- 2% were a member of NHS staff

70% ticked the box 'none of the above' and went onto explain:

- 39% were members of the general public
- 34% were friends or family of a patient
- 15% represented a community group
- 11% were NHS staff (even though there was an option of NHS in the previous question)
- 3% were former patients

Question 3 was about the respondent's postcode and is covered on pages 18 and 19.

Q4. Respondents were asked 'Do you think we could have considered any other alternative options?'



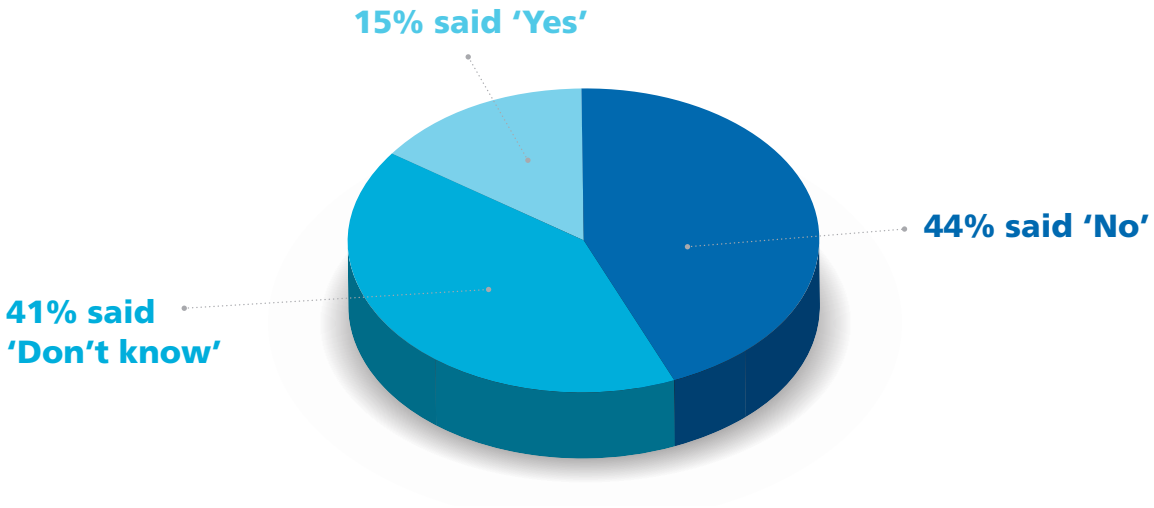
In 132 free text responses 50% of comments were around **recruitment** calling for the hospital trust to recruit clinicians or criticising past attempts to recruit. 29% of comments offered **alternative proposals** and these were variations to the options presented (including but not limited to; use of other sites, privatisation, transfer of staff from other sites and training schemes). 27% called for the unit to remain as is and the **status quo** maintained. 5% commented on **funding** asking for monies to be made available for staff or questioning if this was a money saving exercise. 3% commented on the **consultation** including the decision was a 'done deal' or commenting on how proposals were set out to the public.

'Recruitment drive for the existing facility.'

'You could keep some licensed (most popular) assisted reproductive services at Hartlepool site to avoid disturbing comfort of patients but takes off pressure.'

'A good idea would be for a locum embryologist. To go between the different fertility sites that way the patient would still have the same locum.'

5.2.4. Q5. Respondents were asked 'Thinking about this service are there any other risks or benefits of the options we should have considered?'



In 151 free text responses 40% of comments were around the **impact** on patients proposed changes could have. Many stated undergoing assisted reproductive treatment was already a stressful situation and change could add unnecessary additional stress. Extended waiting times and a strain on the system were also key themes.

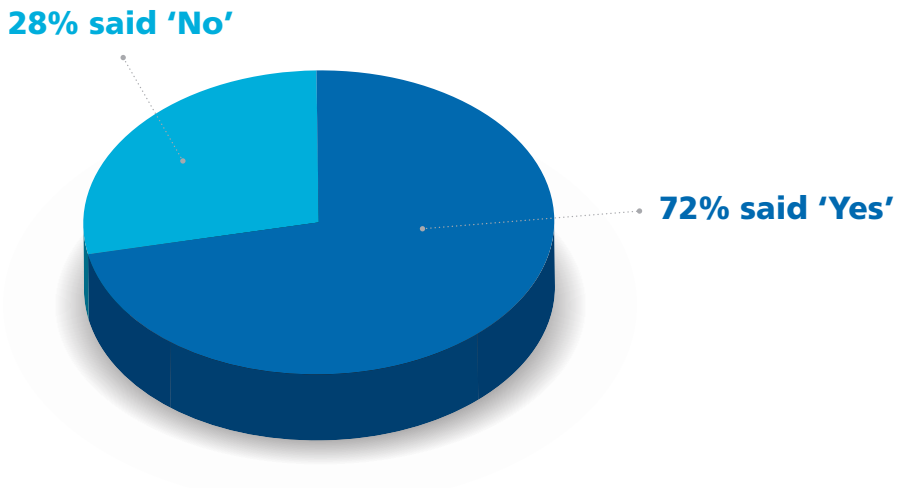
Respondents also used this question (18%) to comment that **staff/facilities** at other sites would also face increased pressure. 16% commented that **travel** could add an unnecessary burden both financially and time spent travelling. 9% went onto restate any **alternative** proposals mentioned earlier. 7% called again for the **status quo**. 5% commented again on **recruitment** failings. 3% of comments were around the **consultation** process (it's a 'done deal' and options presented). 26% of comments were classed as **other** and outside the scope of the consultation.

'Additional stress to people already undergoing stressful treatment.'

'It will create longer waiting lists and put more stress on patients.'

'The upheaval for the patients starting treatment in one place then having to move to another.'

5.2.5. Q6. Respondents were asked 'If you were or are a patient would you be prepared to travel to an alternative site in the North East for assisted reproductive treatment?'



There were 258 free text comments made in this question. **Travel** received the highest number of comments (64%) when the 'No' response was qualified and included the cost of travel, the time involved, questioning why people would have to travel when there is a local unit and calls on time with work commitments.

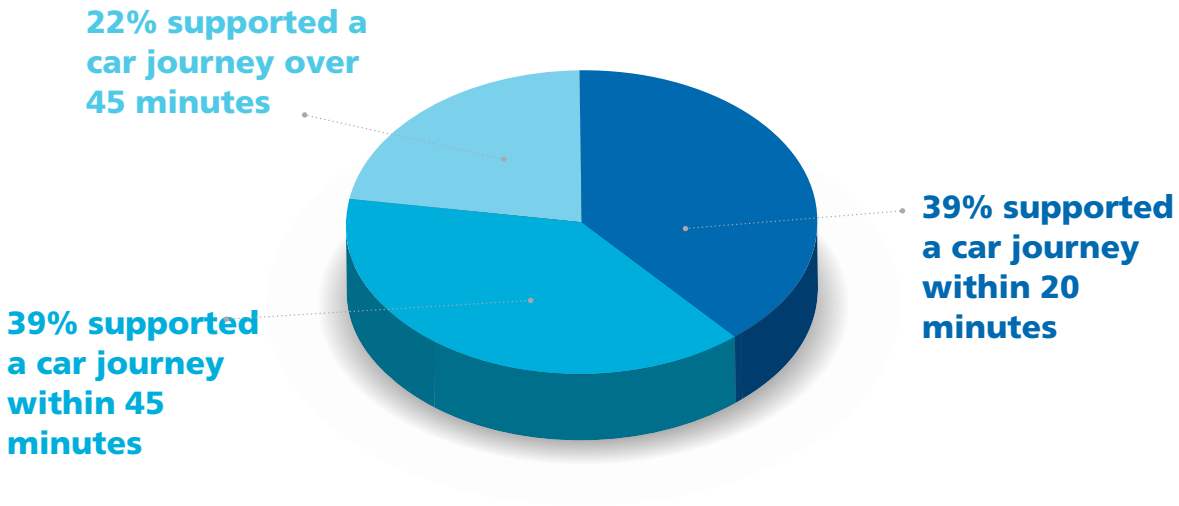
Patient **impact** followed with 26% of all comments and people reiterated about adding stress on top of an already stressful situation. 6% repeated calls for the **status quo**. 18% of comments were classed as **other** and included 'supporting Hartlepool Hospital' as an example.

'Cost and time of travelling some patients might not have the funds or the time.'

'Hard enough to secure time off work. I was treated at Hartlepool and even then had to make up my work hours. Further afield is too much.'

'The nature of IVF means that frequent appointments are necessary - sometimes daily, sometimes without much notice. It would be difficult to do this if the alternative site was too far away, or if you didn't drive/have access to a car. After some of the procedures it wouldn't be appropriate to then travel on public transport for up to an hour.'

5.2.6. Q7. Respondents were asked 'How far do you think it is reasonable to travel to receive assisted reproductive treatment?'



- 39% supported a car journey within 20 minutes that could be up to 1 hour by public transport
- 39% supported a car journey within 45 minutes that could be over 1 hour by public transport
- 22% supported a car journey over 45 minutes that could also be over 1 hour by public transport.

5.2.7. Q8. Respondents were asked 'Based on your answers above, if you were or are a patient requiring these services please rank the options in order of preference that you think will meet the needs of patients. In the box next to each option please click/write 1, 2 or 3 (1 being your top preference and 3 being the last).

The breakdown of support can be shown as follows.

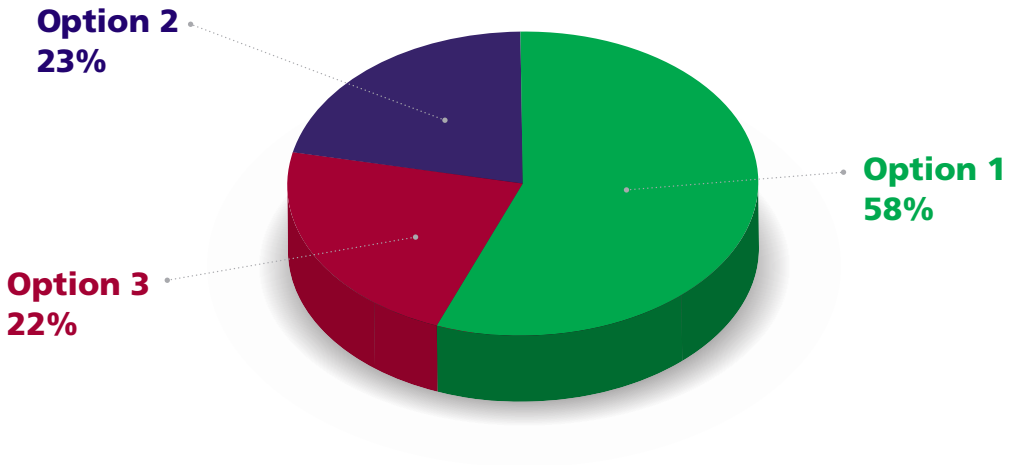
Provider	Ranked 1st	Ranked 2nd	Ranked 3rd	Total
Option 1	58%	19%	23%	**1,037**
Option 2	23%	63%	14%	**991**
Option 3	22%	17%	61%	**989**

Option 1 was ranked the highest of the three options. 58% (of 1,037 respondents) ranking this option as the first preferred choice, with just 19% ranking this option second and another 23% ranking this option third.

Option 2 was ranked second highest of the three options. 23% (of 991 respondents) ranking this option as the first preferred choice, with 63% ranking this option second and 14% ranking this option third.

Option 3 was ranked lowest of the three options. 22% (of 989 respondents) ranking this option as the first preferred choice, with 17% ranking this option second and 61% ranking this option third.

The number of respondents in this question varies and is lower than the total number of respondents because not all paper surveys were completed in full.



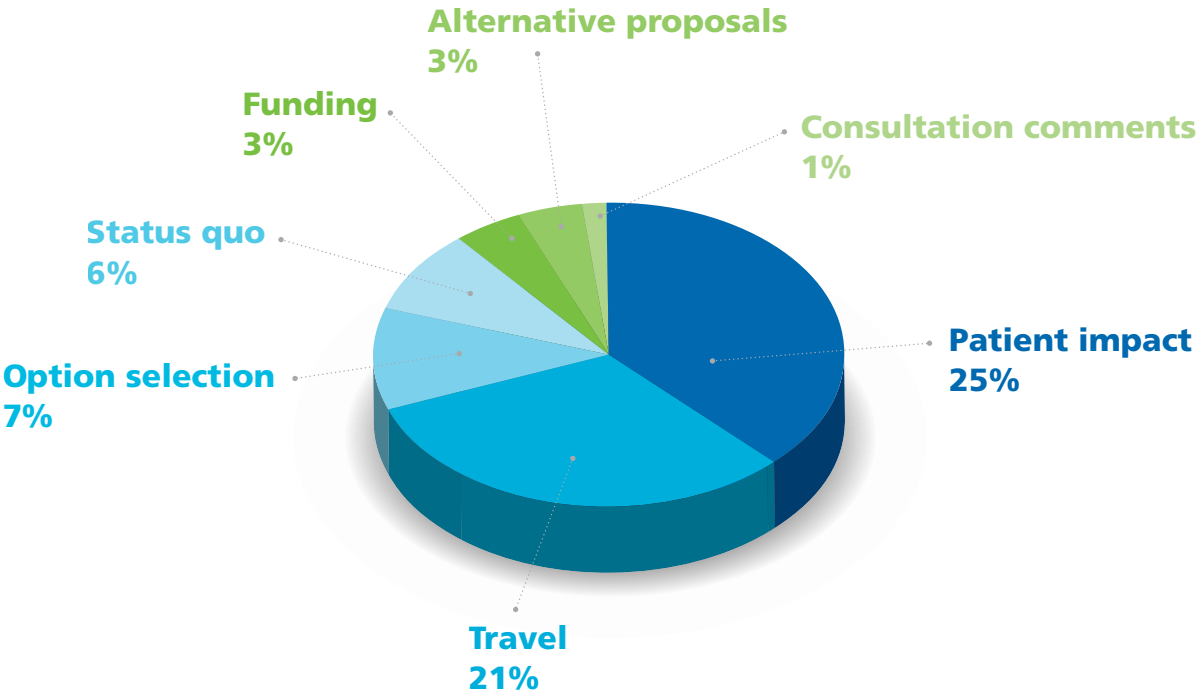
5.2.8. Q8. Respondents were asked 'Please provide a reason for your choice of options'

There were 1,004 free text comments and **Patient impact** was the highest number with 25% of all comments. The majority commenting on there being no change, continuity of care (the Hartlepool team), least amount of people affected and the unit will remain at Hartlepool.

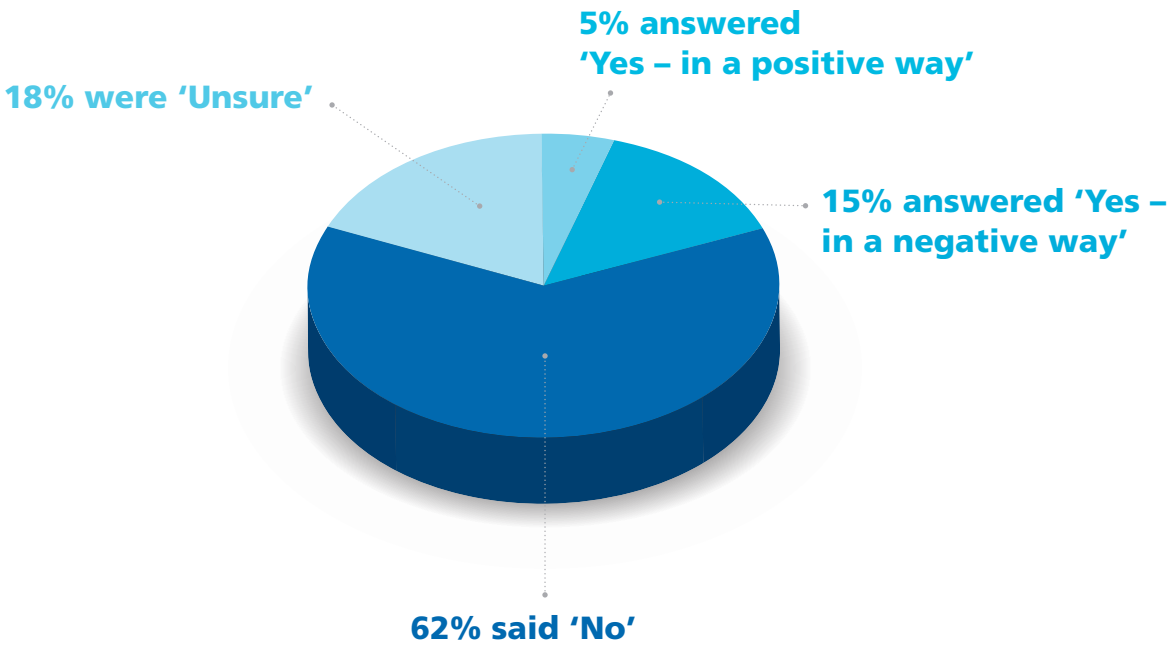
Travel followed with 21% of comments around accessibility, closer to home and eliminating the time and cost to travel. There were comments (in the minority) that stated they would be prepared to travel and alternative sites may be closer for some patients.

7% of comments were simply to reinforce their **option selection** and 6% of comments were repeated calls for the **status quo**.

A large number of comments were classed as **other** and included the Hartlepool hospital reputation and the situation remaining the same. In the minority were comments about the quality of facilities and services at other sites and more choice being available to patients. 3% of comments were around **funding** but views were mixed. Some perceive change will improve viability of the Hartlepool site but alternative views stated it may improve the viability of other sites and specialist care may be better provided from fewer locations. 3% of comments were **alternative proposals** and included creating bigger centres/single units and use of James Cook Hospital. Comments on the **consultation** accounted for 1% criticising the process and how options were presented.



5.2.9. Q9. Respondents were asked 'Do you think you will be affected by the proposed changes?

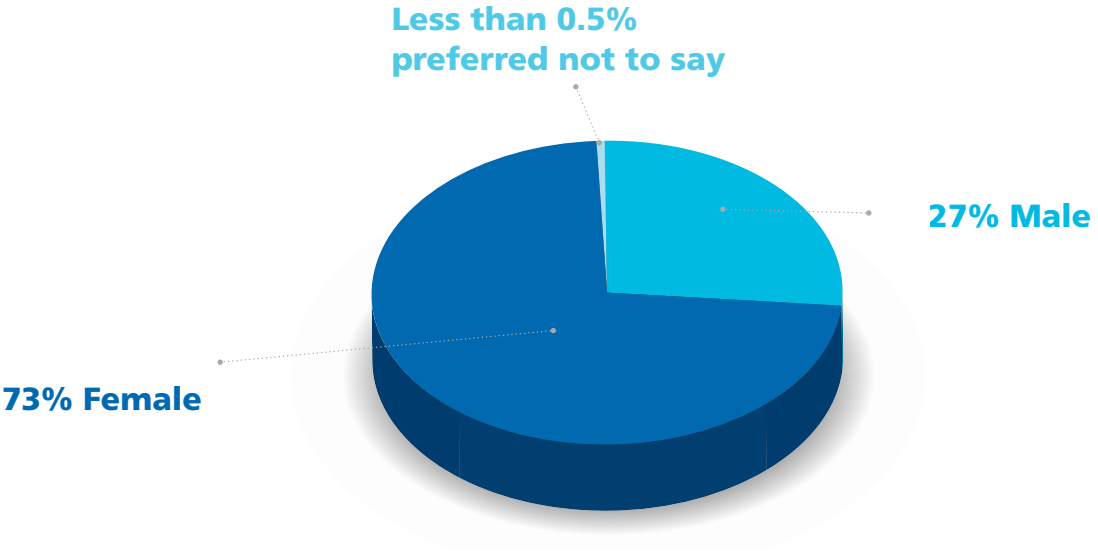


Within 904 free text comments the majority (62% of all responses) said they would **not be a service user** because of age (too young or too old), no need (have a family), not wanting children or already being pregnant.

17% commented on the **availability** of the service and were general comments not relevant to immediate personal use ('my family may need to use the service' and 'I may need to use the service'). 11% were **unsure** or indicated they may be unlikely to use the service. 7% commented on **travel** (time and cost). 5% of comments were around **patient impact** reiterating how stressful receiving ARU treatment can be.

A final section covered questions about the individual and satisfied the CCG's equality duties. These questions were optional to answer. Please note rounding has been applied to numbers.

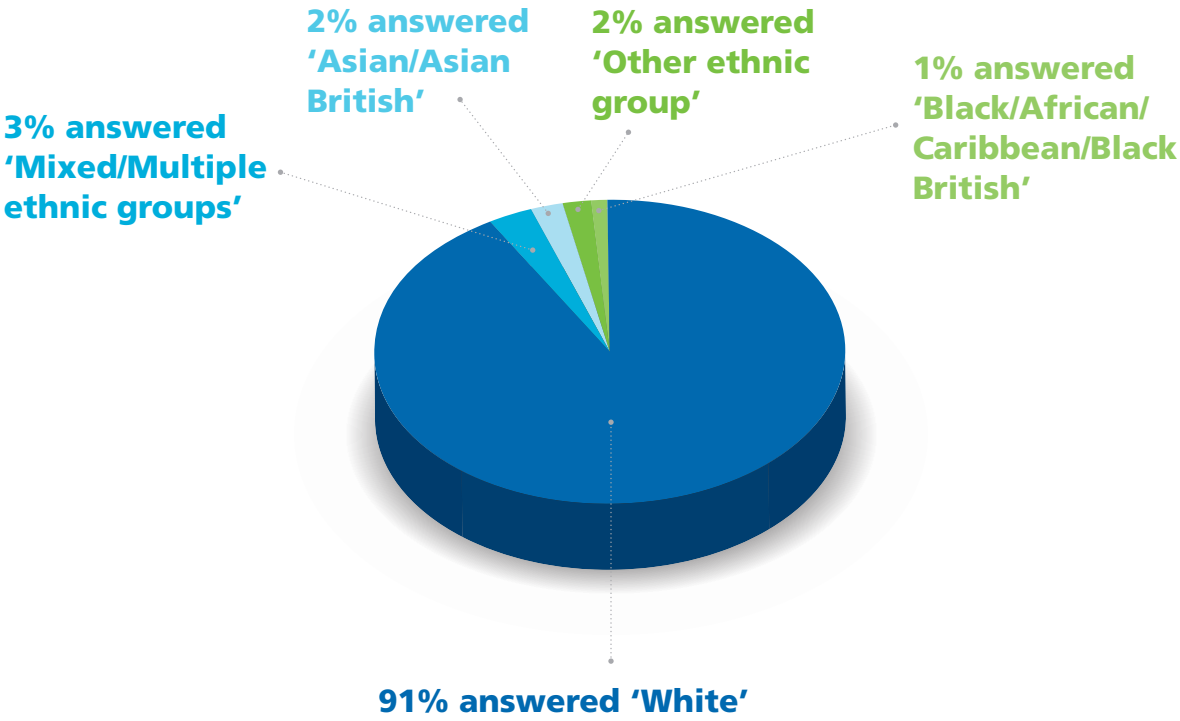
5.2.10. Q10. Respondents were asked 'Please state your gender'



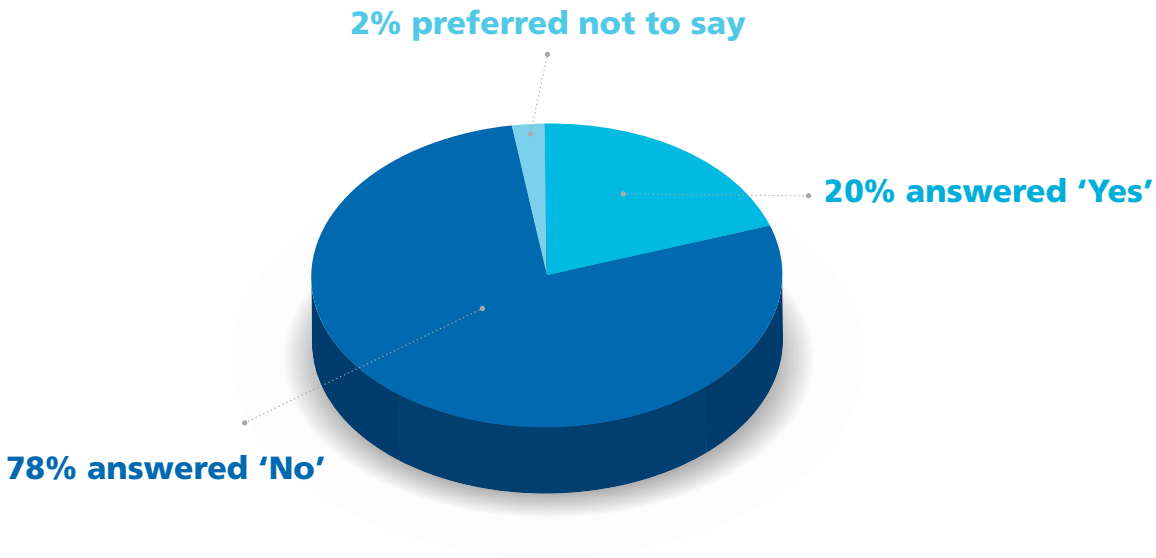
5.2.11. Q11. Respondents were asked 'Please state your age'

	Age band	Age band	Age band	Age band	Age band	Age band	Age band
	20-24	25-34	35-44	45-54	55-64	65-74	75 over
Consultation responses stating age – 1,040	11%	27%	27%	14%	10%	6%	4%

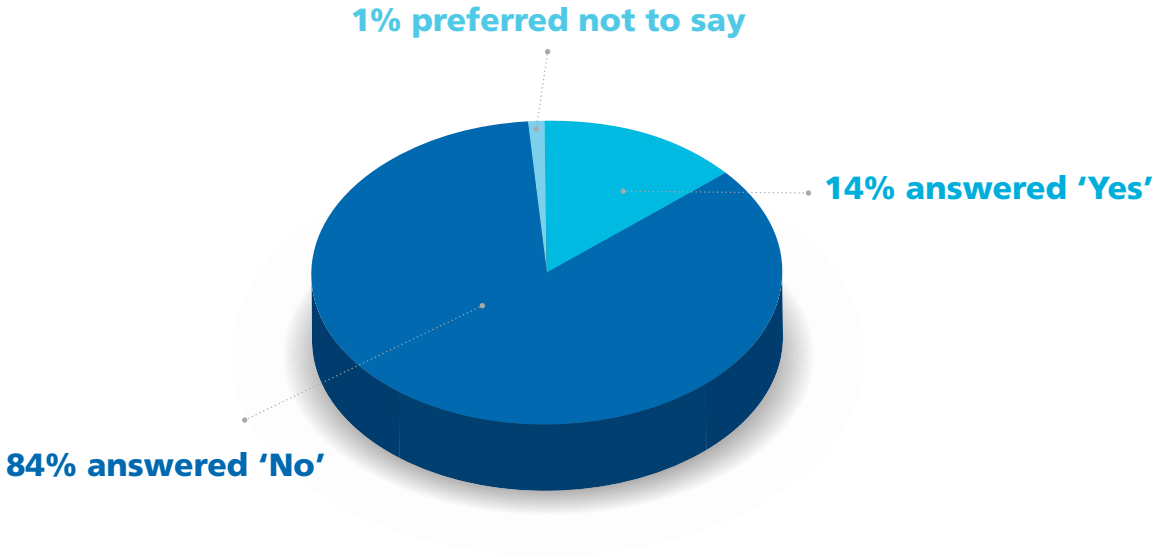
5.2.12. Q12. Respondents were asked 'Please identify which ethnic group you consider yourself to be'



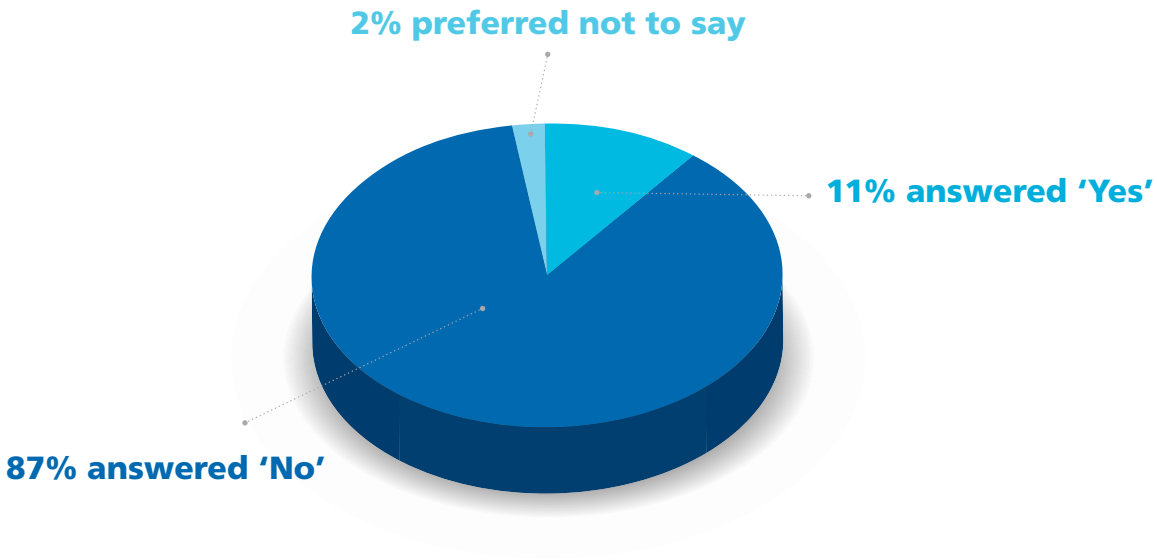
5.2.13. Q13. Respondents were asked 'Please tell us if you are pregnant or have a child under two years old'



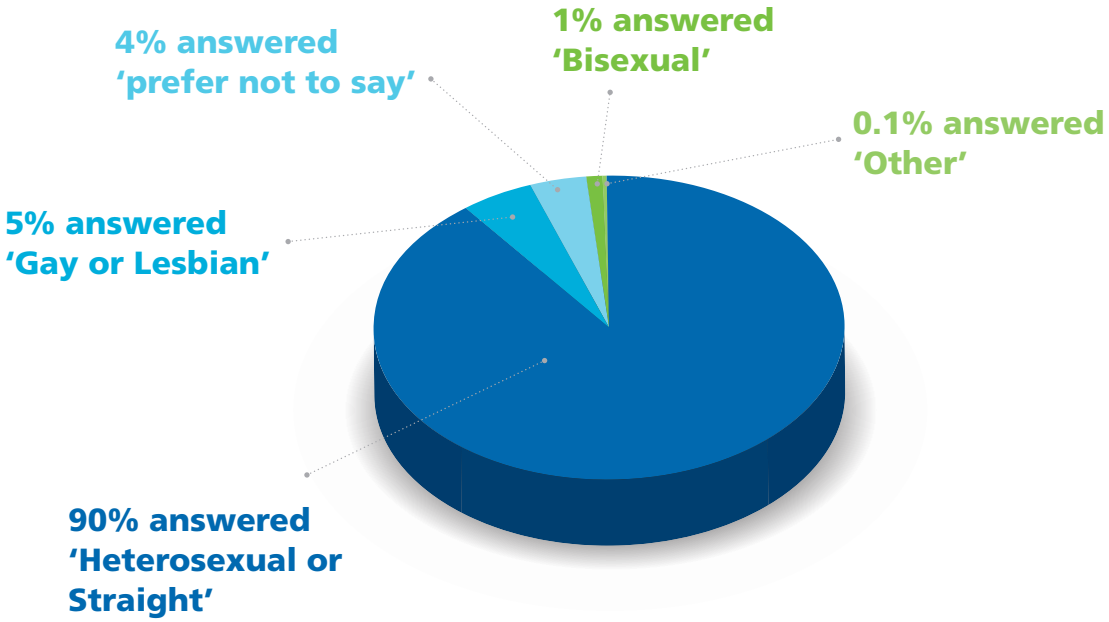
5.2.14. Q14. Respondents were asked 'Do you consider yourself to have a long standing illness or disability?'



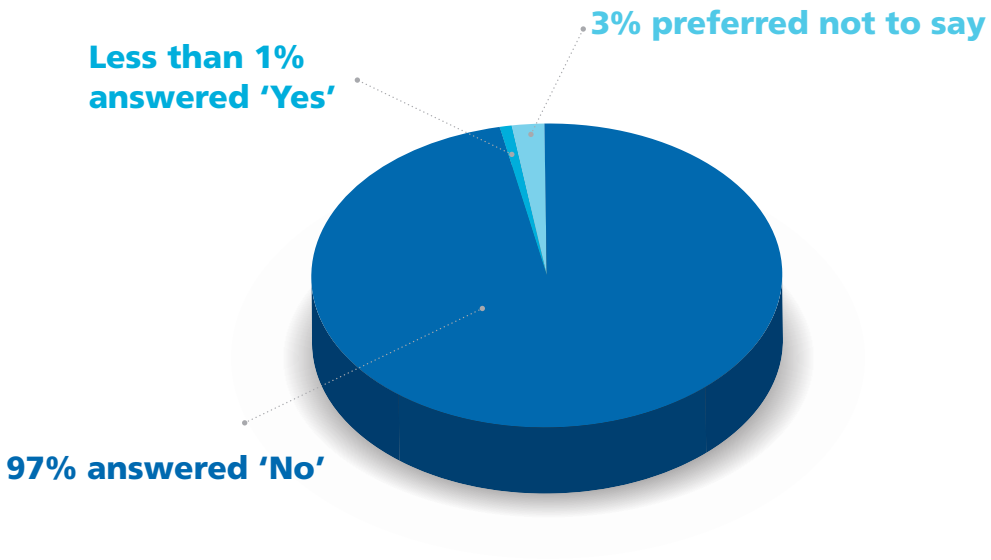
5.2.15. Q14. Respondents were asked 'Are you a carer?'



5.2.16. Q15. Respondents were asked 'How would you describe your sexuality?'



5.2.17. Q16. Respondents were asked 'Have you undergone gender reassignment?'



5.3. Focus groups

19 Focus groups sessions facilitated by voluntary sector partners were held across the Tees Valley over the consultation period. 137 adults were recruited from partner's existing groups, the voluntary sector partners' websites and other promotional materials such as leaflets and posters. They were involved in the discussions that generally followed a structured format of facilitators outlining the background, asking if attendees knew anyone affected by ARU services and asking what was important when undergoing treatment. The feedback from attendees was transcribed for analysis.

The highest proportion of comments were made about the **consultation** and these included (but were not limited to) the options presented, it being a 'done deal' and the methods of communications used and information used.

Comments around **travel** and included sub-themes such as cost, inconvenience, use of public transport, reliance on family for travel and parking at University Hospital James Cook.

There were comments in **support** of the current unit with positive comments about the staff (including the benefits of having a consistent team looking after the patient), service and the benefits of other support services in University Hospital Hartlepool (UHH). Within this theme are also comments from attendees expressing opinions about what they would expect from a service as opposed to comments about the existing service. Related to the above themes was **continuity** where attendees asked about the impact on current patients and what would happen to patients' embryos and data. Another related theme was **patient impact** where attendees expressed concern about adding to what is a stressful time when patients undergo treatment.

In the minority were comments related to the **erosion** of UHH including concerns about services being stripped leading to eventual hospital closure. There were comments about **recruitment** where attendees felt not enough had been done to recruit medical staff to sustain the unit and criticised the channels used to advertise posts.

Finance comments were about the trust looking to save money or the lack of investment in the unit. **Other** comments were generally outside the scope of the consultation including, the absence of trust or CCG staff at focus group meetings and lack of faith in the hospital trust and CCG.

The Hartlepool focus groups accounted for nearly half of all comments with the majority expressing concern regarding the **consultation** process. These included but were not limited to: the data behind decisions, options presented, consultation process and channels of communication used.

5.4. Street surveys

750 street surveys were carried out between 7th and 14th June 2016 in three CCG areas (NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group, NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group and NHS South Tees Clinical Commissioning Group) by a specialist agency.

Face-to-face interviews involved the researcher approaching respondents personally, in the street. The researcher would explain the changes that were happening, encourage reading of the consultation document (where required), respond to questions and facilitate assisted completion of the survey in the presence of the member of public.

The researcher asked the respondent the questions in the survey form and noted their responses. This format enabled the researcher to 'sell' the research to a potential respondent. Face-to-face interviewing is a more costly and time-consuming method than a postal survey, however the researcher can select the sample of respondents in order to balance the demographic profile of the sample.

250 surveys were completed in each of the three CCG areas.

Verbal feedback can be summarised as:

- Many people didn't know that the services might be changing
- Most felt they would travel as far as needed for the service although they stated transport might be costly
- Some didn't think there was much difference in the options
- Some religious groups were vocal against the service.

The 750 paper returns were data input and are included in survey responses.

5.5. Healthwatch

Healthwatch was approached by NHS North of England Commissioning Support Unit (NECS) to run a number of focus groups. Although based in Hartlepool, The Assisted Reproduction Unit is used by residents from Hartlepool, Redcar and Cleveland, Middlesbrough, Stockton-on-Tees, Easington, Sedgefield, Bishop Auckland, Newcastle Upon Tyne and Darlington.

Healthwatch Target Audience

Members of the local population, including but not solely:

- Older and younger people
- People with a disability
- Sexual orientation (LBGT)
- BME
- Different religion or belief
- Pregnant / children under 2
- Persons who have undergone gender reassignment
- People affected by social deprivation

Methodology

- Focus groups were held at local venues with local people. Healthwatch spoke in person with attendees at the groups
- Healthwatch visited existing groups with attendees from our target audience range. We used consultation documents provided to us by NECS to set the scene, and residents completed paper surveys with help from our staff and volunteers
- Healthwatch widely promoted an online survey via social media, our networks and weekly ebulletin. Local residents completed the information online
- Healthwatch promoted and shared the information with friends and family.

Discussions from Focus Groups Themes

- Services should be consistent where possible
- Services should remain as they are for existing clients, to avoid any disruption to an already difficult and emotional process
- If services do have to move they should be provided in one place from start to finish
- Where possible all services should be under one roof, to give the best possible service as this would provide more specialist and experienced care
- Travel was seen as a hindrance in some cases but a lot of people felt that where it was possible they would travel any time/distance to get something they wanted so much
- A suggestion was made to increase staffing by using graduates under a trainee scheme.

All paper surveys were returned to the Freepost address, data input and fed into the main findings.

6. Summary of findings

The preferred option by the public consultation respondents is option 1.

Option 1 consisted of:

- A comprehensive assisted reproductive service including HFEA Licensed and unlicensed provision remains at Hartlepool delivered by an alternative provider.

The risk of this option was:

- The CCG may be unable to secure and commission an alternative provider to deliver at University Hospital of Hartlepool site.

The benefits of this option were:

- Assuming an alternative provider can be secured, the existing provision would be maintained and patients would not see any changes.
- Patients would receive all treatment in Hartlepool.
- There would be no (nil) patients potentially impacted.

Respondents were asked to rank each of the three options first, second or third.

The majority of respondents (58%) ranked Option 1 as their first choice. Option 2 was ranked their top selection by 23% and Option 3 by 22%.

Option 1 received the highest number of respondents – 1,037 compared to 991 for Option 2 and 989 for Option 3.

Although the majority stated their preference is for keeping a comprehensive assisted reproductive service in Hartlepool, over 70% stated if they were or are a patient, they would be prepared to travel to an alternative site in the northeast for assisted reproductive treatment.

39% stated a car journey time of within 20 minutes (up to 1 hour by public transport) was reasonable. 39% stated a car journey within 45 minutes (over 1 hour by public transport) was reasonable and only 22% stated a car journey over 45 minutes (over 1 hour by public transport) was reasonable.

The recommendation is that the CCG take into account feedback from the consultation and use this to inform decision-making. It should also consider issues and concerns in the reported themes and take action to mitigate accordingly. The final published report should enable participants to see how their feedback has informed decision-making.

7. Next steps

The CCG's Governing Body will be receiving papers on the 22nd July 2016.

The Governing Body will then convene on 26th July 2016 to make a decision on proposed future arrangements for the Assisted Reproduction Unit in University Hospital of Hartlepool.

The CCG will share the report with key stakeholders such as local authorities and their overview and scrutiny committees, Healthwatch, Health & Wellbeing Boards and NHS trusts on 28th July 2016.

Public consultation report on proposed future arrangements for the Assisted Reproduction Unit in University Hospital of Hartlepool

Prepared by Proportion Marketing Ltd. On behalf of NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group – July 2016

'This consultation has been monitored by the Consultation Institute under its Consultation Quality Assurance Scheme. The Institute is happy to confirm that the exercise has fully met its requirements for good practice.'

NHS Hartlepool and Stockton-on-Tees
Clinical Commissioning Group
Billingham Health Centre
Queensway
Billingham
TS23 2LA

AUDIT AND GOVERNANCE COMMITTEE

28 July 2016

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Manager

Subject: ACCESS TO TRANSPORT FOR PEOPLE WITH A DISABILITY – SCOPING REPORT

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1. PURPOSE OF REPORT

1.1 To make proposals to the Audit and Governance Committee for the conduct of its forthcoming investigation in to the 'Access to Transport for People with a Disability'.

2. BACKGROUND INFORMATION

2.1 On 7 July 2016, a referral regarding Access to Transport for People with a Disability was received from the Adult Services Committee. The detail of the referral is attached as **Appendix A.** The Audit and Governance Committee, at its meeting on 14 July 2016 accepted the referral and agreed to undertake it within the 10 week timescale.

2.2 The Disabled Persons Transport Advisory Committee (DPTAC) advises the government on transport legislation, regulations and guidance and on the transport needs of disabled people, ensuring disabled people have the same access to transport as everyone else. Transport should be accessible for everyone. Accessible buses, coaches, trains and taxis make it easier for people to visit friends, get to the shops or to work. DPTAC advocate the promotion of an accessible transport system in the advice given to government. An accessible transport system is one that recognises the need for every stage in the journey to be accessible to disabled people.[1]

2.3 The Equality Act 2010 came into force on 1st October 2010, most land transport is covered by the rules on services to the public in Equality Act Part 3. There are greater exceptions for ships and aircraft. The Disability Rights Commission (DRC) issued a statutory Code of Practice Provision and use of transport vehicles in 2006. This sets out in some detail how the DRC saw the transport rules working under the former Disability Discrimination Act 1995 (DDA).

[1] https://www.gov.uk/government/organisations/disabled-persons-transport-advisory-committee

2.4 Even though the DDA has now been superseded by the Equality Act 2010, it has been referred to in past cases and is still helpful. It is likely to be taken into account by the courts where relevant.

2.4 Hartlepool Borough Council is committed to supporting local citizens through effective consultation. Transport and access to transport within the Borough is regarded as one of the top three priorities when consulting with adults with a Disability. Consultation with community groups in recent years has highlighted a decline in the number of wheelchair accessible vehicles, a decline in the frequency and equality of access to private hire vehicles and bus journeys; and difficulties in access and conveyance. Following discussions with local citizens they are concerned at seeing a reduction in the number of opportunities for people to remain independent.

3. OVERALL AIM OF THE SCRUTINY INVESTIGATION/ENQUIRY

3.1 To review the transport provision provided in Hartlepool for people with a disability to ensure that Hartlepool Borough Council is working within the principles of the Equality Act 2010.

4. PROPOSED TERMS OF REFERENCE FOR THE SCRUTINY INVESTIGATION/ENQUIRY

4.1 The following Terms of Reference for the investigation are proposed:-

(a) To identify whether the transport provisions available in Hartlepool, including licensed taxis and private hire vehicles; buses (including the hospital shuttle bus); trains; and buses are accessible for people with a disability;

(b) To examine whether the transport provisions identified in (a) are compliant with the Equality Act 2010 and the DRC Code of Practice;

(c) To identify the number of wheelchair accessible vehicles available for use within Hartlepool and examine:-

- if there has been a decline in the numbers of wheelchair accessible vehicles and the reasons why; and
- barriers and exclusions faced by people with a disability if wheelchair accessible vehicles are not available

(d) To examine good practice from Local Authorities that face similar issues and look at any solutions/improvements that have been implemented;

(e) To explore how access to transport for people with a disability can be developed, maintained and improved, now and in the future, to ensure that transport provision is continually accessible to people with a disability; and

(f) To take evidence from a wide a range of stakeholders and service users to identify the barriers people with a disability face without access to good transport links

5. POTENTIAL AREAS OF ENQUIRY / SOURCES OF EVIDENCE

5.1 Members of the Forum can request a range of evidential and comparative information throughout the Scrutiny review.

5.2 The Forum can invite a variety of people to attend to assist in the forming of a balanced and focused range of recommendations as follows:-

(a) Member of Parliament for Hartlepool;
(b) Chair of Hartlepool's Adult Services Committee;
(c) Ward Councillors;
(d) Director of Child and Adult Services and the Support Services Team
(e) Director of Public Health and the Public Protection Team/Licensing Team;
(f) Director of Regeneration and Neighbourhoods
(g) Hartlepool and Stockton-on-Tees Clinical Commissioning Group;
(h) GP's / Specialist GP's;
(i) North Tees and Hartlepool NHS Foundation Trust;
(j) Hartlepool Healthwatch;
(k) Bus, rail and private hire taxi companies;
(l) Local residents;
(m)Key stakeholders, including:
- The New Hartlepool MS Support Group
- Incontrol-able
- Hartlepool Carers and Hartlepool Young Carers

(n) Voluntary and Community Sector groups;
(o) Representatives of minority communities of interest or heritage

5.3 The Forum may also wish to refer to a variety of documentary / internet sources, key suggestions are as highlighted below:-

(a) https://www.gov.uk/government/policies/accessible-transport?page=2
(b) https://www.gov.uk/transport-disabled/taxis-and-minicabs
(c) https://tfl.gov.uk/transport-accessibility/
(d) http://www.transportforall.org.uk/news/uberwav-new-wheelchair-accessible-vehicles-hit-the-road

6. COMMUNITY ENGAGEMENT / DIVERSITY AND EQUALITY

6.1 Community engagement plays a crucial role in the Scrutiny process and diversity issues have been considered in the background research for this enquiry under the Equality Standards for Local Government. Based upon the research undertaken, paragraph 5.2 includes suggestions as to potential groups which the Forum may wish involve throughout the inquiry (where it is felt appropriate and time allows).

7. REQUEST FOR FUNDING FROM THE DEDICATED OVERVIEW AND SCRUTINY BUDGET

7.1 Consideration has been given, through the background research for this scoping report, to the need to request funding from the dedicated Overview and Scrutiny budget to aid Members in their enquiry. At this stage no additional funding has been identified as being necessary to support Members in their investigation. Members, however, may wish to seek additional funding over the course of the investigation and the pro forma attached at **Appendix A** outlines the criteria on which a request will be judged.

8. PROPOSED TIMETABLE OF THE SCRUTINY INVESTIGATION

8.1 Detailed below is the proposed timetable for the review to be undertaken, which may be changed at any stage:-

28 July 2016 – Scoping Report

August 2016 – Working / Task and Finish Group to look at:-

Meeting 1 (potential date 8 August at 10am) – Current accessible transport provision in Hartlepool - covering terms of reference (a), (b) and (c)

Meeting 2 – (potential date 15 August at 2pm) – To seek the views of service users and their families and interested stakeholders to identify current issues / problems with the transport provision in Hartlepool – covering terms of reference (f)

Meeting 3 – (potential date 22 August at 4pm) - Good practice and future access to transport provision - covering terms of reference (d) and (e).

1 September 2016 – Feedback from the group work to the Audit and Governance Committee and formulation of recommendations

22 September 2016 – Draft Final Report

3 November 2016 - Draft Final report presented to the Adult Services Committee

9. RECOMMENDATION

9.1 Members are recommended to agree the Audit and Governance Committee's remit of the investigation outlined in paragraphs 4 and 5 and the proposed timescale outlined in paragraph 8.

Contact Officer: - Joan Stevens
Chief Executives Department – Legal Services
Hartlepool Borough Council
Tel: - 01429 284142

Email:- joan.stevenshartlepool.gov.uk

BACKGROUND PAPERS

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

(a) Disabled Persons Transport Advisory Committee - https://www.gov.uk/government/organisations/disabled-persons-transport-advisory-committee/about#priorities

APPENDIX A

PRO-FORMA TO REQUEST FUNDING TO SUPPORT CURRENT SCRUTINY INVESTIGATION

Title of the Overview and Scrutiny Committee:
Title of the current scrutiny investigation for which funding is requested:
To clearly identify the purpose for which additional support is required:
To outline indicative costs to be incurred as a result of the additional support:
To outline any associated timescale implications:
To outline the 'added value' that may be achieved by utilising the additional support as part of the undertaking of the Scrutiny Investigation:
To outline any requirements / processes to be adhered to in accordance with the Council's Financial Procedure Rules / Standing Orders:
To outline the possible disadvantages of not utilising the additional support during the undertaking of the Scrutiny Investigation:
To outline any possible alternative means of additional support outside of this proposal:

Audit & Governance- Access to Transport for People with a disability

Referral from: **Cllr Stephen Thomas**

Chair of Adult Services Committee

Background

Hartlepool Borough Council is committed to supporting local citizens through effective consultation. Transport and access to transport within the Borough is regarded as one of the top three priorities when consulting with adults with a Disability. Consultation with community groups in recent years has highlighted a decline in the number of wheelchair accessible vehicles, a decline in the frequency and equality of access to private hire vehicles and bus journeys; and difficulties in access and conveyance.

Statutory requirements

The Equality Act 2010 came into force on 1st October 2010, most land transport is covered by the rules on services to the public in Equality Act Part 3. There are greater exceptions for ships and aircraft.

The Disability Rights Commission(DRC) issued a statutory Code of Practice Provision and use of transport vehicles in 2006. This sets out in some detail how the DRC saw the transport rules working under the former Disability Discrimination Act 1995 (DDA).

Even though the DDA has now been superseded by the Equality Act 2010, it has been referred to in past cases and is still helpful. It is likely to be taken into account by the courts where relevant

Disabled Persons Transport Advisory Committee

The Disabled Persons Transport Advisory Committee (DPTAC) advises the government on transport legislation, regulations and guidance and on the transport needs of disabled people, ensuring disabled people have the same access to transport as everyone else. On 12 June 2013, it was decided to retain DPTAC to advise Department for Transport on accessibility issues relating to disabled people.

The reasons for referring the issue

Transport should be accessible for everyone. Accessible buses, coaches, trains and taxis make it easier for people to visit friends, get to the shops or to work.

Following discussions with local citizens they are concerned at seeing a reduction in the number of opportunities for people to remain independent.

Without access to good transport links people remain at risk of social isolation and are unlikely to be able to remain active citizens without the opportunity to access education training and employment, sport and recreation.

The objectives of statutory scrutiny process

Hartlepool Borough Council is required to work within the principles of the Equality Act and where it procures, provides or promotes transportation within the Borough it must consider the impact of its services for people with a Disability ensuring equality of access to transport as prescribed within the DRC code of practice.

Useful links

www.gov.uk/transport-disabled/cars-buses-and-coaches

www.drc.org.uk/services_and_transport.aspx

Timescales for reporting back to the referring body

The referrer respectively requests that Audit and Governance consider this referral and if successful would suggest a report back within 10 weeks to enable sufficient time for members to consider the local position in relation to our statutory duties under the Equality Act 2010.

This issue is not being dealt with by another committee.

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

29th April 2016

The meeting commenced at 9.30 am in the Civic Centre, Hartlepool

Present:

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

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors Cranney (as substitute for Councillor Richardson) and Chris Simmons
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group – Dr Schock and Karen Hawkins (as substitute for Alison Wilson)
Representative of Healthwatch –Margaret Wrenn
Other Members:
Representative of Cleveland Police – Chief Superintendent Gordon Lang (as substitute for Simon Nickless)

Officers: Kelly Bainbridge, Better Care Fund Project Manager
Joan Stevens, Scrutiny Manager
Amanda Whitaker, Democratic Services Team

61. Apologies for Absence

Elected Members, Hartlepool Borough Council – Councillors Carl Richardson and Paul Thompson
Representative of Hartlepool and Stockton-on-Tees Clinical Commissioning Group – Alison Wilson
Director of Child and Adult Services, Hartlepool Borough Council – Sally Robinson
Director of Public Health, Hartlepool Borough Council - Louise Wallace
Chief Executive, Hartlepool Borough Council – Gill Alexander
Representative of Hartlepool Voluntary and Community Sector – Tracy Woodhall
Representative of Cleveland Police – Simon Nickless
Representative of Healthwatch - Ruby Marshall
Representative of Tees Esk and Wear Valley NHS Trust – David Brown

62. Declarations of interest by Members

None

63. Minutes

The minutes of the meeting held on 14 March 2016 were confirmed.

64. Better Care Fund Plan (*Director of Child and Adult Services*)

The Better Care Fund Plan for 2016/17 was presented to the Board for approval. Guidance had been published on 23 February 2016 regarding Better Care Fund Planning Requirements for 2016/17. The guidance set out eight conditions which local areas needed to meet as detailed in the report.

Also presented were the following planning requirements together with the timetable for submissions:-

- A jointly agreed narrative plan including details of how national conditions are being addressed;
- Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;
- A scheme level spending plan demonstrating how the fund will be spent;
- Quarterly plan figures for the national metrics.

It was noted that the Plan for 2016/17 had been developed by the Council and the CCG with input from providers and built on the priorities agreed in the 2015/16 plan. The BCF Plan narrative document for 2016/17 was appended to the report. The planning template that supported the narrative plan set out in further detail the specific funding requirements; expenditure plan for 2016/17 and target setting for metrics. The BCF Planning Template for 2016/17 was appended to the report**.**

Board Members were advised that there was a requirement in 2015/16 for quarterly performance reports to be signed off by the Health and Wellbeing Board and submitted to the Department of Health, with the Q4 return for 2015/16 due to be submitted by 27 May 2016. This reporting requirement would continue for 2016/17 but dates for quarterly returns to be submitted had not been issued.

It was noted that the BCF Pooled Budget had been fully committed in 2015/16 with slippage used to support one off pressures in adult social care and Disabled Facilities Grants. Plans had been agreed that fully committed the budget for 2016/17 and the budget would continue to be monitored throughout the year through the Pooled Budget Partnership Board. There was a requirement to have a signed s75 Partnership Agreement in place by 30 June 2016.

The Better Care Fund Project Manager and the Associate Director of Commissioning and Delivery responded to questions arising from the report. It was recognised that there was a necessity for the Plan to accord with the concept of bespoke community hubs. Discussion followed on issues associated with social isolation and the role of GPs in ensuring connectivity

with other agencies and health professionals. The Board was assured that the Better Care Fund Plan aimed to bring together other plans and a proactive approach was envisaged. An allocation to care co-ordination would be in place this year in GP practices and would link to early intervention services, although it was recognised that not all access was through GPs.

Board Members highlighted staffing issues and difficulties associated with the recruitment of nurses. A number of areas were identified in relation to addressing recruitment issues, although it was recognised that not all those issues could be addressed through the Better Care Fund Plan. Reference was made to the operation of a 6 day model of working and the Chair of the Board advised that the Finance and Policy Committee had agreed to locate social workers at hospital based on a 7 day business case model. The Chair highlighted that the change to the model had not been reported to Finance and Policy Committee. The Board was advised that the decision had been made by Pooled Budget Partnership Board. However, the Chair advised that there had been a charge against the Local Authority budget. It was considered that an update report should have been submitted to Committee in relation to arrangements which it was recognised were outside the remit of the Better Care Fund.

The Chair sought clarification regarding a proposal to 'means test' telehealth and telecare services and how that would accord with the Better Care Fund. Whilst endorsing the Better Care Fund Plan, it was requested that a report be submitted to the Board on the impact of the Fund. The Board was advised that it would be necessary to set performance measures and outcomes. Stockton Borough Council had recently been successful in a bid relating to funding impact and that work would be linked to Hartlepool. A Working group had been convened to determine reporting and performance measures to determine outcomes delivered by services and a model was being worked up.

The Chair requested that for each scheme funded through the Better Care Fund monies, there was a clear overview and review of each service to indentify the outcomes that would be delivered. The Chair requested that this be provided in the future alongside the performance reports to the Board.

In response to clarification sought from an Elected Member, the representative of Cleveland Police acknowledged that it was essential for Partners to work together and advised the Board of a number of preventative initiatives which had been introduced including Cleveland Connected.

Decision

(i) The Board approved the 2016/17 BCF Plan and agreed to receive quarterly updates throughout the year.

(ii) It was agreed that a report be submitted to the Board detailing the impact of the Better Care Fund.

Meeting concluded at 10.20 a.m.

CHAIR

SAFER HARTLEPOOL PARTNERSHIP
MINUTES AND DECISION RECORD
11 March 2016

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

Present:

Councillor: Christopher Akers-Belcher (In the Chair)
Denise Ogden, Director of Regeneration and Neighbourhoods
Clare Clark, Head of Community Safety and Engagement
Barry Coppinger, Office of Police and Crime Commissioner for Cleveland
Chief Inspector Lynn Beeston, Chair of Youth Offending Board
Steve Johnson, Cleveland Fire and Rescue Authority
John Bentley, Safe in Tees Valley
Karen Hawkins, Hartlepool and Stockton on Tees Clinical Commissioning Group

In accordance with Council Procedure Rule 5.2 (ii) Councillor Jim Lindridge was in attendance as substitute for Councillor Marjorie James, Karen Clark as substitute for Louise Wallace, Superintendent John Lyons as substitute for Chief Superintendent Gordon Lang, Rosana Roy as substitute for Julie Allan, David Eggleston as substitute for Barbara Gill, Gilly Marshall as substitute for Stewart Tagg and Danielle Swainston as substitute for Sally Robinson

Also present:
Ian Hayton, Chief Fire Officer
Rachelle Kipling, Office of Police and Crime Commissioner for Cleveland
Louise Soloman, Cleveland Police

Officers: Rachel Parker, Community Safety and Research Officer
Denise Wimpenny, Principal Democratic Services Officer

52. Apologies for Absence

Apologies for absence were submitted on behalf of Councillor James, Hartlepool Borough Council, Louise Wallace, Director of Public Health, Hartlepool Borough Council, Superintendent Gordon Lang, Cleveland Police, Julie Allan, National Probation Service, Barbara Gill, Tees Valley Community Rehabilitation Company, Stewart Tagg, Housing Hartlepool, Sally Robinson, Director of Child and Adult Services, Hartlepool Borough

Council.

53. Declarations of Interest

None at this point in the meeting. However, an interest was declared by Councillor Lindridge later in the meeting (Minute 60 refers)

54. Minutes of the meeting held on 22 January 2016

Confirmed.

55. Matters Arising from the Minutes

With regard to Minute 45, Matters Arising from the Minutes in relation to the Taxi Marshalling Scheme and a request that all funding stream options be explored, the Head of Community Safety and Engagement reported that no further funding contributions had been forthcoming from taxi firms. Other partners had indicated they were willing to make a contribution. It was noted that given the shortfall was £5,000, if any other partners were willing to contribute the level of contribution would reduce for other partners. The Chair sought the Partnership's approval to delegate authority to the Chair and Head of Community Safety and Engagement to liaise with partners to agree the final levels of funding contributions.

With regard to Minute 46, Strategic Assessment 2014 and the decision taken that the issue of early morning restriction orders (EMRO) be referred to the Licensing Committee for review, the Committee was advised that the Licensing Committee had considered this matter at its meeting on 24 February 2016 and had determined that the issue of EMRO's be referred back to the Partnership with a request that evidence be presented that demonstrated a need for an EMRO whereupon the Licensing Committee could give the matter detailed consideration at a future meeting.

The Chair reported that Neville Cameron would no longer be attending future Partnership meetings and requested that the Police and Crime Commissioner convey the Partnership's thanks to Neville for this contribution.

Decision

(i) That authority be granted to the Chair and Head of Community Safety and Engagement to liaise with partners to agree the final levels of funding contributions for the Taxi Marshalling Scheme.
(ii) That the information given be noted and the issue of EMRO's be referred back to the Partnership to provide evidence that supported the need for an EMRO.
(iii) That the Police and Crime Commissioner convey the Partnership's thanks to Neville Cameron for his contribution to the Partnership.

56. Domestic Violence and Abuse Strategy 2016-2019

(*Director of Regeneration and Neighbourhoods*)

Purpose of report

To agree a process for developing the Safer Hartlepool Partnership Domestic Violence and Abuse Strategy 2016-2019.

Issue(s) for consideration

The Head of Community Safety and Engagement presented the report which set out the background together with the proposed process and timeline to the development of the Domestic Violence and Abuse Strategy 2016-19. Work would begin on developing the Strategy in March 2016 and a local needs assessment would be undertaken to ascertain the extent of domestic violence and abuse in Hartlepool. Key findings of the needs assessment would be used to inform the development of the Strategy, including the proposed strategic objectives and priorities.

The draft Strategy would be presented to the Partnership in June 2016 and, subject to Partnership approval, would be ready to go out for consultation immediately after, details of which were provided. It was anticipated that the finalised strategy would be presented to the Partnership in September 2016.

The Police and Crime Commissioner welcomed the introduction of a National Strategy given that there had been a North East Strategy in place since 2013. It was noted that the PCC's office was currently doing a lot of work in support of the North East Strategy, details of which were provided and the PCC's willingness to support the future development of the Strategy was noted. In response to a query as to whether abuse involving child against parent had been included in the needs assessment given increasing prevalence of this issue, the Head of Community Safety and Engagement expressed support for inclusion of this issue and advised that soundings would be taken from the Youth Council as part of the Face the Public consultation arrangements. The benefits of including restorative justice was highlighted which the Head of Community Safety and Engagement agreed to explore. With regard to consultation on the Strategy, it was suggested that the consultation be extended to include the Consultative Forums.

Decision

(i) That the proposed schedule for developing and consulting on the Domestic Violence and Abuse Strategy 2016-2019 be approved subject to extending the consultation to include the Consultative Forums.

(ii) That the suggestions of the Partnership in relation to inclusion of abuse involving child and parent and the option to include restorative justice within the Strategy be explored.

57. Community Safety Plan 2014-17 (Year 3) (*Director of Regeneration and Neighbourhoods*)

Purpose of report

To consider the annual refresh (Year 3) of the 2014-17 Safer Hartlepool Partnership Community Safety Plan, attached at Appendix 1.

Issue(s) for consideration

It was reported that the Partnership had considered and approved the first draft Community Safety Plan (Year 3) 2014-17 and the Plan had also been considered by the Council's Audit and Governance Committee and Finance and Policy Committee. The final version of the Plan was attached at Appendix A and included reference to early morning restriction orders and restorative justice issues as requested by the Partnership at the last meeting. The request from the PCC to include the logo in the final Plan was accepted by the Partnership.

Decision

That the Community Safety Plan 2014-17 (Year 3) be approved subject to the inclusion of the Cleveland Police and Crime Commissioner's logo within the document.

58. Home Office Consultation – Enabling Closer Working Between Emergency Services (*Director of Regeneration and Neighbourhoods*)

Purpose of report

To inform the Partnership of Government plans to introduce new legislation to enable closer working between emergency services.

Issue(s) for consideration

The Director of Regeneration and Neighbourhoods introduced the report which provided background information to the Government's plans to introduce new legislation to enable closer working between emergency services. Following a consultation process the Government intended to legislate to introduce a high level duty to collaborate on all three emergency

services and enable PCC's to take on the functions of Fire and Rescue Authorities, details of which were set out in the report.

The Chair welcomed the Police and Crime Commissioner and Chief Fire Officer who were in attendance at the meeting to provide their views in relation to the Government's proposals. Both the PCC and Fire and Rescue Authority expressed their support for the pending legislation and highlighted the measures that were already in place towards meeting such requirements.

The Chief Fire Officer referred to the strong democratic accountability within the Fire Authority and a memorandum of understanding that had recently been developed in terms of movement towards collaboration in relation to assets and buildings and sharing accommodation across authorities. Discussions had also commenced in relation to a number of closer working initiatives including managing fleet, extending partnership working to identify better ways of protecting the public and examining back office functions with a view to bringing services closer together.

The Police and Crime Commissioner reported on the existing high levels of collaboration, effective communication links and the PCC's commitment to make the best use of reducing resources between the emergency services to do their best for communities.

The Director of Regeneration and Neighbourhoods updated the Partnership on the discussions that had taken place with the Council's Chief Executive in relation to formalising collaboration activities. The Chief Fire Officer referred to pressures on the North East Ambulance Service particularly in relation to the level of call outs and the importance of partner agencies supporting the Ambulance Service with medical emergencies where possible was emphasised.

The opportunity to share office space at Stranton Fire Station was noted. The Chair advised that this information could be fed into the community hub model.

Decision

That the information given and comments of the Partnership be noted.

59. Respect Your Neighbourhood – Environmental Crime Campaign (*Director of Regeneration and Neighbourhoods*)

Purpose of report

To provide an update on the 'Respect Your Neighbourhood – Environmental Crime Campaign'.

To consider the Partnerships continuing support for Neighbourhood Action Days over the forthcoming year.

Issue(s) for consideration

The Director of Regeneration and Neighbourhoods reported on the background to the establishment and purpose of the Respect Your Neighbourhood Environmental Crime Campaign. The Partnership was referred to a copy of the report submitted to the Council's Neighbourhood Services Committee in January, attached at Appendix A, which outlined progress to date in relation to the Campaign and sought the Partnership's support for Neighbourhood Action Days for the forthcoming year.

The report included a summary of days of action for 2015/16, the outcome of a recent review of Neighbourhood Action Days and proposals to ensure the continued success of the campaign.

The Committee welcomed the initiative and the Chair took the opportunity, on behalf of the Committee to thank the staff involved for their hard work in making the campaign such a success.

The benefits of increasing the number of action days to two per month was discussed and the option to feed this suggestion through the Anti-Social Behaviour Group was highlighted. Whilst in support of the Neighbourhood Action Days, which were well received by residents, the Chair requested that the feasibility of increasing the number of actions days be explored. The Chair requested that this suggestion be referred to the Neighbourhood Services Committee for consideration.

Decision

That the suggestion regarding increasing the number of Neighbourhood Action Days to 2 per month be referred to the Neighbourhood Services Committee for consideration.

At this point in the meeting Councillor Lindridge declared a personal interest in the following item of business as a Member of the Police and Crime Panel.

60. The Integrated Neighbourhood Police Team Review

(*Representative from Cleveland Police*)

Issue(s) for consideration

A representative from Cleveland Police, who was in attendance at the meeting, provided the Partnership with a detailed and comprehensive presentation in relation to the future of the Integrated Neighbourhood Police Team following a recent review into the reconfiguration of local policing. The presentation included an overview of future arrangements and focussed on the following:-

- Local Policing Towards 2020
- Background to reason for review - budget cuts and the force delivering local policing with 100 fewer PCs than the current model of delivery requires
- Strategic Threat and Risk Assessment
- Balancing strategic threat and risk assessment against available staff
  2010 – 1643 officers
  2014 – 1308 officers
  2016 – 1267 officers
- How we will do this – local policing, enabling services and collaborative services
- Vision of local policing – restructure of service
- Measures to protect vulnerable people
- Role of Incident Resolution Teams - reallocate officers to support policing plans
- Neighbourhood Policing will continue to be a central strand of local policing model – core role of PCSO's in Neighbourhood Policing would be maintained
- Vulnerable localities index results
- The 3 Ss approach
- Key changes including benefits of change to communities, organisation, officers and staff
- Protect, intervene and prevention initiative
- Recruiting PCSO's to bring numbers back up to 132
- Proposed changes to officer shift patterns to meet demand when most needed

Following conclusion of the presentation the Partnership discussed the issues highlighted in the presentation. The representative responded to issues raised by Members in relation to the operational impact of the proposed changes to staff shift patterns and the proposed changes to protect children from exploitation and on-line grooming and deal with issues

of this type more effectively.

Clarification was provided in relation to the allocation of resources process following some concerns expressed that resources may be re-directed to areas outside of Hartlepool. Assurances were provided that resources allocated to Hartlepool would remain in Hartlepool and whilst the Chief Constable had the power to reallocate resources within the Cleveland area this would only occur in exceptional circumstances. It was reiterated that there would be no reduction in PCSO's in Hartlepool.

In response to a request, the Police representative agreed to provide information to all Elected Members on the changes to shift patterns once finalised and to share information on Cleveland Police Victim's First Policy.

Reference was made to the recent roll out of the Anti-Social Behaviour and Vulnerable Victims System, the benefits of which were shared with the Partnership in terms of the ability to share more accurate up to date information and improve support to vulnerable victims. Thanks were expressed to the Police and Crime Commissioner and Lynn Beeston in her role as Chair of the Youth Offending Board for their contribution towards its implementation. Members were keen to receive more information on the Victim's First process and it was noted that a presentation would be submitted to the Partnership in due course. The launch of the restorative justice approach and the importance of adequate support for victims was emphasised.

The Chair thanked the representative for his attendance and informative presentation.

Decision

(i) The contents of the presentation and comments of Members were noted.

(ii) That the changes to police officer shift patterns be shared with Elected Members once finalised.

(iii) That information regarding Cleveland Police Victim's First Policy and newly commissioned Victims Service be submitted to a future meeting of the Partnership.

61. Safer Hartlepool Partnership Performance (*Director of Regeneration and Neighbourhoods*)

Purpose of report

To provide an overview of Safer Hartlepool Partnership performance for Quarter 3 – October 2015 to December 2015 (inclusive).

Issue(s) for consideration

The Community Safety and Research Officer provided the Partnership with an overview of the Safer Hartlepool Partnership performance during Quarter 3, as set out in an appendix to the report. Information as a comparator with performance in the previous year was also provided.

In the discussion that followed presentation of the report, the Community Safety and Research Officer responded to queries raised in relation to crime figures by type. Whilst Partnership Members were pleased to note a 6% reduction in recorded crime for this reporting period it was reported that as at the end of February Hartlepool projected a 12.8% increase in crime.

In response to a query raised, clarification was provided in relation to the troubled families programme working arrangements as well as the claims process. Disappointment was expressed that there was no data available from the Foundation Trust in relation to the level of alcohol related harm hospital admissions. Members were advised that the Trust had indicated that due to data quality issues the information was not available. The CCG representative added that the CCG was currently working with the Trust in this regard as there had been problems with data provision across the board as a result of introduction of a new patient administration system. This issue would be monitored by the Contract Management Board and it was envisaged the problem would be rectified by the end of the month. The Chair requested that the data be circulated when available.

Decision

(i) That the Quarter 3 Performance figures and comments of Members be noted and actioned as appropriate.

(ii) That alcohol related harm hospital admissions data be provided when available.

62. VEMT (Vulnerable Exploited, Missing and Trafficked) Update (*Director of Child and Adult Services*)

Purpose of report

To update Members of the Partnership on the work being undertaken in relation to VEMT (Vulnerable, Exploited, Missing and Trafficked)

Issue(s) for consideration

The report provided background information in relation to the responsibility of all partners of the Local Safeguarding Children's Board to work together

to protect children and young people from harm. The report set out the current national context and the work that was ongoing within Hartlepool to reduce the risk of children and young people being subject to sexual exploitation.

All Tees Local Safeguarding Children's Boards had identified VEMT as a priority and a Tees Sub Group had been established for all partners to work together to protect children from sexual exploitation, details of which were provided. The Group had developed a partnership action plan, attached as an appendix to the report, to take into account the Joint Strategic Needs Assessment, national research and information provided by Cleveland Police as well as local information.

Children who go missing from home or care were particularly vulnerable to being exploited and it was important that all practitioners were aware of this and worked to support these children. With regard to the current Hartlepool situation, the VEMT Practitioners Group in Hartlepool currently had 17 children open on its agenda, all 17 of whom were female and aged between 12 and 17 years of age.

Members welcomed the VEMT conference planned for April 2016 which aimed to raise awareness with schools and look at ways that schools could discuss these issues with children and young people. The importance of prevention in the early years was discussed and the need to engage with primary schools was suggested. Emphasis was placed upon the role of parents being vigilant in terms of monitoring what their children were accessing on line and the need to raise the profile of issues of this type with parents. The links between substance misuse around children and safeguarding issues was discussed as well as the benefits of developing links between safeguarding and substance misuse which it was suggested should be picked up by the Partnership's Substance Misuse Group.

Decision

The Partnership noted the work being undertaken in relation to VEMT and to be vigilant to the risks of child sexual exploitation.

63. Response to the Proposal on the Provision of Court and Tribunal Services in the North East Region

(*Director of Regeneration and Neighbourhoods*)

Purpose of report

To update the Partnership on the outcome of the recent Ministry of Justice consultation in relation to proposals to close the Hartlepool Magistrates and County Courts.

Issue(s) for consideration

The Director of Regeneration and Neighbourhoods reported on the background to the national consultation on the provision of court and tribunal estate in England and Wales and proposals to close eight courts and tribunals in the North East. The results of the consultation and Ministry of Justice response highlighted the decision to close Hartlepool Magistrates' Court and County Court which would be moved to Teesside Magistrates' Court and Teesside Combined Court. Further details were attached as appendices to the report. Initial implementation dates indicated that the courts would cease to provide a public facing service between January and March 2017.

The Chair referred to the strong case put forward by the Council against the proposals and expressed disappointment regarding the decision.

Decision

That the Ministry of Justice response and proposed timescale for closure of the Hartlepool Magistrates Court and County Court be noted.

64. 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.

65. Any Other Business – Current Review of Youth Justice System – Update

The Chair of the Youth Offending Board reported on the ongoing review of the Youth Justice System and the final report that was due for completion in the summer. An interim report revealed that since 2006 the number of young people cautioned had fallen by 77% and the number of young people entering the youth justice system for the first time was down by 81% which was testament to the excellent work carried out in recent years. The young people that remained in the system were those individuals with more challenging or complex needs. Whilst the number of young offenders had fallen, re-offending figures had increased locally which was in line with the national picture.

Reference was made to the key principles central to effective youth justice which included the importance of education. Whilst it was envisaged that there may be proposals to revert back to the former approved school arrangements as opposed to youth custody arrangements, there would

continue to be secure custody arrangements for vulnerable or dangerous cases. It was reported that there would be more flexibility to deliver services locally, the details of which were awaited. The financial position of the Youth Offending Service was also yet to be announced and it was expected that budgetary pressures would continue.

A Member was of the view that a number of young people involved in the Youth Justice System often experienced difficulties with literacy problems which may be a contributory factor in terms of poor attendance levels. Emphasis was placed upon the need to establish links with schools and parents in relation to restorative justice interventions.

Decision

That the information given be noted.

The meeting concluded at 11.55 am.

CHAIR