PLEASE NOTE VENUE

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM AGENDA

Thursday 26th October 2006

at 10.00am

in Community Room, Central Library, York Road, Hartlepool

MEMBERS: ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM:

Councillors Barker, Akers-Belcher, Brash, Fleet, Griffin, Lauderdale, Lilley, Rayner, Wistow, Worthy and Young.

Resident Representatives: Mary Green and Evelyn Leck

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

   3.1 The minutes of the meetings held on 6th and 19th September 2006.

4. **RESPONSES FROM THE COUNCIL, THE EXECUTIVE OR COMMITTEES OF THE COUNCIL TO FINAL REPORTS OF THIS FORUM**

   No items.

5. **CONSIDERATION OF REQUEST FOR SCRUTINY REVIEWS REFERRED VIA SCRUTINY CO-ORDINATING COMMITTEE**

   No items.

PLEASE NOTE VENUE

6. **CONSIDERATION OF PROGRESS REPORTS / BUDGET AND POLICY FRAMEWORK DOCUMENTS**

No items.

7. **ITEMS FOR DISCUSSION**

7.1 **Social Prescribing Scrutiny Investigation:-**

(a) National Perspective/Social Prescribing – *Scrutiny Support Officer*

(b) Evidence from HVDA & Author of Report Commissioned by Hartlepool Partnership & HVDA in relation to 'Developing Social Prescribing in Hartlepool' - *Scrutiny Support Officer*

(c) Introduction of New Deal in the Community Social Prescribing Project – *Presentation from Programme Manager for Community Development and Inclusion*

(d) Written submission from Hartlepool MIND in relation to Social Prescribing in Hartlepool – *Scrutiny Support Officer*

(e) Social Prescribing – *Presentation by Dr Brash*

7.2 Consultation on Community Care Eligibility Criteria – *Report of the Director of Adult and Community Services*

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

ITEMS FOR INFORMATION

i) Date of Next Meeting Tuesday 14th November 2006 commencing at 10.00am in the Community Room, Central Library, York Road, Hartlepool.

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM

MINUTES

6th September 2006

Present:

Councillor: Gerald Wistow (In the Chair)

Councillors: Councillors Caroline Barker, Stephen Belcher, Jonathan Brash, Mary Fleet, Sheila Griffin and Geoff Lilley.

Resident Representatives:
Evelyn Leck

Also Present:
Ian Dalton, Chief Executive of the North Tees and Hartlepool National Health Trust
Ali Wilson, Director of Primary Care & Modernisation, Primary Care Trust

Officers: Graham Jarrit, Borough Librarian
Sajda Banaras, Scrutiny Support Officer
Angela Hunter, Principal Democratic Services Officer

31. Scrutiny Presentation by Chief Executive of the North Tees and Hartlepool NHS Trust – Covering Report

(Scrutiny Support Officer)

The Chair informed Members of the Forum that the Secretary of State had decided to refer Professor Darzi's proposals for the PCT reconfiguration to an Independent Reconfiguration Panel. This Panel would consider the proposals with a view to making recommendations to the Secretary of State. The Chief Executive of the North Tees and Hartlepool NHS Trust, Ian Dalton, gave a comprehensive presentation to the Forum which highlighted the key issues as being:

- New management team was in place
- The quality of care provided was good
- Finance had been a major threat but was getting back on track because tough measures were being taken
- The University of Hospital of Hartlepool can have a good future
- The NHS was changing faster than at any time since it was created – this necessitated the need to keep changing in order to survive.

A discussion followed where the following issues were raised:

How had such a deterioration taken place in the Trust's finance since 2001? The Chief Executive of the Trust indicated that there were various reasons for the difficulties being incurred with the finances of the Trust and they were not uncommon among a number of other hospitals. There were several measures in place to deal with these difficulties which included a vacancy freeze, streamlining of administration, pooling of medical secretaries and better purchasing arrangements for supplies.

Does the vacancy freeze include any redundancies? The Chief Executive indicated that compulsory redundancies would be avoided wherever possible, however, this could not be entirely ruled out. The vacancy freeze may lead to other options, for example redeployment.

Some departments have already been relocated to Stockton, would any other departments be affected? The Chief Executive advised that there would be movement both ways between Hartlepool and Stockton as single site provision of some services was generally more efficient.

Members felt that the Trust was a good corporate citizen for both Hartlepool and Stockton with regard to employment but there was concern that the balance of jobs across both sites would change? Although the Chief Executive informed Members that it was difficult to give a formal commitment, the Trust were expected to carry out the same work every year at less cost and it may become unaffordable in the future to continue. A Member raised the concern of staff redundancies and job movement between Stockton and Hartlepool and would the balance of jobs be equally divided between the two sites. It was suggested that a compact on fairness in jobs for both towns may be feasible. The Chief Executive responded that although he would be happy to sign up to a Compact, he could not give any formal commitment.

How was staff morale affected and what was in place to deal with this? The Chief Executive indicated that the staff at the Trust were hardworking employees and it was felt that although staff could cope with difficulties across a short timescale that this would not be the case over an extended period. It was therefore imperative that any changes to the organisation be carried out quickly. There were measures in place for staff to give feedback, anonymously if necessary.

How significant were the numbers of staff leaving the NHS and how did this affect the vacancy freeze? The Chief Executive indicated that staff turnover was approximately 11% per annum. However, he added that it was not an absolute vacancy freeze and that on no account would it affect the hospital operationally. Essential clinical vacancies were considered individually as and when they arose.

Some patients had been informed that their operations had been cancelled as they were on a 'B' list? The Chief Executive informed Members that there was no such list in use. Occasionally operations were cancelled but this was rare and mainly due to emergency situations arising. He added that he had written personally to patients who had their operations cancelled and in the main they were very tolerant and understanding of the situation.

If patients have to travel to North Tees, would there be a bus route to accommodate this? The Chief Executive responded that although he would be fully supportive of a bus route to North Tees, the Hospital could not subsidise this. However, he would able to provide any relevant information needed in order facilitate this, for example patient numbers.

What is the hospital's position regarding the implementation of the Darzi report? The Chief Executive indicated that the report was broadly accepted by the University Hospital of Hartlepool along with James Cook, although there were no specific views regarding the maternity and gynaecology Services that were currently being re-examined. However, the Chief Executive added that he believed strongly that the services should be consultant-led on one site.

If the University Hospital of Hartlepool did not become a Centre for Excellence, what would the implications for the future of the Hospital be? The Chief Executive felt that the impact should be relatively minor. He added that the Centre for Excellence for paediatrics and gynaecology would be an extra service and that the Hospital was to become a major surgical and emergency admissions centre in any event.

What would be the impact on jobs at Hartlepool's Hospital? The Chief Executive indicated that this would depend upon what reconfiguration model was adopted. The paediatric and maternity services were relatively small services compared to the medical emergency service which would continue to be provided at Hartlepool.

It had been suggested that waiting times varied according to which PCT the patient comes from? The Chief Executive responded that this was not the case and that clinical priority should determine the treatment provided. Currently urgent cases were dealt with first with the remainder being dealt with in chronological order.

Was there a surplus of beds on a daily basis? The management of the beds within the hospital was carried out very efficiently and there were no cases of large wards having empty beds. He added that quality staff make very good use of the beds through ward rounds and the timings of discharging patients.

Was there any determination to manage beds at the point of referral? The Chief Executive confirmed that patients were not turned away and beds were not rationed. Beds were managed through responding to the conditions

of the time, for example if a nasty flu epidemic arose, planned patients would be rescheduled.

Would any land sales contribute towards the deficit? The Chief Executive indicated that any profit made on land sold could be used although this was not expected to be a major contributor. He added that the objective of land sales was to sell any land that was not required clinically.

Are patients still required to telephone the hospital on the morning of admittance to confirm that a bed was still available? The Chief Executive responded that this was normal practice nationally and this was part of the management of the beds available. The management of beds was an unpredictable business and the Chief Executive indicated that he was keen to separate planned and emergency services.

Is there occasions when the results of tests need to be seen by a consultant in another hospital? The Chief Executive indicated that this would depend upon the type of test being undertaken. Advances in modern technology enabled x-rays to be taken in one hospital and examined in another and some tests needed to be carried out at a specialist hospital under laboratory conditions. However, none of the above should impact on patients care.

Mr Dalton was thanked for his very informative presentation and for providing answers to the questions of Members of the Forum.

Decision

Members noted that content of the presentation and discussions would be used to aid the Forum complete the Annual Health Check process.

32. Apologies for Absence

Apologies for absence were received from Councillors John Lauderdale, Gladys Worthy and resident representative Mary Green.

33. Declarations of interest by Members

Councillors Caroline Barker declared a personal and non-prejudicial interest in minute 31 and Jonathan Brash declared a personal and non-prejudicial interest in minute 39.

34. Minutes of the meeting held on 25th July 2006

Confirmed.

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

None.

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

None.

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

None.

38. Annual Library Plan 2006/07 *(Director of Adult and Community Services)*

Members were asked to consider the draft Annual Library Plan which had been referred to Scrutiny for consultation from Cabinet on 3rd July 2006. The Plan was a key strategic document which formed part of the Council's Budget and Policy Framework. Consultation had already taken place with Neighbourhood Consultative Forums, library users and key stakeholders. As a result of this consultation, a number of additions to the plan had been made and they were summarised within the report.

A discussion followed in which the following issues were raised;

There seemed to be a problem for people with sight problems with the lighting in the toilets that had been installed to prevent drug use? The Borough Librarian indicated that the lighting did generally prevent drug use and it was not a constant problem. He added that it would be a good idea to re-examine the lighting in the toilets to try and rectify this issue and have regular inspections of the cleanliness if the appropriate funding was in place.

How did the library support the Adult and Community Services Department's targets for supporting vulnerable adults? The Borough Librarian informed Members that they were currently working with the Tees Valley Mental Health Trust and MIND to provide books on prescription for adults with mental health problems. Steps were being made to integrate other services including the youth service.

The Borough Librarian was thanked for his attendance and for responding to Members questions. Forum Members were also very supportive of the way the Library Service and the Adult Service were integrating.

Decision

i) The Plan was noted.
ii) The problems associated with the toilets in the Library be referred to Cabinet and the Neighbourhood Services Scrutiny Forum for further consideration.

39. Scrutiny Investigation into Access to GP Services – Closing the Loop Report *(Scrutiny Support Officer)*

The Scrutiny Support Officer presented a report that aimed to 'close the loop' into the investigation into the Access to GP Services. The final report was presented to the PCT Board Meeting on 30th July 2006. It had been agreed that the PCT would develop an action plan to address access issues to fulfil the recommendations made within the report. The Action Plan was attached by way of appendix with each recommendation and action to be taken by the PCT Board. It was reported that the Action Plan was ongoing and would be continuingly updated. The representative from the PCT indicated that the results of recommendation 4 and 7 patient surveys would be forwarded to the Scrutiny Forum for Members information.

A discussion followed in which the following issues were raised:

There still appeared to be an issue with a particular surgery with queuing outside on a morning before it opened? The representative from the PCT indicated that an effort had been made to ensure that as many mechanisms were available to book appointments as possible, including internet pre-booking. Although the queuing outside this surgery had decreased, it appeared that no matter what time the surgery opened, people still preferred to queue outside.

A Member noted the fact that the Dyke House area was not served by either a GP surgery or pharmacy, could this be looked at? The representative from the PCT responded that although it was not feasible to have practices in every part of the town, there was a need to ensure most services were accessible, ie through drop-in clinics. There was a greater concentration of facilities in the town centre and the location of any future services would need to be considered carefully.

Recommendation 6 supported the opportunity to consult a GP within 2 working days, this was a long time? The representative from the PCT indicated that this was a national target although it actually depended upon the urgency of the situation. For urgent appointments there should be a facility to be seen within 24 hours. Members were informed that a new facility had recently opened in the Owton Ward which was available for the whole town, although this had not been fully publicised yet.

The Forum thanked the Director of Primary Care and Modernisation for her attendance and for responding to Members questions. Members felt that this

was an on-going issue with a considerable amount of follow-up required.

Decision

Members noted the proposed actions detailed within the Action Plan.

40. Any Other Business

The Scrutiny Support Officer informed Members that the recommendations relating to a joint working protocol between Scrutiny and the PPI was no longer appropriate given the changes in Government Policy whereby PPI Forums will be replaced by Local Involvement Networks (LINKs), a statutory body for every local authority area.

Members were informed that two additional meetings had been arranged for Tuesday 19th September and Thursday 26th October 2006.

GERALD WISTOW

CHAIRMAN

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM

MINUTES

19th September 2006

Present:

Councillor: Gerald Wistow (In the Chair)

Councillors: Councillors Jonathan Brash, Mary Fleet, John Lauderdale, Geoff Lilley and Gladys Worthy.

In accordance with Paragraph 4.2(ii) of the Council's Procedure Rules Councillor Rob Cook attended as a substitute for Councillor Sheila Griffin.

Resident Representatives:
Mary Green

Also Present:
Councillor Steve Wallace, Chair of Hartlepool PCT
Chris Willis, Hartlepool PCT
Carmel Morrs, Hartlepool PCT
Peter Price, Hartlepool PCT
Karen Gater, Hartlepool PCT

Officers: Paul Walker, Chief Executive
Tony Brown, Chief Solicitor
Ewan Wier, Adult and Community Services Department
Charlotte Burnham, Scrutiny Manager
Sajda Banaras, Scrutiny Support Officer
Angela Hunter, Principal Democratic Services Officer

41. Apologies for Absence

Apologies for absence were received from Councillors Caroline Barker, Stephen Belcher and Sheila Griffin.

42. Declarations of interest by Members

Councillors Jonathan Brash, Mary Fleet and Steve Wallace declared personal and non-prejudicial interests in minute 47.

43. Minutes of the meeting held on 6th September 2006

Due to the unavailability of the minutes, consideration was deferred until the next meeting.

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

None.

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

None.

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

None.

47. Hartlepool PCT – Future Board and Management Arrangements *(Scrutiny Support Officer)*

The Chairman of the PCT presented a report which summarised the challenges faced by new PCT Boards in meeting the demanding criteria set out by the Department of Health.

A discussion followed in which it was questioned under which legislation was the local authority being consulted and was this statutory consultation. The Chair of the PCT responded that this was not statutory consultation, as it would have had to be undertaken over a 13-week period, and this consultation had to be completed by the end of September. The Acting Chief Executive of the PCT added that as the consultation was not directly about a change in service provision, it was not liable to be undertaken on a statutory basis. The Chief Solicitor indicated that whether consultation was done on a statutory basis or not, an essential element was to allow sufficient time for consultees to respond adequately and fully having regard to the nature of the issues involved. He added that failure to comply with this could invalidate the process and leave any decision taken without proper consultation open to challenge.

The Chairman of the Adult and Community Services and Health Scrutiny Forum confirmed that in line with the advice received from leading Counsel the Forum would undertake this investigation within the Health Scrutiny Guidance as a Statutory Consultation. Whilst the PCT did not accept legal

advice received by the Council, the Chairman of HPCT was invited to make his presentation on the basis that it did not compromise the Forum or the PCTs respective legal positions. In light of the timescales involved the Chairman also confirmed that a three week consultation period is insufficient to allow the Scrutiny process to be followed through and respond to the October deadline for HPCT.

The Chairman of the PCT recommenced with his presentation and indicated that the main challenges being faced by the PCT were:

- Management Cost Savings
- Joint/Shared Management
- Budget Deficit
- Fitness for Purpose Assessment
- Joint Working and Locality Focus

The report indicated that after considerable efforts, Hartlepool PCT's Senior Management Team could not find a way to maintain a separate management structure dedicated solely to the Hartlepool PCT Board, that achieved the necessary 15% savings, satisfied the Fit for Purpose criteria and enabled delivery of the financial recovery plan. However, the following two options were suggested by the Senior Management Team as possible ways forward:

- Option 1 – one management team servicing four PCT Boards
- Option 2 – two management teams, one servicing Hartlepool and North Tees PCT, the other Middlesbrough and Redcar & Cleveland.

The Acting Chief Executive informed Members that the PCT had tried to address how this whole process can be used to strengthen partnership arrangement with the local authority. She added that by 2008, most NHS Trusts should received Foundation Trust Status. Attached by way of appendix was a diagram that showed the four boards across the Teeswide area and how they may be managed by Teeswide Sub-Committees, a Remuneration & Terms of Service Committee and a Joint Strategic Planning and Commissioning Committee.

Also attached by way of appendix was a diagram showing the proposed Tees Management Arrangements. This included separate Directorates for both North and South of Tees Chief Executive's as well as Teeswide Directorates and Functions. The Acting Chief Executive indicated that the proposed structure should help to look and plan ahead as well as ensuring patients receive the best care with a choice of providers and locations. As far as Public Health was concerned, it was suggested that there needed to be improvements made with regard to joint working with the local authority and that links with the community needed to be strengthened.

A discussion followed in which the following issues were raised:

Would the role of the PCT Board including allocating spending? The Chair of the PCT indicated that decisions would be taken by the Board but that

the bulk of the Board were non-executive. A decision was being awaited from the Appointments Commission with regard to the candidates interviewed for a place on the Board.

Would the Joint Strategic Planning & Commissioning Committee be an accountable body? The Acting Chief Executive confirmed that the Committee would be from across the four boards and the Teeswide Director would need to operate within a framework. The Terms of Reference for this Committee would be formed by the Board. It was added that the majority of expenditure that would be overseen by this Committee was that of GPs.

Would individual PCTs delegate their spending responsibility to that body with the decisions made by the Committee? Karen Gater ??? responded that Hartlepool PCT would retain a board and has a statuory duty to balance the books. PCTs cannot subsidise each other and they must ensure their books were balanced. The Chair added that all PCTs must agree before any proposals go forward. The Chief Executive indicated that the Terms of Reference of the Committee had not been formed yet, but they would not act contradictory to the Board.

Did Option 2 not have the same disadvantages as Option 1 but in a more diffuse manner? The Chair of the PCT indicated that this should not happen if the proposals were implemented correctly. He added that Hartlepool and Stockton would pair up naturally as they operated under the same ethos, as do Middlesbrough and Redcar.

Would the partnership of Hartlepool and Stockton not rely on a similar agreement being made between Middlesbrough and Redcar? The Chair of the PCT responded that this may be the case, however Middlesbrough and Redcar see themselves as working together in a natural way also.

What did the 'Fitness for Purpose' assessment mean to the people of Hartlepool? The Chair of the PCT indicated that this assessment should mean that the people of Hartlepool have access to a health service with a choice of provider. Information would be provided to patients to enable them to make an informed choice. In order for this to work efficiently, there must be robust contracts in place. The Director of finance added that the whole system needed to have more rigorous monitoring in place as it was so complex. Increasingly individuals were choosing to go elsewhere for treatment.

The Director of Public Health added that the proposals should lead to getting maximum health gain for the allocated budget, including prevention. The whole package of the commissioning process was important to ensure investment was made in the right areas.

How was primary care being taken forward? The Acting Chief Executive informed Members that the financial position over the next 18 months was not good. However, primary care was seen as an area for development and was in the Vision for Care for Hartlepool.

There was concern that the majority of the job cuts would occur at operational level? The Chair of the PCT indicated that any job cuts would be shared across both Hartlepool and Stockton sites. However, he added that the proposal was to reduce the layers of management within the structure.

Would patients be referred to a particular hospital dependent on the cost of their treatment? The Chair of the PCT advised that there was a national tariff in place for all treatment. The Director of Finance added that all patients would be referred to Hartlepool Hospital unless they required specialist treatment that could be provided elsewhere. Patients could choose to be treated elsewhere, provided the treatment was provided at the national tariff. The Chair of the PCT informed Members that the people of Hartlepool had a loyalty to their local hospital and that this relationship should be maintained.

Concern was expressed that patients were being told to use Hartlepool maternity services as North Tees was closed adding extra pressure, who would decide this course of action? The Chair of the PCT indicated that this should be a question for the hospital and their management. However, the Acting Chief Executive added that in reality, patients were moved to another hospital to help deal with any pressures.

Hartlepool and Stockton appeared to be in conflict with regard to the Darzi review, how would a single management team deal with this? The Chair of the PCT indicated that the Boards would take on board the views of the non-executive and if necessary, executive members would abstain from voting. If Boards did have conflicting views, officers, including the Chief Executive would need to deal with this. The Chief Executive added that the organisations involved would need to find a way of working together.

What if the management team had to make a public statement and the Boards had different views? The Chair of the PCT advised that he felt that the Chairman of the PCT should be the public face as officers could be pulled in two directions. The Chief Executive indicated that any major decisions would be taken by the Joint PCT Committees that will be formed.

There was some concern that serving 2 boards would be twice as hard as serving 1, although there appeared to be no alternative to this option? The Chair of the PCT advised that there did not appear to be a perfect plan to be implemented, but this was the least worse of the options given and did have some benefits.

The representatives from the PCT were thanked for their informative presentations and for answering Members questions.

Decision

In line with advice obtained from leading Counsel in relation to health service reforms, the Adult and Community Services and Health Scrutiny Forum has conducted this investigation as a statutory investigation as outlined in Health

Scrutiny Guidance. This preserves the Forum's right to refer the issue to the Secretary of State. However, in the spirit of partnership working the Forum agreed to accommodate this request and Members agreed to hold a further joint meeting with Members of Scrutiny Co-ordinating Committee on 29 September 2006 to expedite the issue in line with the PCT's requirements.

GERALD WILSTOW

CHAIRMAN

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM

26 October2006

Report of: Scrutiny Support Officer

Subject: NATIONAL PERSPECTIVE - SOCIAL PRESCRIBING

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1. PURPOSE OF REPORT

1.1 To present Members with the National Perspective in relation to Social Prescribing.

2. BACKGROUND INFORMATION

2.1 In undertaking an investigation into Social Prescribing and in line with standard scrutiny practice it is useful for Members to consider the national context within which the social prescribing concept is grounded. The following is an extract from the 'our health, our care, our say' White Paper which sets out the Government's vision to provide people with good quality social care and NHS services in the communities where they live.

Social Prescribing

"2.93 Chapter 5 sets out our proposals for introducing information prescriptions for those with long-term conditions, to enable them to access a wider provision of services. A range of different 'prescription' schemes, such as exercise-on- prescription projects, have been established or piloted in a number of areas and have often been very successful.

2.94:- We would like to see increasing uptake of well-being prescriptions by PCTs and their local partners, aimed at promoting good health and independence and ensuring people have easy access to a wide range of services, facilities and activities."

[Extract from - Chapter 2 White Paper – Our Health, Our Care, Our Say']

3. RECOMMENDATION

3.1 Members are requested to note the content of this report.

Contact Officer:- Sajda Banaras – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
Tel: 01429 523 647
Email: Sajda.banaras@hartlepool.gov.uk

BACKGROUND PAPERS

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

(i) Our health, our care, our say: a new direction for community services.

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM

26 October 2006

Report of: Scrutiny Support Officer

Subject: EVIDENCE FROM HVDA & AUTHOR OF REPORT COMMISSIONED BY HARTLEPOOL PARTNERSHIP & HVDA IN RELATION TO 'DEVELOPING SOCIAL PRESCRIBING IN HARTLEPOOL'

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1. PURPOSE OF REPORT

1.1 To introduce to the Adult and Community Services and Health Scrutiny Forum representatives of HVDA and the author of the jointly commissioned report (by Hartlepool Partnership & HVDA entitled 'Developing social prescribing in Hartlepool' who are providing evidence at today's meeting.

2. BACKGROUND INFORMATION

2.1 As the Members will be aware, part of the role of this Scrutiny Forum in conducting an in-depth investigation is to seek views from all relevant stakeholders in relation to the issue under investigation. It is by gathering evidence from a variety of sources that the Forum is able to build up a knowledge base to assist it in taking the inquiry forward.

2.2 It is to this end that the Author and Commissioner of the report 'Developing Social Prescribing in Hartlepool' are in attendance at today's meeting. Following an initial presentation of the report (**Appendix A)** Members are requested to ask any questions felt appropriate to gather sufficient evidence to assist in its production of a final report.

3. RECOMMENDATION

3.1 Members are requested to note the content of this report and ask any questions felt appropriate in conducting the Scrutiny Review into Social Prescribing.

Contact Officer:- Sajda Banaras – Scrutiny Support Officer

Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
Tel: 01429 523 647
Email: Sajda.banaras@hartlepool.gov.uk

BACKGROUND PAPERS

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

Developing Social Prescribing in Hartlepool

Commissioned by
Hartlepool Partnership
Hartlepool Voluntary Development Agency

Produced by Paul Hyde – Independent Consultant

February 2006

Contents

Developing Social Prescribing in Hartlepool
1. Background

Social Prescribing

1.1 The brief for this study was to explore ways that social prescribing could be developed in Hartlepool. Social prescribing is a mechanism for linking patients in primary care with a range of non-medical activities and support.

1.2 The aim was to develop a model for social prescribing in Hartlepool that will provide an assessment of an individuals needs and a referral process to direct them towards the most appropriate source for responding to those needs.

1.3 The study was commissioned following discussions around the 2006-2008 Neighbourhood Renewal Fund Health & Care programme where the role of social prescribing was raised. The Health & Care Strategy Group felt that there was an opportunity to better co-ordinate existing and future activities around healthy lifestyles and standardise the system of referral from GPs to those services.

1.4 Social prescribing fits well with new and emerging strategies for health and social care. It provides a potential link between primary care, local authority and voluntary sector funding and dovetails with the call for increased action around the ill health prevention agenda and moves to increase mental well-being.

1.5 Speaking ahead of the release of the new health white paper at the end of January 2006, health secretary Patricia Hewitt outlined how more services will be moved into the community and hoped the proposals would give people more choice in how they were treated, it is possible to see how a social prescribing scheme could dovetail with these new proposals.

1.6 She said: 'I see this as the next stage in the improvements that we're making to the NHS and to social care.

1.7 'First of all giving people more information and support so that they can stay healthy and independent for as long as possible.

1.8 'Secondly giving people more choice and more control over their health and social care services when they need that support and that treatment and thirdly more services being delivered more conveniently closer to people's homes, much more personally, and tailored to their particular individual needs.'

2. The National Picture

2.1 The initial study of national social prescribing type schemes considered the range of services currently being delivered. It is clear that the activities provided through social prescribing type initiatives are now many and varied. In locations throughout the UK these include:

2.2 Information was found on a wide variety of exercise on prescription schemes providing from10 sessions for the shortest programmes up to 36 sessions. Activities available are varied and include:

2.3 Gym sessions, exercise to music classes, swimming, walking, badminton, aqua aerobics, golf, bowls, specific exercise classes for specific conditions eg. 'Strokability', 'Osteo-action'. There are also examples of gentle exercise including walking and armchair exercise.

2.4 The majority of exercise on prescription appears to be operated through local authority provision and are operated with a combination of health, local authority and regeneration funds.

2.5 Other local authority linked provision within 'on-prescription' schemes included learning on prescription (typically with Adult Education) and books on prescription (A project in Middlesbrough where self help books are 'prescribed' through the libraries).

2.6 There was evidence of private sector activities through a 'Slimming on Referral' scheme operated as a partnership between local PCT's and Slimming World.

2.7 There is voluntary sector provision linked to social prescribing. This includes specific programmes that have taken a lead in developing referral schemes such as art on prescription (Sunderland Art Studio) and several mental health charities. There are many other providers in the voluntary sector delivering services linked to exercise on prescription schemes as well as those providing debt counselling and other specialised services. There is evidence of a growth in low-level support and community befriending schemes.

2.8 There is evidence of some 'repackaging' by the voluntary sector to explore the health/social care potential of their work and be included in referral schemes an example being the Green Gyms to describe the conservation work carried out by the British Trust for Conservation Volunteers.

2.9 It would appear that there are more direct referrals from health care staff to the voluntary sector, set up on a group-by-group basis, rather than co-ordinated 'social prescribing' schemes

3. National Best Practice

3.1 While there is information and evaluations of individual projects, and projects that link together to form exercise on prescription schemes or link provision around mental health services the researcher has not been able to find examples of schemes that link referrals to provide comprehensive social prescribing models.

3.2 It would appear that a more co-ordinated approach to develop the potential for social prescribing is currently being debated and considered.
"General Practitioners and Community Nurses are ideally placed to identify how loneliness and isolation might be precursors to more severe problems. Primary care social prescribing initiatives are growing more common. The prescription by GPs of exercise and education are two such examples[1]".

3.3 There is also debate, and some action, which considers how social prescribing could financially support the delivery of services. "Social prescribing could put the funding of a home support service or day club on a much firmer footing. This idea is not so unusual and costs could be shared between the Primary Care Trusts, Acute Trust and local government. For example, some casualty departments have responded to the influx of older patients with chronic chest conditions in winter by employing community based resources specifically geared up to make preventive visits to older people at risk"[1].

3.4 Another national study considers if the term social prescribing is correct "Prescribing may not be a helpful term as it suggests lack of dialogue and ownership, may be seen as patronising and implies that the therapist is the expert. However the term does bring the approach within GPs' frame of reference and offers a start in moving away from a medical model. In exercise referral schemes, GPs themselves did not like the term prescribe and used refer".[2]

3.5 The study also considers who would refer people: "Primary care is not just GPs. Other members of the multi-disciplinary primary health care should be engaged and may prove more accessible and amenable to the goals of social prescribing. Local initiatives report varying degrees of success in getting engagement with primary care / GPs. At times, the key driver has been to direct patients away from GPs to other members of the primary care team and to other resources".[2]

[1]From WHEN INDEPENDENCE BECOMES ISOLATION By Douglas Webb

[2]From: Developing social prescribing referral models in mental health: pathways from primary care health care to non-medical interventions
Lynne Friedli, Mental Health Promotion Specialist

3.6 Setting criteria for social prescribing may be restrictive, although there is value in having a checklist of what to look for in patients as an aide memoir.

3.7 While there is scope to develop access through primary care to other resources and opportunities, other routes, such as community development, must also remain open so that people can participate and find activities that they want. Through referral to HVDA social prescribing could identify opportunities for establishing new self-help groups and through referrals to the HVDA Volunteer Centre help develop opportunities for people to work as a volunteers.

Findings for the study of national examples

3.8 While no examples of schemes that link referrals to provide comprehensive social prescribing models were found the evaluation of individual projects, and projects that link together to form exercise on prescription schemes do provide useful information.

3.9 Exercise on prescription schemes appear to be well established in most areas. There has been a national quality assurance framework for exercise referral systems in place since 2001.

3.10 Initially these exercise on prescription programmes were targeted at people with a range of physical medical conditions including:

- coronary heart disease
- hypertension
- obesity
- diabetes
- problems caused by falls
- musculo-skeletal problems, such as chronic low-back pain

3.11 It would appear that once established the referrals to these exercise on prescription programmes grew, initially to include people with risk factors that could lead to coronary heart disease. This included being overweight, smoking, high cholesterol, family history of heart disease, high blood pressure or a stressful lifestyle.

3.12 By helping people to be physically active the exercise schemes were viewed as a preventative measure for a range of medical conditions and as a way to assist in the treatment for people who already suffer from these conditions.

3.13 Referrals to exercise on prescription appeared to grow further to include people with a range of mild to moderate mental ill health conditions. The Mental Health Foundation claims there is 'now mounting evidence that a supervised exercise programme could treat mild to moderate depression as well as, if not better than drugs'.

3.14 From the schemes that have been evaluated it would appear that a referral to a new activity is likely to be taken up by around 50% to 60% of the people referred. This uptake is considered to be approximately the same as the proportion who redeem a prescription for medicines.

3.15 The uptake can be improved by introducing practical measures to support people to take up their 'social prescription'.

3.16 While there are examples of direct referrals into exercise classes (where a health based assessment will be made at the start of the exercise) for other types of referrals there was usually someone acting as a 'broker' to carry out an assessment and work with the person to identify the best course of action. As in the example of the Nottingham 'learning on prescription' scheme where; "an advisor works with the patient to identify activities that could help to alleviate symptoms, such as an assertiveness class, yoga, painting or computer training. The patient is then supported through the enrolment process".

3.17 As an alternative to establishing a social prescribing scheme Cambridge CVS (the support agency for community voluntary sector groups in Cambridge) produced a directory of voluntary services specifically for primary care staff to encourage more direct referrals. This approach has appeared to have had limited success when compared to a social prescribing scheme. While the directory had raised the awareness of the voluntary sector in around 40% of primary care staff it had resulted in increases in referrals from around 24%.

3.18 The reported benefits people can gain from being involved in social prescribing appear to be wider than the direct benefit associated with the activity they take part in. Dr Michael Varnam, GP at Nottingham's Windmill Practice, made this comment about the prescriptions for learning, where people had accessed adult education: "Prescriptions for learning have helped lots of our patients live fuller lives. People report less pain, more energy, greater amounts of fun, and they consult less often."

Case Study East Enfield and East Haringey 'Exercise on Prescription' scheme.

3.19 There has been a comprehensive evaluation[3] on a social prescribing scheme in East Enfield and East Haringey that provides more detailed data. This exercise on prescription scheme involves participants in a long exercise course (36 sessions – compared with 10 sessions for the Hartlepool Exercise for Life Programme).

[3]A summary of two studies undertaken in East Enfield and East Haringey: a survey of physical activity and health behaviours and an evaluation of an 'Exercise on Prescription' scheme. (Papadopoulosl , Lay & Yankey).

3.20 Less than two thirds (60%) of those referred attended the initial induction to the scheme. This is said to be the same as the proportion who redeem a prescription for medicines[3].

3.21 Three quarters of people felt they had enjoyed taking exercise much more than they had expected and two thirds said that taking exercise had made them feel better about themselves to a greater degree than they had expected[3].

3.22 Three months after completion of the programme, changes in lifestyle had been maintained and eight out of ten people were exercising. Comparing their health with a year ago, six out of ten said their physical health was better and a third said their emotional health was better[3].

3.23 A year from the start of the programme, a broadly representative proportion of those who completed a questionnaire immediately after the programme, completed the last in the series of questionnaires. Everyone was exercising and eight out of ten said they were exercising more than once a week. Half of the participants had improved the rating of their physical health and a third had improved the rating of their emotional health in comparison with the ratings before the programme. Again, it was those who had completed 31 - 36 sessions who sustained the changes experienced during the programme[3].

3.24 Of those who completed less than half of the sessions on the programme, 40% reported that a new or short-term physical problem had affected them in the four weeks prior to the start of the programme. Similarly, those people who were unmarried or did not have a partner were significantly more likely to become non-attenders[3].

3.25 From qualitative data obtained by telephone interview, other possible factors that could signal non-attendance were explored. A significant factor was a new short-term physical problem; 40% of all non-attenders reported that they had been affected by a new problem prior to starting the programme, compared to 17% of attenders. Non attenders affected in this way commented on their health limiting their attendance and expressed concerns about exercising with their current health problems[3].

3.26 Individuals who had been referred for being overweight, and who subsequently became non-attenders, indicated that they found **exercise** hard and that they had difficulty keeping up with others. Furthermore, some women wanted single sex sessions[3].

3.27 Some older non-attenders had concerns about being prescribed **exercise** by their GP and felt that the programme was inappropriate for their needs[3].

[3]A summary of two studies undertaken in East Enfield and East Haringey: a survey of physical activity and health behaviours and an evaluation of an 'Exercise on Prescription' scheme. (Papadopoulosl, Lay & Yankey).

3.28 General practitioners (GPs) who refer patients to the scheme, predominantly for primary prevention in the case of coronary heart disease and secondary prevention in patients with risk factors associated with coronary heart disease or anxiety and depression, perceived the administration of the scheme to be good. They were positive about the psychosocial benefits to patients, but less so about the medical impact of the programme[3].

3.29 The findings from the East Enfield and East Haringey 'Exercise on Prescription' scheme study suggest that everyday life events, such as short-term illness, circumstances, such as age or the presence of a partner, and reason for referral can influence participation rates for exercise on prescription schemes. It is likely that these factors operate independently of the attractiveness and accessibility of the scheme itself. The evidence generated from this evaluation shows that participants who complete 75% of the sessions can benefit from the scheme, regardless of age, gender, employment status or reason for referral.

3.30 The information generated by the non-attenders in the course of this evaluation offers some practical guidance for the design of a social prescribing scheme. The findings suggest that when social prescribing is limited to offering just exercise options it will attempt to refer people to activities they do not feel are appropriate to their needs.

Private Sector Case Study

3.31 An evaluation of 'Slimming on Referral' a partnership between a private sector company and PCT was considered. Slimming on Referral gives free membership of a local Slimming World group to patients referred by their GP. Referred patients attend at no cost to themselves for an initial 12-week period; the cost to the NHS is subsidised by Slimming World. This evaluation was of interest for several reasons; it included a cost comparison; it was working to measurable health improvement targets; it demonstrated how a scheme can be marketed to primary health care staff.

3.32 After 12 weeks patients may elect to carry on attending their Slimming World group and pay the weekly fee themselves or may be offered another 12-week period of attendance by their GP. In this way provision of subsidised support can be targeted long term towards those who are income-disadvantaged while other patients are able to continue at their own cost.

[3]A summary of two studies undertaken in East Enfield and East Haringey: a survey of physical activity and health behaviours and an evaluation of an 'Exercise on Prescription' scheme. (Papadopoulosl , Lay & Yankey).

3.33 A study examining attitudes to enrolment, attendance patterns, outcomes and factors associated with successful participation in Slimming on Referral was funded by Greater and Central Derby Primary Care Trusts and Slimming World. A total of 107 patients were recruited from two general practices over a five-month period. Outcomes showed that the required target of between 5% and 10% weight loss for health improvement was achieved in a significant percentage of patients referred to the programme.

3.34 The cost of Slimming on Referral to the PCT was £44.50 per patient, which includes joining fee and 12 weeks' attendance (offering a 'saving' to the NHS of £12.90 on the normal cost through a subsidy by Slimming World). The costs of current obesity therapy options, such as drug treatment, are far higher with the average cost of 12 weeks' prescription of orlistat around £123; for sibutramine the cost is around £112, depending on dosage.

3.35 The long-term financial benefits for Slimming on Referral patients were noticeable improvements in health and wellbeing. Many report that they require less medication, including anti-hypertensive medication and diabetes treatment, and some no longer require any medication at all once they have lost weight successfully.

4. Current Provision in Hartlepool

4.1 The study considered two social prescribing schemes operating in Hartlepool.

- The MIND scheme – providing support and services for people with mental health issues.

- The Hartlepool Exercise for Life Programme (HELP) - providing a range of exercise sessions.

4.2 These two schemes are not formally linked, so there is a separate referral form in use for each scheme with each GP.

4.3 The schemes do link at an operational level. There are referrals between the two schemes and MIND run sessions on the weight loss support groups organised by HELP.

4.4 The MIND scheme has open referral – people can self refer and the referral forms are widely distributed to other (non health care) professionals and to other voluntary sector groups.
The HELP scheme is a closed referral scheme – only referrals from health care staff are accepted - people cannot self refer. People are encouraged to continue to exercise and there is an 'Active Card' membership scheme offering discounted rates at local authority venues.

4.5 The MIND scheme does not have a formal structure; the programme of support is designed with the service user to meet their needs and can last for any period of time.
The HELP scheme has a formal structure; a programme of 10 sessions is selected from a range of sessions.

4.6 While this study considered the two social prescribing schemes operating in Hartlepool there are other direct referrals from health care staff to help people access other provision.
This other activity has been established through:

- Direct promotion to health care staff from groups delivering services.

- General publicity and promotion that has made health care staff aware of the services.

- The existing knowledge of the health care staff.

Hartlepool MIND

4.7 Hartlepool MIND currently receives referrals from most of the 54 GP's in the town (estimate at between 60% to 70% of GP's referring to MIND). Most GP's use a referral form supplied by MIND some get people to call direct. Other providers including some VCS groups also use the MIND referral form.

4.8 MIND carry out a 'holistic assessment' of anyone who is referred to them and then provide in house services or refer on to another service. In some cases direct support is provided by MIND staff to support the person so they can access services, this includes accompanying people to attend sessions etc.

4.9 MIND estimate that 90% of people referred to them attend for the holistic assessment and that over 90% take up further sessions/activities following their assessment. During the past 12 months Hartlepool MIND have carried out 572 assessments. The table below records the progress made by clients referred to them during the past 12 months.

Accessed volunteering	70
Enrolled into Education	107
Medication has been reduced as a result of accessing Mind	61
Came off medication as a result of accessing Hartlepool Mind	19
Gained Employment	45
Returned to employment (came off benefits)	47

Hartlepool Exercise for Life Programme (HELP)

4.10 The Hartlepool Exercise for Life Programme is an exercise on prescription scheme operated by HBC and supported by the Hartlepool PCT. People who are referred receive an assessment to select the right activity.

4.11 Referrals to HELP are received from a range of health service settings including GP's, dieticians, nurses, health visitors, hospitals and various mental health organisations.

4.12 HELP have referral forms in all 16 GP practices in Hartlepool and have received referrals from all, although one uses letters rather than form. HELP reported that they are working mainly, but not exclusively, with older people.

4.13 It is estimated by the HELP co-ordinator that the scheme is currently receiving around 500 referrals a year although 40% do not turn up and 10% do not complete the programme so has a completion rate of 50%. Everyone referred onto the scheme is contacted by telephone by the HELP co-ordinator.

4.14 The HELP scheme is currently using a range of eight local authority and community venues throughout Hartlepool to offer 11 different activities. HELP

has formed working partnerships with the PCT Health Development Team and Manor Residents Association to deliver some of the services. Some of the programme provides additional support alongside exercise sessions for example the 'Shapes and Sizes' weight loss support group supplements one hour of exercise with an additional hour when Pharmacists, Community Nutritionists, MIND and a Diabetic Nurse talk to the group members. There is a small sessional charge for attending most sessions although one of the weight management and a men's health group are free.

4.15 A referral to the Hartlepool Exercise for Life Programme is for a limited time usually 10 sessions over a ten-week period. Although they do encourage people to continue to exercise and are encouraged to take up offers linked to the venues. However to get back onto the HELP programme people would have to go back to their GP. HELP occasionally refers people onto MIND and refers to the HBC Walks for All programme.

4.16 HELP uses 7 part time/sessional qualified fitness instructors to run the classes. The HELP co-ordinator reported problems a shortage of qualified instructors in Hartlepool at the current time.

5. Information on the local voluntary sector provision from previous research in Hartlepool

5.1 Information in the following section is taken from 'Hartlepool Voluntary Sector Organisations and Hartlepool Primary Care Trust Mapping Exercise/Study November 2003'. Information from this mapping exercise provides an insight into the health and social care services being delivered by the voluntary/community sector in Hartlepool.

5.2 A total of sixty-two organisations took part in this study recording a wide range of services that were being delivered by the voluntary sector in Hartlepool to a range of people. The sample included a significant number of organisations (29%) whose primarily purpose was to provide services for people with a specific medical condition.

5.3 Information on how people got to use the services offered by the voluntary sector show that while most are through self-referral their link with statutory agencies lead to a considerable number of referrals. However the results suggest that at the time of the study the link between health care professionals may not be as strong as the link with local authority staff.

5.4 Almost all the organisations (over 90% of the sample) were actively involved in activities that encouraged health and well being among service users.

5.5 Table 1 shows how voluntary/community groups in Hartlepool were delivering services that impacted on issues that had been identified as local health priorities.

Table 1

Identified issue	**'match' from the sample**
smoking	Several initiatives for smoking cessation and information/advice. Evidence of community based work and work with young people.
Inactivity	Keep fit classes. Exercise for older people. Sports activities for people with disabilities. Children's sports activities. Training for more leaders.
Drug & alcohol abuse	One dedicated project. Others involved with group work. Information. Advice. Housing.
Unhealthy diet	Many organisations taking an active role. Advice, information. Training.
HIV/AIDS and sexual health	One dedicated project. Others involved in information.

5.6 Table 2 shows how voluntary/community groups in Hartlepool were delivering services that impacted on a number of medical issues.

Table 2 'Medical' issues

Identified issue	**'match' from the sample**
Heart disease	Information. Advice. Exercise, Diet
Diabetes	One dedicated project.
Cancer	Information. Advice.
Mental illness	Two dedicated projects. Provision of supported housing. Many organisations providing activities/support.
Obesity	Organisations taking an active role with diet/healthy eating. Exercise sessions, sports activities.

5.7 Table 3 shows how voluntary/community groups in Hartlepool were delivering services that impacted on a number of wider determinants of health issues.

Table 3 Wider determinants of health

Identified issue	**'match' from the sample**
Housing & Homelessness	Four dedicated projects. Housing for vulnerable people. Home improvement. Refuge for women fleeing domestic violence.
Transport	Organisations providing home visits. Activities in community settings. Groups organising transport for service users. Hire/loan of wheelchairs/scooters.
Income	Advice on debt management. Maximising income through benefit advice/action.
Social support	Befriending service. Social groups for many people with specific conditions. Social activities for carers. Social activities for older people.
Environment	Dedicated project for home improvement.
Education	Community based action from training providers. Groups with training/guest speakers.
Accidents	Prevention work with older people.
Fuel Poverty 'health through warmth'	Information and advice.

5.8 Table 4 shows how voluntary/community groups in Hartlepool were delivering services that impacted on a number of social issues.

Table 4 Social Issues

Identified issue	**'match' from the sample**
Teenage Pregnancy	Information and advice.
Domestic violence	One dedicated project. Information and advice. Housing project. Relationship counselling.
Crime & Community Safety	Information and advice. Target Hardening (home security) project.

5.9 Information from the Mapping Exercise/Study demonstrates that the voluntary sector is already active in delivering services that link with identified health priorities, a number of medical conditions, social issues and other wider determinants of health. These services use a wide variety of venues across Hartlepool.

6. How a social prescribing scheme could benefit GP's.

6.1 The term 'heart-sink patient' has been in use for some time to describe a patient that keeps presenting himself/herself at the GP's surgery. "There are certain patients whose usually frequent appearance makes the doctor's heart sink. The heart sink patients are those who vex us, and so with such a wide and subjective definition there is considerable variation in terms of who fits the description and who would be described as such by whom. Essentially they are those patients who leave us (the GP) with negative feelings (eg: anger, frustration, inadequacy) on completion of the consultation. While they may have genuine illness but not be coping with it is more likely they may be experiencing purely social problems including loneliness or they may be clinically depressed." (From Patient UK)
A social prescribing scheme would offer an option for referring a 'heart-sink patient' for an assessment that may be able to better meet their needs.

6.2 It is estimated that nationally up to 40% of people attending their GP will have a mental health problem and that over 75% of all people consulting their GP will have at least one psychosocial problem. While GP's are often in a position to be knowledgeable about the specific social conditions their patients face and can therefore identify psychosocial issues primary care staff have limited time and resources to address these issues. A social prescribing scheme would offer an option for referring patients for an assessment that may be able to better meet their needs.

6.3 The voluntary sector is considered to be in a unique position to work with patients with complex social problems, however the voluntary sector can be difficult to access. A social prescribing scheme would provide the route into the services available.

7. Key Findings

From the national research

7.1 It has not been possible to identify a simple 'off the shelf' model for social prescribing from the research into existing national practice.

7.2 Many GPs did not like the term 'prescribe' and preferred the use of 'refer' for the exercise schemes.

7.3 However the term 'prescribe' does bring the approach within GPs' frame of reference and offers a start in moving away from a medical model.

7.4 Evaluation of exercise on prescription schemes show:

- The take up of the exercise 'prescription' is about the same as the proportion who redeem a prescription for medicines.
- Setting criteria for social prescribing may be restrictive, although there is value in having a checklist of what to look for in patients as an 'aide memoir'.

From the local research

7.5 The two existing 'social prescribing' schemes that are operating in Hartlepool appear to be successful and could be used as a foundation for building a more comprehensive social prescribing scheme.

7.6 There is current provision within the Hartlepool community/voluntary sector from a number of 'referral ready' groups that could be accessed as part of a social prescribing scheme.

7.7 There is a potential problem of 'information overload' if services that could be suitable for social prescribing are independently promoted to health care staff and other potential points of referral. A co-ordinated approach is required to maximise the potential of social prescribing.

7.8 Although the 'Information overload' has not yet happened the three voluntary organisations that were interviewed as part of this study one was gaining direct referrals (MIND) and one was actively perusing links with GP's (Headland Development Trust). As there are over 60 voluntary sector organisations delivering health/social care services in Hartlepool the need to guard against them all seeking to establish independent methods of referral.

7.9 GP's and other primary care staff are already referring people to voluntary sector provision, however these referrals are based on the individual's

knowledge of what is available. A GP interviewed as part of this study felt that the local voluntary/community sector has a lot to offer but the interface needs to be right and stressed the need for quality assurance and effective monitoring so that services could be trusted.

8. Potential models for social prescribing in Hartlepool

Three options were considered and discussed during this study:

Option	Description	Likely outcome
1. Do nothing	There is some social prescribing already in place. Other referrals to services are based on individuals' knowledge and trust of other services.	More groups and activities attempting to gain referrals independently.
2. Directory of services	A directory of services specifically designed and promoted to primary care staff and other potential referrers. Reliance is still on the knowledge and trust of the person making the referral.	Limited success in raising awareness (based on Cambridge CVS model) Limited improvement in uptake of other services.
3. Referral for assessment	Referral by primary care staff and others to a third party for a holistic assessment. Third party is tasked with holding up to date information on services to refer onto. Opportunity to build in mechanisms for measurement and evaluation.	Potential for high uptake Positive Impact on reducing the repeat attendance at GP surgeries

8.1 Option 3 was considered to represent a comprehensive social prescribing scheme and has been further explored

9. Exploration of option 3

9.1 To develop a comprehensive social prescribing scheme it would appear that there are four key elements that need to work in unison.

1	2	3	4
Marketing	**Assessment**	**Support**	**Delivery**
For the referrer	**To assign services**	**To support the uptake**	**Delivery of services**
A clear message that promotes a single reliable service	A holistic assessment	Appropriate support to help people take up the referral	A network of 'referral ready' organisations offering a range of services
Key considerations	**Key considerations**	**Key considerations**	**Key considerations**
A single contact number to access the scheme The collection of monitoring and evaluation data with effective	Geographic spread of assessors across the town Knowledge base of the person carrying out this assessment	Potential role for volunteers	Geographic coverage Payment for the services delivered

Marketing

9.2 For the person making the referral there needs to be a clear message that promotes the service. This message needs to encompass the issues that people are facing that could be improved if they are referred for an assessment. The message will reflect the range of services that can be included in the social prescribing scheme. The design of this 'marketing message' will be critical to the success of the scheme

9.3 While GP's are one of the key referring groups there are other statutory and voluntary sector agencies that could refer people onto the scheme, it would also benefit if it remained open for self-referral and for referrals from family/carers/friends.

9.4 Existing research demonstrates that referrals for people to access health and social care services delivered by the community/voluntary sector in Hartlepool are already being made by:

- Police/wardens
- School staff
- People involved in helping people access Disabled Facilities Grants
- Social housing providers
- Prison staff
- Church
- Social Workers
- Community Psychiatric Nurses
- Psychiatrists
- Occupational Therapists
- Other voluntary sector groups
- Voluntary sector support agencies

Assessment

9.5 This model sees the client referred to a third party for a 'holistic assessment'. The holistic assessment outlined is based on the current practice developed by Hartlepool MIND.

9.6 Although it will depend on the individual a typical assessment will be expected to take one hour to complete.

9.7 The assessment will be client directed so the client is involved in deciding what will work for them, when they can start and where they will attend.

9.8 The assessment will be 'outcome informed' the client decides what is needed as an outcome then the service decides what to do. So the client could for example decide that they may want to loose weight or stop smoking or feel less stressed etc.

9.9 The knowledge base of the person carrying out the assessment needs to be both comprehensive and up to date so that a full range of services can be offered as options.

Support

9.10 It is important that people being offered services are also offered the appropriate support to help them take up this offer. There may be opportunities for some of this support to be offered by volunteers.

9.11 It has been demonstrated that being able to offer support helps to achieve high take up of services offered (greater than 90% uptake for Hartlepool MIND compared to a typical uptake of 60% for exercise on prescription schemes).

Delivery

9.12 There are many groups and activities within the statutory and voluntary sector that could be involved in the delivery of services.

9.13 The groups/activities involved in the service delivery would need to operate a data collection/monitoring to assess the impact of the scheme.

9.14 For a scheme to work there would need to be a mechanism that enabled payments to be made to service providers for the delivery of services.

10. Barriers to developing social prescribing in Hartlepool

10.1 There are a number of barriers that the design of a social prescribing scheme needs to consider:

10.2 **The need to gain the support and trust of primary health care staff especially GP's.**
For a system to work it needs to be trusted by GP's and other key referrers.
If possible GP's should be involved in the design of a system.

10.3 **The need for common monitoring and evaluation methods with a social prescribing scheme.**
There needs to be robust systems in place to gather the monitoring data required to measure the impact of a social referring scheme. It is important that this information is fed back in an appropriate way to the people making referrals.

10.4 **The fragility of the voluntary sector.**
The voluntary sector is facing a funding crisis and many organisations are at threat of closure or are having to scale down their operations. While strategically the voluntary sector is being increasingly identified as an important deliverer of services their inclusion within the procurement process is not developing at the same pace, this is happening at a time when sources of funding (for example EU funds) used by the sector will not be available from 2006 onwards.

10.5 **Funding for the service delivery.**
If there is not access to funds that 'follow' the person in receipt of a social prescription then the service deliverers will be further stretched financially. While in theory this appears to fit with Practice Based Commissioning and Payment by Results it is yet to be explored in practice.

10.6 **Waiting times for certain services**.
Some of the key services delivered by the voluntary sector are working at capacity and have long waiting lists (for example up to 8 weeks for some Hartlepool MIND services). If further demand is put on these services without offering additional resources waiting times will increase.

11. Development Pathway

11.1 There is the potential for a small-scale pilot that would run at a limited number of GP surgeries and other referral points. This would allow for a gradual start and could target provision in a number of key geographical locations.

11.2 **Development pathway tasks**

Design/fund	There will be a need to identify GP surgeries and other referral points that would be willing to take part in the pilot. The pilot would need to be costed and funding secured
Steering group	The steering group should include: Existing social prescribing groups (HELP/MIND/PCT Health Development), voluntary sector (service delivery groups and those active in the area where the pilot operates), support groups (HVDA), GP and other referral (if possible – must be consulted with if not involved in the steering group)
Incorporation of existing provision	Inclusion of the existing MIND and HELP schemes at the point of referral.
Appoint lead organisation	There will be the option of having an existing group develop this small-scale pilot although the scheme needs to be perceived as independent and have a new identity of any existing groups, so that it is not associated with any specialisms.
Assessment staff	Creating a post, or recruitment of part time staff, to carry out holistic assessments.
Design of publicity/marketing	Developing the marketing message that promotes the service
Training	There would need to be people trained to carry out the holistic assessments
Service delivery network	The groups/activities involved in the service delivery
Monitoring evaluation	The groups/activities involved in the service delivery would need to agree on the data collection/monitoring to assess the impact of the scheme.
Support role	Recruitment and training of volunteers

11.3 There may be a need to appoint a consultant to underwrite the development work identified in the development pathway tasks (11.2).

11.4 A social prescribing pilot scheme would need to maintain and extend the two current social prescribing schemes in Hartlepool. It would benefit if it could incorporate the existing MIND and HELP schemes at the point of referral. This would mean that there would be a single contact and single referral form. Evidence suggests, from the areas where exercise on prescription is the sole option, that if this does not happen then referrals can be made that are inappropriate.

11.5 There may be opportunities to link the holistic assessment with the new Health Trainers/Connected Care Workers. This potential link should be explored with PCT staff.

11.6 The groups and activities involved in the service delivery will allow a range of new opportunities to be included in the social prescribing pilot. It also needs to consider ways of increasing provision to enlarge the activity base around physical activity through support to initiatives such as the Belle Vue Sports and Community Centre and the Headland Development Company provision.

11.7 There need to be opportunities to explore the potential of support through Practice Based Commissioning as a way of providing funding that would 'follow the referral'. The latest guidelines on the Practice Based Commissioning structure states 'Practices and localities will be well placed to understand and address local health issues, particularly if they draw on PCT public health expertise and voluntary sector links. This multi-sectoral engagement is important but can be time consuming and sometimes frustrating. However it does offer the opportunity to influence a wide range of organisations so that their resources can better contribute to improving health and reducing inequalities'.

11.8 The potential impact of a Hartlepool social prescribing scheme would link with several of the NRF Health and Care Strategy Group Themes:

- Improving Health – Lifestyle Factors
- Older People
- Mental Well Being
- Access to Services

Roll out

11.8 The roll out of a social prescribing scheme for Hartlepool should use information gathered during the pilot.

11.9 There may be a number of options and opportunities for how the social prescribing scheme could develop. It may be possible for an existing group, or groups, to develop the scheme or to use a social enterprise structure, and ethos, to further develop a social prescribing scheme. While the scheme will be 'not for profit' a social enterprise could develop opportunities for entrepreneurial marketing to maximise the potential for the scheme.

11.10 A developing social prescribing scheme for Hartlepool should also consider incorporating private sector provision as with the Slimming World model.

11.11 A developed social prescribing scheme for Hartlepool could link a variety of provision and activities referring people to:

- Mental Health support
- Exercise on prescription
- Weight management
- Volunteering
- Education
- Employment
- Training
- Leisure activities

12. Developing Social Prescribing in Hartlepool

As part of this study Interviews were held with:

- Peter Price – Director of Public Health & Well Being, PCT
- Keith Bayley – HVDA
- Margaret Boddy – Exercise Referral Scheme, HBC
- Iain Caldwell – Hartlepool MIND
- Carole Johnson – Health Development Team, PCT
- Sarah Foster – Headland Development Trust
- Alex Sedgwick – Belle Vue Sports, Community and Youth Centre
- Ali Wilson – Director of PCT development and modernisation
- Carl Bashford – Head of Mental Health Commissioning
- Dr Carl Parker – practicing GP in Hartlepool
- Julian Penton – Hartlepool NDC

In addition to the studies/report listed information has been drawn from:

- Communities on Prescription Report of April 2003
- Hartlepool MIND Impact on GP Prescribing Survey Findings
- Solutions not medication - Hartlepool NDC 2004
- Slimming on Referral – Tackling Obesity in Primary Care

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM

26 October 2006

Report of: Scrutiny Support Officer

Subject: WRITTEN SUBMISSION FROM HARTLEPOOL MIND IN RELATION TO 'SOCIAL PRESCRIBING IN HARTLEPOOL'

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1. PURPOSE OF REPORT

1.1 To present to the Adult and Community Services and Health Scrutiny Forum a written submission from Hartlepool MIND in relation to the Forums scrutiny investigation into social prescribing.

2. BACKGROUND INFORMATION

2.1 As the Members will be aware, part of the role of this Scrutiny Forum in conducting an in-depth investigation is to seek views from all relevant stakeholders in relation to the issue under investigation. It is by gathering evidence from a variety of sources that the Forum is able to build up a knowledge base to assist it in taking the inquiry forward.

2.2 It is to this end that the Hartlepool Mind are invited to submit evidence to this Forum. Whilst representatives of Mind were unable to attend today's meeting given the close partnership working between the Community and Voluntary Sector when developing and implementing such initiatives the **appended** report with be presented by representatives of NDC. Following an initial presentation of the report (**Appendix B)** Members are requested to ask any questions felt appropriate to gather sufficient evidence to produce an evidence based final report.

3. RECOMMENDATION

3.1 Members are requested to note the content of this report and ask any questions felt appropriate in conducting the Scrutiny Review into Social Prescribing.

Contact Officer:- Sajda Banaras – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
Tel: 01429 523 647
Email: Sajda.banaras@hartlepool.gov.uk

BACKGROUND PAPERS

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

Hartlepool Mind
Social Prescribing

Hartlepool Mind is a mental health charity providing counselling, support, workshops, courses, training, consultancy, information, advocacy, health activities and advice, to help people reduce mental health problems, increase social inclusion and improve people lifestyles.

Mind's Philosophy

Hartlepool Mind have developed a comprehensive mental health philosophy and approach to working with people experiencing mental health problems, social isolation, social exclusion and general wellbeing issues.

Working from the Human Givens: Every human being has innate Needs that must be met to flourish and develop as a fully functioning being. The Human Givens are: to give and receive **attention**, to be **part a community**, to be **stretched, to learn** new skills, **intimacy**: connection to others, a sense of **control** over our lives **status**, **privacy** and sense of **self esteem**.

Client driven model: Hartlepool Mind has developed this approach from American Psychologist Scott Miller. This theory states the client's language and frames of reference are enlisted and used as a foundation of self discovery and development. This moves away from medical narrative or a psychopathology narrative that is used to explain clients' current experience and reduce it down into neurochemical, genetic or brain anatomical anomalies, which can leave clients feeling disempowered. The client driven model focuses on outcomes, client's theory of change, client setting the goals to be achieved and the clients view of the relationship between the helper and the client and by which means will be effective.

Mind body system: Hartlepool Mind have developed a version of the biopsychosocial model of mental health. The traditional model describes how social and psychological factors can influence the body and brain to develop mental health problems. A more advanced model is based on cutting edge research that understands all mental health problems arise from an interaction between the mind, brain and body system. The mind, brain and body interactive model (MBBI model, Iain Caldwell) is based on research on the autonomic nervous system, endocrine system, psychoneuroImmunology (PNI) and neuropeptide system. These four pathways regulate how the mind influences the body and how the body influences the mind.

Social Prescribing

Hartlepool Mind offers a range of social solutions for people with mild to moderate mental health problems.

Process

- **Referral:** Hartlepool Mind provides an open referral system, wherby people are able to refer themselves and/or services can refer people into the project.
- **Assessment:** A holistic assessment is completed, which describes the persons issues, identifying how the client would like to be helped and the clients resources and strengths. The assessment is a combination of psychological and social elements
- **Brokerage:** Hartlepool collaboratively establishes the needs of the client and identifies which services could meet theses needs. Hartlepool Mind will contact the services and seamlessly connect the client to the service
- **Navigation:** The project prepares people to access services and prepares services to receive people.

Social Prescriptions

Hartlepool Mind

- Therapy
- Self help courses
- Workshops
- Advocacy
- Self help books
- Recovery support work
- Computerised CBT

Voluntary and Statutory

- Benefits advice
- HELP
- Arts
- Advice

Outcomes

Employment
Education
Volunteering
Improved health
Reduced prescribing of medication
Families supported
Improved self management of long term conditions
Improved wellbeing
Reduced emotional distress

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM

26 October 2006

Report of: Director of Adult and Community Services

Subject: CONSULTATION ON COMMUNITY CARE ELIGIBILITY CRITERIA

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1. PURPOSE OF REPORT

1.1 To seek Members' views, as part of a consultation process on proposals to change the Fair Access to Care Services eligibility criteria.

2. BACKGROUND INFORMATION

2.1 In January 2006 Cabinet agreed to consult on raising the Fair Access to Care Services eligibility criteria to "substantial" needs.

2.2 The Council currently provides statutory Social Care services such as home care or day care to those people who needs are moderate, critical or substantial. Those people with lower level needs are given advice and information on other help which may be available to them in the community. These are services like Age Concern, Hartlepool Carers, Shopmobility and social groups.

2.3 Council's are expected to review their access criteria in each year's budget cycle. The Council is thinking about changing the eligibility criteria so that in the future people assessed as having moderate care needs may not receive statutory social care services. This means that those with moderate needs would be given advice and information like those with lower level needs.

2.4 The proposed changes would help the Council to free up resources to develop preventative community service open to all. Also, to better support those people in need of high levels of statutory care.

3. CONSULTATION PROCESS

3.1 The consultation period is October to December 2006. The process will look at whether or not people agree with the proposed change and what

community services they would most like to see developed or supported. People's views will be presented to Cabinet Members in January 2007.

3.2 All partner agencies, service users and carers, voluntary bodies, service providers and neighbourhood forums are being consulted on the options.

3.3 The means of consultation being used include established planning groups and relevant forums, presentation to meetings, individual letter, and focus groups.

3.4 The public information produced in relation to the Department's consultation process is attached at **Appendices 1, 2, 3, 4 and 5** to the report for information.

4. RECOMMENDATIONS

4.1 That Members of the Forum participate in the consultation process and express their views on the proposed changes in relation to:-

(a) The proposal to change the eligibility criteria and re-invest some of the savings in support to community based services for all; and

(b) Should the Council agree the proposed changes, what sort of community based services would the Forum like to see developed?

Contact Officer:- Alan Dobby
Assistant Director (Support Services)
Adult and Community Service Department
Hartlepool Borough Council
Tel: 01429 529312

BACKGROUND PAPERS

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

(i) Cabinet Report 14 August 2006 – Consultation on Community Care Elilgibility Criteria.

(ii) Scrutiny Co-ordinating Committee 15 September 2006 - Consultation on Community Care Eligibility Criteria.

Nicola Bailey
Director of Adult & Community Services

P O Box 96
Civic Centre
Hartlepool
TS24 8YW

HARTLEPOOL
BOROUGH COUNCIL

APPENDIX 1

Dear Sir or Madam,

Fair Access to Care Consultation

We are **THINKING** about changing the way we decide who should receive Social Care Services.

We invite you to complete the attached questionnaire **by Monday 20th November 2006** so that we can inform Councillors of your views.

You can ask a friend, relative carer or member of staff to help you fill in the questionnaire. You can also ring the Adult and Community Services consultation **HELP LINE on 01429 523740** which is open **Monday to Friday between 10.00am until 4.00pm until the 20th November 2006.**

If you require this letter in a different format (large print, Braille, easy English with pictures, different languages or on tape) please ring the **HELP LINE on 01429 523740.**

We are also holding various meetings locally to ask people for their views. Further details are provided later in this letter.

Please note at this stage we are **ONLY** consulting on a possible change to the eligibility criteria (rules) for Social Care services.

The following documents attached to this letter provide further information.

- **Document 1** – **Fair Access to Care leaflet**. This leaflet explains how Social Care Services in Hartlepool decide who is eligible for services.
- **Document 2** – Explains why we are **THINKING** about the possible changes to the eligibility criteria (rules).
- **Document 3 –** Provides examples of current Social Care services provided within the Fair Access to Care bandings (MODERATE, SUBSTANTIAL and CRITICAL).

Continued overleaf

How can I have my say?

There are a number of ways you can have your say. **You can do this by:**

1. **Completing the enclosed questionnaire - Your Views**

   Please return the completed questionnaire in the prepaid envelope enclosed with this letter **by Monday 20th November 2006.**

2. You can ask staff who visit you to help you complete the questionnaire.

3. **You can e-mail** your views to socialcareservices@hartlepool.gov.uk

4. **You can come along to one of the following public meetings (anyone with access or language needs who wishes to attend a public meeting should contact the consultation HELP LINE on 01429 523740**.

   - **Central Library**

     Thursday 9th November – 6.00pm at the Community Room, Central Library, York Road

   - **North Neighbourhood Consultative Forum**

     Wednesday 29th November – 10.00am at West View Community Centre, Miers Avenue.

   - **Central Neighbourhood Consultative Forum**

     Thursday 30th November – 10.00am at the Conference Suite, Belle Vue Community, Sports and Youth Centre, Kendal Road.

   - **South Neighbourhood Consultative Forum**

     Friday 1st December – 10.00am at Owton Manor Community Centre, Wynyard Road.

5. **You can write to the Director of Adult and Community Services by Monday 20th November 2006.**

What happens next?

All the views from the questionnaire and meetings will be gathered together and a report will be presented to Councillors in January 2007. This report will be made available to all those who take part in the consultation.

Thank you for your help.

Yours sincerely,

N.K Bailey

Nicola Bailey
Director of Adult and Community Services

7.2
APPENDIX 2

QUESTIONNAIRE – YOUR VIEWS

Adult and Community Services Department
Fair Access to Care Consultation

Possible changes to the Eligibility Criteria (rules) for receiving Social Care Services

What we would like you to do

Please complete the attached questionnaire to give us your views on possible changes to the eligibility criteria (rules) for Social Care Services.

What to do if you need help

You can ask a friend, relative, carer or member of staff to help you fill in this form or you can ring the consultation **HELP LINE** on **(01429) 523740 Monday to Friday between 10am to 4pm until 20th November 2006.**

The following documents are enclosed with your questionnaire:

- **Document 1** - Fair Access to Care summary leaflet. This leaflet explains how Social Care Services in Hartlepool decide who is eligible for services.
- **Document 2** - Explains why we are **THINKING** about the possible changes to the eligibility criteria (rules).
- **Document 3** – Provides examples of current services provided within the Fair Access to Care bandings (MODERATE, SUBSTANTIAL and CRITICAL).

Confidentiality

Yours answers to the survey are strictly confidential. Names will never be associated with any answers or comments made.

What will be done with the results of the survey?

All the views from the survey will be gathered together and a report will be presented to Councillors in January 2007. This report will be made available to all those who take part in the consultation.

Sending back the completed questionnaire

Once you have completed the questionnaire please return it in the pre-paid envelope provided by **Monday 20th November 2006.**

Questionnaire – Your Views
Fair Access to Care Consultation

1. About you (the person who receives the service). Please tick (√) one box.

a. Are you a: Service User ❑ or Carer ❑

b. Gender Male ❑ Female ❑

c. What is your age range?

Under 18	❑	18-29	❑	30-39	❑	40-49	❑
50-59	❑	60-69	❑	70-79	❑	80+	❑

2. What do you think about the idea of changing the eligibility criteria (rules) for statutory care services, and re-investing some of the savings in support to community based services for all?
Please tick (√) one box ❑

I agree with the idea ❑
I DO NOT agree with the idea ❑
I am not sure ❑

If you do NOT agree with the idea, please can you tell us why not?

If you are NOT sure, please can you tell us why?

3. If the Council did make the change, what sort of community based services would you MOST like to see?

Some examples are provided below. Please put a tick (√) against the ones you MOST want to see.

Sitting or short break services (Sometimes known as respite services)	Yes ☐
Meeting People ('Drop in'/social activities)	Yes ☐
Meal Preparation	Yes ☐
Day Care	Yes ☐
Help getting to appointments etc.	Yes ☐
Transport	Yes ☐
Shopping	Yes ☐
Cleaning	Yes ☐
Laundry	Yes ☐
Prescription Collection	Yes ☐
Money Collection	Yes ☐

Please say (in the space below) what other services you would like to see:

THANK YOU for taking the time to let us know your views.
Please return the questionnaire in the enclosed pre-paid envelope provided by Monday 20th November 2006

Carers

Carers have a right to an assessment of their own needs. Carer's eligibility for service is determined by assessing the risk to their caring role. The bands broadly cover the same areas as FACS.

Carers are unpaid, although they may receive certain carers benefits. They care for a relative, friend or partner needing support because of their age, or a physical or learning disability including mental illness.

Name	Tel No.
Age Concern	01429 424002
Benefits Enquiry Line	0800 243355
Advocacy Information Foundation	01642 327583 Ext. 324
Commission for Social Care Inspection (CSCI)	01325 371720
Citizens Advice Bureau	01429 866582
MIND	0845 7660163
Patient Advice Liaison Service (PALS)	01429 522874
Hartlepool Carers	01429 283095
NHS Direct	0845 46 47
Blind Welfare	01429 272494
Hartlepool Deaf Centre	01429 222206

To find out more about FACS or to get in touch with Adult & Community Services contact:

The Duty Team
Hartlepool Borough Council
Adult and Community Services
Civic Centre
Victoria Road
Hartlepool TS24 8AY

Telephone: **(01429) 266522**

BT Text Direct: **(18001) 01429 266522**

Website: **www.hartlepool.gov.uk**

E-mail:
socialcareservices@hartlepool.gov.uk

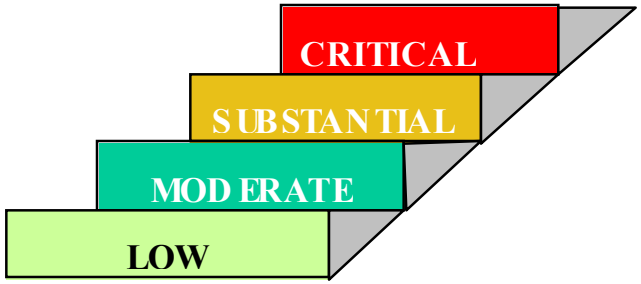
Emergency Out of Hours Service:
Telephone: 08702 402994
Minicom: (01642) 602346

If necessary this leaflet can be provided in a number of different formats. This could include Braille, large print, audio tape, computer file and languages other than English. For further information contact Support Services on 01429 523964

APPENDIX 3 (DOC 1)

For use with Fair Access to Care Consultation Only

Fair Access to Care



How Social Care Services assess eligibility

HARTLEPOOL BOROUGH COUNCIL

Introduction

This leaflet explains how Social Care Services in Hartlepool decide who is eligible for services.

What are eligibility criteria?

It is important that Social Care Services spends its money supporting those people who have the greatest needs.

Eligibility Criteria are the rules we use to make sure this happens.

What is Fair Access to Care Services (FACS)?

The Government has issued FACS eligibility criteria. This is a framework to make sure that anyone aged 18 or over, seeking support from Social Care Services, have their needs dealt with fairly across the country.

We must use the FACS framework when deciding whether a person is eligible for services.

FACS is based on the way in which a person's needs may put their independence at risk.

What affects a person's independence

There are four areas of a person's life which are important to their independence—these are:

- Autonomy (control over your own life) and freedom to make choices.
- Being healthy and safe, and free from abuse or neglect.
- Being able to manage your personal and other daily tasks.
- Being able to be involved in family and the wider community life.

How does Fair Access to Care Work?

The FACS rules are divided into four bands:

- **Low**
- **Moderate**
- **Substantial**
- **Critical**

The **low, moderate** and **substantial** bands describe levels of need and how these levels of need affect a person's independence. The **critical** band describes situations when a person's independence is most 'at risk'.

Who will receive services?

The government guidance allows Council's to decide which level they will provide services for. In Hartlepool we will offer advice and information to everyone but at present we must focus our support on people who have **critical, substantial** and **moderate** needs. These levels may change in the future. If you are assessed as being in the **low** band you will be offered advice and information.

What do the bands mean?

The table below summarises what the FACS categories mean. A booklet explaining the bands in further detail is available. Contact the Duty Team on 01429 266522 for more details.

LOW

They are beginning to have some difficulties in managing personal care or domestic routines

MODERATE

There is (or is likely to be) an inability to carry out several personal care or domestic routines

SUBSTANTIAL

Serious—the situation is in real danger of breaking down so that they will lose their independence.

CRITICAL

Life is (or is likely to be) threatened.

What if I am unhappy with the decision?

If you disagree with a decision made under the FACS criteria, you can appeal against it. Contact your Care Manager or the Duty Team for more details.

Adult and Community Services Department
Fair Access to Care Consultation

Possible changes to the Eligibility Criteria (Rules) for receiving Social Care Services

We are **THINKING** about changing the way we decide who should receive Social Care services.

What happens at the moment?

- To make sure everyone has fair access to Social Care services we look at your level of needs.
- We look at whether you are able to live safely and independently at home. This is called a needs assessment.
- These 'levels of need' have been decided by the government and are called **LOW, MODERATE, CRITICAL** and **SUBSTANTIAL.**
- In Hartlepool we provide Social Care if you have **MODERATE, SUBSTANTIAL or CRITICAL NEEDS.**

What are we thinking about changing?

- We are thinking about changing the rules so that people with the **GREATEST** needs receive the most help.
- This change means that we may provide Social Care services to those with **SUBSTANTIAL** and **CRITICAL** needs **ONLY.**
- Those with lower level needs (**MODERATE AND LOW**) would be directed to other service available in the community. Examples are, Age Concern, Hartlepool Carers, Hartlepool Deaf Centre, Luncheon and Friendship Clubs etc.
- The change would also mean we could provide more money to help these community services, which are open to all people.
- If you have **MODERATE** Needs and are already receiving help we would **CAREFULLY** look at your situation. We **WILL NOT WITHDRAW** services unless it is safe to do so.

(A booklet explaining Fair Access to Care in more detail is available. For a copy please contact the Consultation help line on 01429 523740).

APPENDIX 5 (DOCUMENT NUMBER 3) **7.2**

Examples of current social care services provided by the Adult and Community Services Department
(Note: A decision on services is normally made following an assessment of needs).

LOW RISK TO INDEPENDENCE (LOW BANDING)	EXAMPLES OF CURRENT SERVICE RESPONSE
The Government guidance says NEEDS are LOW when: • There is, or will be, an inability to carry out one/two personal care or domestic routines. And/or • Involvement in one/two aspects of work, education or learning cannot, or will not, be sustained. • One/two support systems and relationships cannot, or will not be sustained. • One/two family and other social roles and responsibilities cannot, or will not, be undertaken.	We DO NOT provide or purchase care for needs which fall within this band. We DO provide: • Advice and information • Re-direct you to other agencies including voluntary support services such as: ▪ Age Concern ▪ Hartlepool Carers ▪ Alzheimer's Trust ▪ Retired Resource Network • Social Activities (Various clubs including luncheon, friendship, Friendship clubs, and leisure)
MODERATE RISKS TO INDEPENDENCE (MODERATE BANDING)	**EXAMPLES OF CURRENT SERVICE RESPONSE**
The Government guidance says the needs are MODERATE when: • There is, or will be, an inability to carry out several personal care or domestic routines. And/or • Involvement in several aspects of work, education or learning cannot or is likely not to be sustained. • Several support systems and relationships cannot, or will not be sustained. • Several family and other social roles and responsibilities cannot, or will not be undertaken.	We may provide one or more of the services detailed below following an assessment of needs. • Homecare which may include, help with dressing, preparing meals, etc. • Short breaks for service users and carers • Provision of minor adaptations and community equipment • Day Care at a moderate level • Social rehabilitation services • Support to access work or further education/training • Frozen meals • Advice and information • Re-direct to other agencies (as described in the lower band)

Continued overleaf

SUBSTANCIAL RISKS TO INDEPENDENCE (SUBSTANCIAL BANDING)	EXAMPLES OF CURRENT SERVICE RESPONSE
The Government guidance says the needs are SUBSTANCIAL when: • There is, or is likely to be, only partial choice or control over vital aspects of the immediate environment. And/or • Abuse or neglect has occurred, or is likely to occur. • There is or is likely to be, an inability to carry out the majority of personal care or domestic routines. • Involvement in many aspects of work, education or learning cannot, or is likely not to be sustained. • The majority of family and other social roles and responsibilities cannot, or is likely not to be undertaken.	We may provide one or more of the services detailed below following an assessment of needs. • Homecare which may include, help with dressing, preparing meals, etc. • Short breaks for service users and carers • Support to access more suitable accommodation • adaptations and community equipment • Day Care at a substantial level • Rehabilitation services • Support to access work or further education/training • Advice and information • Re-direct to other agencies (as described in the lower band)
CRITICAL RISKS TO INDEPENDENCE (CRITICAL BANDING)	**EXAMPLES OF CURRENT SERVICE RESPONSE**
The Government guidance says the needs are CRITICAL when: • Life is, or will be threatened. And/or • Significant health problems have developed, or will develop. • There is, or will be, little or not choice and control over vital aspects of the immediate environment. • Serious abuse or neglect has occurred, or will occur. • There is, or will be, an inability to carry out vital personal care or domestic routines. • Vital involvement in work, education or learning cannot, or will not be sustained. • Vital social support systems and relationships cannot, or will not be sustained. • Vital family and other social roles and responsibilities cannot, or will not, be undertaken. • Appropriate social care can be provided to meet critical need in order to remove or reduce the risks to independence associated with the need.	We may provide one or more of the services detailed below following an assessment of needs. • 24hour care placement • Homecare which may include, help with dressing, preparing meals, bathing, etc • Short breaks for service users and carers • Day care at a critical level • Support to access work or further education/training • major adaptations and community equipment • support to access more suitable accommodation • money management/maximising income • Rehabilitation services • Advice and information • Re-direct to other agencies (as described in the lower band)