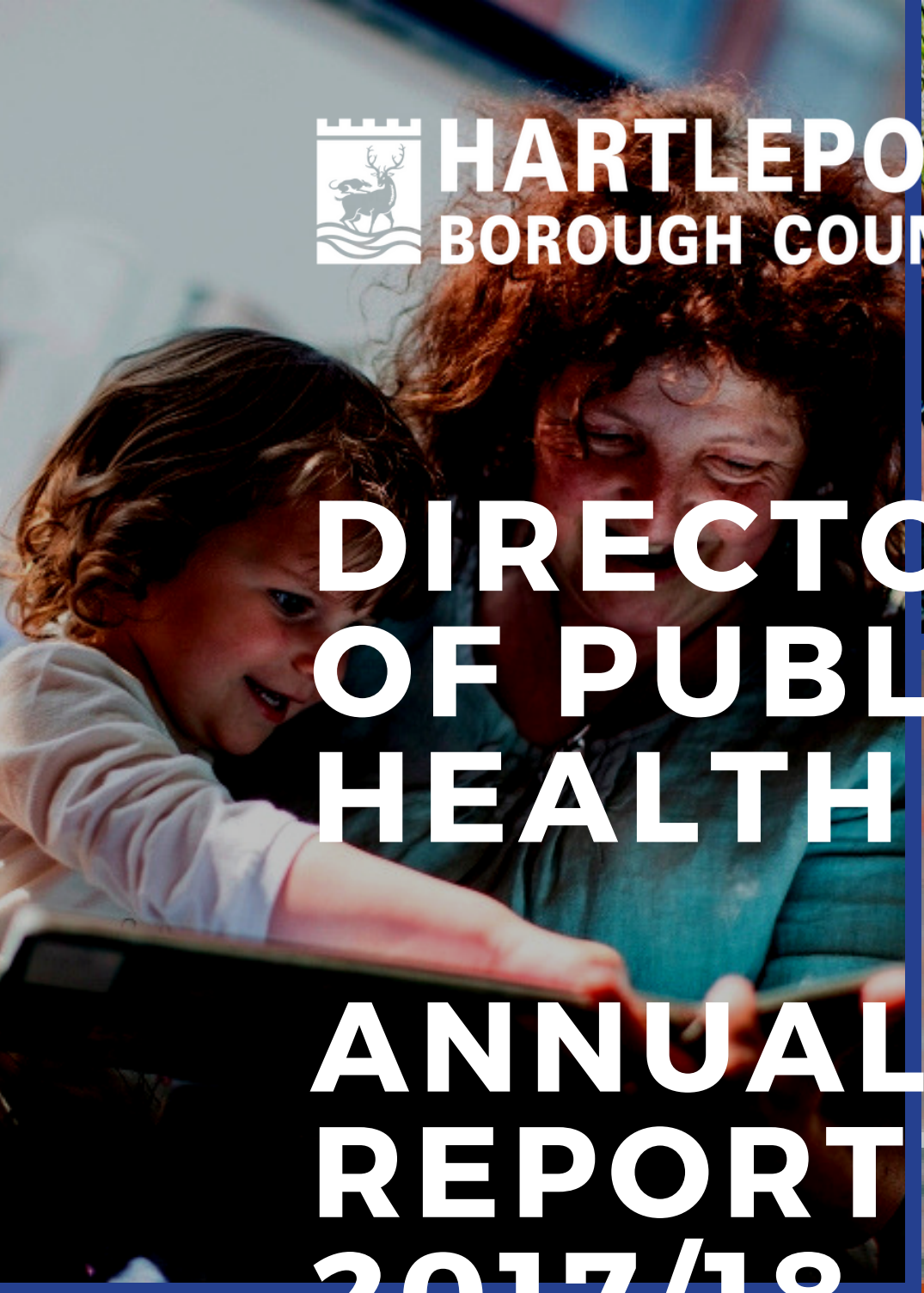
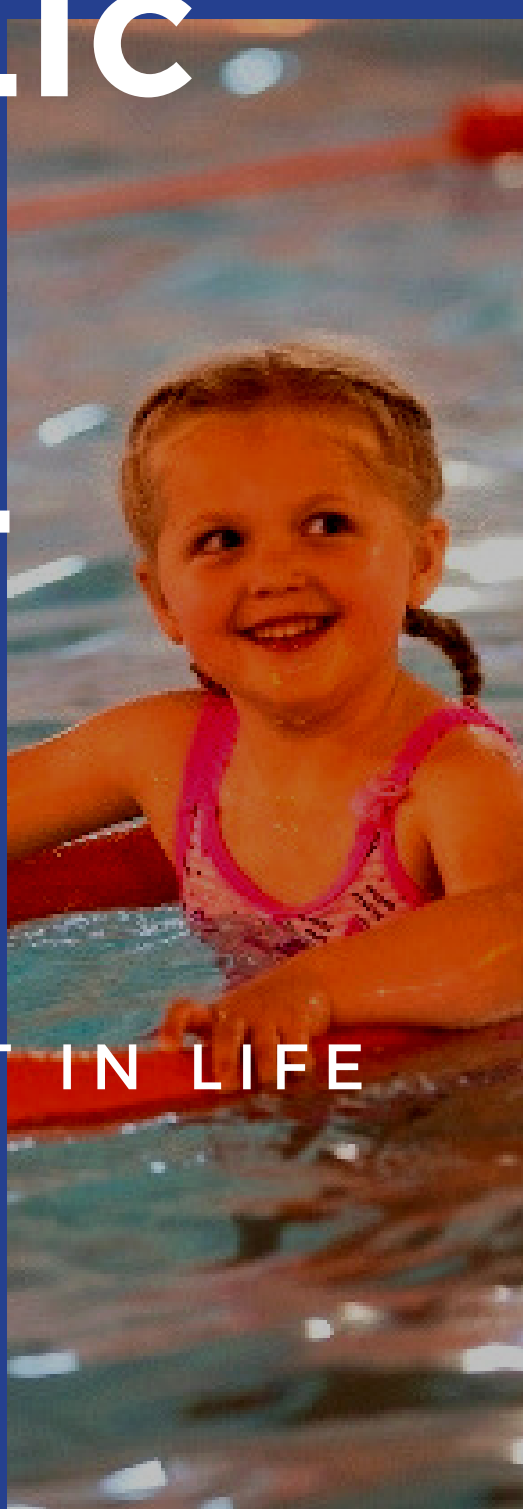
HARTLEPOOL BOROUGH COUNCIL

DIRECTOR OF PUBLIC HEALTH

ANNUAL REPORT 2017/18





BEST START IN LIFE

CONTENTS

FOREWORD.

It is a privilege, as Interim Director of Public Health since May 2018, to present this annual report. One of the statutory duties of a Director of Public Health, reiterated in the Health and Social Care Act 2012, is to produce "an independent annual report on the health of local communities."

In last year's report my predecessor, Dr Paul Edmondson-Jones, reminded us of another statutory duty, which is to maintain an up to date Joint Strategic Needs Assessment (JSNA). It is a pleasure to report that the JSNA is being restructured and rewritten in a way that makes it easier to track the life-course of our residents from "starting well" to "dying well" and relates more closely to the strategy for health and wellbeing. A few general points from the new JSNA are shown in chapter 1, and a further expansion of needs relating to "starting well" appear in chapter 2.

The JSNA is truly a joint assessment, drawing on the input of all partners in the Health and Wellbeing Board. Their contributions are gratefully acknowledged. The JSNA underpins our understanding of the nature and scale of the challenges, points to possible solutions, directs our commissioning and provision of services and helps us evaluate progress. One of its major features is to point to inequalities in health and wellbeing, and these remain a high priority for action.

Last year's report had a special focus on "ageing well." Two other features of that report were "social inclusion" and "regarding our residents as assets, not just needs." These two characteristics can be seen in much of our work this year and particularly in this year's needs assessment for drugs and alcohol services, where we have included people who used those services to shape our understanding of the needs and as a valued asset in addressing them. That assessment is described in chapter 3.

A recurring theme for councils and the NHS in England this year has been "prevention". It has been cited by the Secretary of State for Health and Social Care as one of his top three priorities. Chapter 4 is devoted to this topic.

In a period of prolonged austerity, attention naturally turns to value for money. Chapter 5 gives a brief account of stewardship of the public health grant this year – how it was embedded across all Council areas of activity and the anticipated return on that investment in terms of improved health and wellbeing. We are accountable for that grant not only to Public Health England (whose support we also gratefully acknowledge) but also to the people of Hartlepool and their elected representatives. It is worth noting that in this chapter, as in the rest of the report, the activities and outcomes are those of the whole Council and its partners in health and wellbeing; it is not simply an account of the work of the public health department. Health improvement is a collaborative effort. Public health is everyone's business.

The past year has been one of challenge, achievement and change. It is a pleasure to introduce Dr Patricia Riordan as the new and substantive Director of Public Health. She takes up the role in February 2019. I am confident that the readers of this report will give her every support, and will look forward to reading her report next year.

DR PETER BRAMBLEBY

INTERIM DIRECTOR OF PUBLIC HEALTH, HARTLEPOOL BOROUGH COUNCIL

CHAPTER 1

A snapshot of health and wellbeing in Hartlepool

The Public Health Outcomes Framework is a set of indicators collated by Public Health England (PHE) and published on their website. They highlight local authority performance across the full spectrum of public health. Since numbers can be small, and variations happen between years, the indicators often combine three years' data to smooth this out. Not all indicators are updated every year, and there is a slight time lag in getting all the national data collated and analysed. For details of each indicator please visit the **PHE website**.

Here is a snapshot of some important findings for Hartlepool:

Matters of life and death

Indicator	Period	Hartlepool	NE Region	England
Life expectancy at birth - males (years)	2014-16	76.4	77.8	79.5
Life expectancy at birth - females (years)	2014-16	81.3	81.5	83.1
Healthy life expectancy - males (years)	2014-16	57.7	59.7	63.3
Healthy life expectancy - females (years)	2014-16	57.4	60.6	63.9
Gap in life expectancy at birth - males (years) between most and least deprived areas)	2014-16	11.7	-	-
Gap in life expectancy at birth - females (years) between most and least deprived areas)	2014-16	10.2	-	-
Gap in healthy life expectancy - males (years) between most and least deprived areas)	2014-16	17.2	-	-
Gap in healthy life expectancy - females (years) between most and least deprived areas)	2014-16	14.9	-	-
Dying before 75 years - males and females (rate per 100,000)	2015-17	456	396	332
Dying from causes considered preventable - males and females (rate per 100,000)	2015-17	252	223	182

A new indicator this year is healthy life expectancy – the period of time in which people can expect to report good health. Although on average women in Hartlepool can expect to live five years longer than men, they do not enjoy more years in good health. Another stark finding is that the inequality gap between Hartlepool's most affluent 10% and least affluent 10% is very much wider, for men and women, when we look at quality at end of life and not just length of life. Behind these figures, the main causes of the gap in length are cancer, heart disease and respiratory disease, but the main threats to quality of life come from mental health problems (especially dementia and depression), musculoskeletal problems and problems with hearing and vision. As a consequence of these findings, we should not just seek to prevent "killer" diseases but also seek to prevent those that limit wellbeing. Another significant finding is that more people in Hartlepool die before their time (75 years in this indicator) that elsewhere, and much of this is driven by preventable diseases related to lifestyle choices.

Death from drug misuse is another area of low performance for Hartlepool. There has been an increasing trend for three years in Hartlepool for this cause, moving away from a position of statistical similarity with the England average. This year we have undertaken a comprehensive needs assessment for drugs and alcohol, and drafted a whole new specification which we will implement in 2019 (see chapter 4).

In sickness and in health

Indicator	Period	Hartlepool	NE Region	England
Self-reported "high happiness" score (%)	2015-16	70.7	-	74.7
Sickness absence (% working days lost)	2015-17	2.5	1.5	1.1
Dying in hospital (%)	2016	51	48	47
Dying in hospice	2016	9	4	5
Successful treatment of opiate addiction (%)	2017	6.3	4.9	6.5
Successful treatment of alcohol addiction (%)	2017	24	31	36

In surveys, most people say they would prefer to die at home but the figures show that at least half die in hospital. On the favourable side, twice as many Hartlepool people die in a hospice than the national average. Our successful treatment rates for opiate addiction, though low, are similar to the national average but are not so good for alcohol addiction.

Healthy lifestyles

Indicator	Period	Hartlepool	NE Region	England
Walking to work (%)	2016-17	18.7	20.4	22.9
Cycling to work (%)	2016-17	1.5	2.0	3.3
Fast food outlets per 100,000 population	2014	143.6	102.4	88.2
Regularly use outdoor space for health (%)	2015-16	11.3	17.3	17.9
Eat 5 portions of fruit or veg per day (%)	2016-17	49.6	56.5	57.4
Physically inactive adults (%)	2016-17	27.4	24.6	22.2
Smoking prevalence - adults (%)	2017	19.2	16.2	14.9

If we are to tackle people dying before their time, or living longer in poor health, then here are some obvious pointers. There is much that the Council already does to make healthy choices easy choices but in the final analysis it requires individuals to heed the information and use the opportunities for taking control over their own wellbeing.

When it comes to portions of fruit and vegetables consumed by adults, Hartlepool has the lowest rate in the country. This is a decline of 4.4% on the previous year, and compares with an England average that has increased slightly from its previous rate, so the gap is widening. The subject of prevention is discussed in chapter 5.

Other determinants of wellbeing

Indicator	Period	Hartlepool	NE Region	England
Households in fuel poverty (%)	2016	14.7	13.8	11.1
Adult unemployment (%)	2017	10.3	6.2	4.4
Violent crimes (per 1,000 population)	2017-18	26.2	30.2	23.7
First time offenders - all ages (per 100,000)	2017	176.6	161.6	166.4
Income-deprived people over 60 years (%)	2015	24.4	-	16.2
Average weekly earnings for employed (£)	2015	420	400	440

Public health is everyone's business and the causes and remedies lie deep. Here are some determinants of health and wellbeing that are worth watching and tackling.

Best start in life?

Indicator	Period	Hartlepool	NE Region	England
Birth weight at term below 2.5kg (%)	2016	3.4	3.0	2.8
Breastfeeding initiation (%)	2016-17	38	59	79
Children in low income families	2015	27	22	17
Children in care (per 100,000)	2016	129	92	62
Teenage mothers (% of all new mothers)	2017	2.0	1.4	0.8
Children in youth justice system (per 1,000)	2017	7.2	7.0	4.8
Ready for school aged 5 (%)	2016-17	69.6	70.7	70.7

"Getting the best start in life" is the focus of the next chapter but included here for completeness of the overview.

For breastfeeding initiation Hartlepool is the worst performing authority in England. Hartlepool has seen a decline of 11.7% in its breastfeeding initiation rate in the last two years, from 49.6% to 37.9%. In the same period both the England and North-East averages have increased by 0.2%. This statistic has been the focus of discussion between our own 0-19 nursing service, the hospital midwifery service and the Clinical Commissioning Group who commission the hospital service. Breastfeeding is just part of the preparation for parenthood and is the focus of much work (see the next chapter).

Children in low income families, both under 16s and all dependent children under 20, are indicators which have seen improvement over the 10 year data collection period, but at a slower rate than the England average, meaning that the current gap between England and Hartlepool is larger than it was in 2006.

Hartlepool's under-18 conceptions rate is the second highest in England. Hartlepool had experienced a declining trend in under-18 conceptions for 9 years from 2006 to 2014 but since then it has been rising while the England average continued to decline.

CHAPTER 2

Special focus: "Starting Well"

Adverse Childhood Events (ACEs). *With special thanks to Dr Joanne Buntin, Educational Psychologist, Hartlepool Psychology Team.*
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In 1995, doctors Vincent Felitti and Robert Anda launched a large study in the United States that enquired about the child and adolescent experience of 17,000 people, comparing their childhood experiences with their later adult health records.

The findings were startling. Adverse Childhood Experiences (ACEs) - a term Felitti and Anda coined to encompass the chronic, unpredictable and stress-inducing events, were common. These included experiences that directly harmed, such as physical, verbal or sexual abuse, physical or emotional neglect; and those that affected the environments in which children grow up, such as parental separation, domestic violence, mental illness, alcohol abuse, drug use or imprisonment. Further ACE surveys have expanded this list to include abuse by brother or sister, witnessing violence in the community, being bullied, involvement with the foster care system, poverty, living in a war zone, or losing a family member to deportation.

Some distress is inevitable in the early years, but what elevated these factors to “toxic stress” was their frequency, severity and absence of relief or escape.

Another pioneer in the field, Dr Nadine Burke-Harris, uses the following analogy. Imagine you encounter a bear in the woods. Adrenaline kicks in and the body prepares for fight or flight. The primitive part of the brain remembers this and the next time a bear is encountered the response is even quicker – no need to think about it. Now imagine you lived with a bear in the room. The stress would be repeated and severe. This toxic stress is now known to permanently affect early brain development and health of body organs like heart and lungs. Then, to a child conditioned to stress, a simple reprimand at school or harsh word from a schoolmate can provoke rage to kick in without conscious thought, and the cycle continues. Such children are not wicked – they are wounded.

The researchers found that the higher the exposure to adversity and trauma, the more likely it was that an individual had long-lasting physical and mental health conditions. What surprised the researchers was that the harm was not simply restricted to emotional development and mental health, but was a risk factor for common diseases of adulthood such as cancer, heart disease, autoimmune conditions and diabetes. For example, someone with an ACE score of four was more than four times more likely to suffer from depression than someone with an ACE score of 0. From a score of zero to a score of six there is about a 50-fold increased likelihood of suicide attempts.

Effects of childhood trauma are often first evident in school. More than half of those with scores of four or more reported having learning or behavioural problems in school compared with those with a score of zero.

Does this mean that a child with a raised ACE score has irremediable damage? To some degree, yes, which is why prevention is so critical, but much can be done to mitigate the harm and restore reasonable behaviour, emotional resilience and healthier life expectancy. The three main thrusts of therapy are: to identify and remove the sources of stress as much as possible; to provide the child with a trusted adult (or adults) as a route of escape and to work on the child's own strategies for emotional maturity and appropriate responses to stressful situations.

Through a coordinated approach across the Children's Strategic Partnership, Hartlepool is embarking on becoming an ACE-aware town. In this it is following an evidence-based and experience-based trail from the USA and Britain. Scotland, and in particular Glasgow, is leading the way in the UK. The behavioural psychology team is at the forefront, and most schools and children's services are strongly committed.

A good example of Hartlepool's commitment is the Empowering Parents, Empowering Communities project described below.

Empowering Parents, Empowering Communities (EPEC): How we hope to help prevent the long-term effects of adverse childhood experiences (ACEs) in Hartlepool. *With special thanks to Jill Coser MSc, Parenting Lead, Hartlepool Borough Council.* ***jill.coser@hartlepool.gov.uk***

What is EPEC? In Hartlepool we are on a journey that has the potential to transform the way we support families facing the challenges of disadvantage. Hartlepool Borough Council has just become a member of the EPEC community. EPEC is a well-tested, highly effective method of prevention and early intervention that can transform the scale, reach and impact of local parenting support. EPEC combines local professional parenting expertise using evidenced-based methods with a parent-led approach that builds community resilience.

We have recently recruited 12 enthusiastic local parents from various communities, who are currently undertaking a 3 month training course to deliver the EPEC "Being a Parent" course. This course has been developed to promote child well-being and includes:

- Attachment and parent-child relationships.
- Understanding and managing children's feelings and parents' emotional regulation.
- Parenting roles, expectations and culture.
- Parent listening, communication, play and interaction skills.
- Positive behaviour management and discipline strategies.
- Managing parent and family stress.

The current EPEC group - trainer Jill Coser is at the front, left.

The growing evidence from this programme indicates that parents who attend an EPEC course can expect to see improvement in their children's social, emotional and behavioural development (Asmussen, K., Feinstein, L., Martin, J. & Chowdry H. (2016). Foundations for life: What works to support parent child interaction in the early years. London: Early Intervention Foundation). There is also compelling evidence to support working directly with parents to enable them to provide the nurturing and supportive environment needed for their children to thrive.

Why EPEC? We urgently need these improvements in Hartlepool as we have a significant number of children with social, emotional and behavioural difficulties that undermine developmental progress and educational achievement. Despite the high quality of our schools, 25% of local children do not reach expected levels at the end of primary school, with this negative trend continuing throughout secondary school. On leaving school, 47% of young people in our town do not achieve five GCSEs in A*-C. Many of these young people will have experienced adverse childhood experiences and will transition into adulthood with reduced opportunities and an increased likelihood of poor mental and physical health in later life.

"Despite difficulties in my own childhood, losing my mum as a young adolescent, becoming a teenage parent and having my own mental health difficulties, I am striving to be the best parent I can be. To overcome these obstacles in life I have been optimistic and shown strength. Despite my early difficulties I am a great parent and provide the love and support my children need. Through EPEC I am now learning so much about child development, how to manage difficult behaviour and how to encourage more positive behaviour. This is having a real impact in my home and my confidence is growing by the week. I am excited about the opportunities ahead of me and cannot wait to support other parents. I already know parents in my area that would really benefit from this course and I am looking forward to getting started."

Hartlepool EPEC Parent

We understand the reasons for poor child outcomes are complex, cumulative and life-limiting. We found many of the parents completing the ACE questionnaires on their own childhood experience had themselves been exposed to adverse childhood experiences. Some of these parents went on to poor educational attainment, being out of work and having mental and physical health difficulties. These experiences have in turn impacted on their resilience as parents and they have struggled to provide nurturing, calm and consistent environments for their own children. Yet, conversely some parents who have experienced a high number of ACEs have provided loving environments for their own children and are enjoying being a parent themselves. These parents are focussed on being the best parent they can be and are enthusiastic about learning new skills and broadening their horizons. They have invaluable experiences of building resilience and coping under difficult circumstances. We want to convert this knowledge and potential to empower not only themselves but also parents in our communities. The first 12 Parent Group Leaders are only the beginning of the EPEC journey and by July 2019 we hope this figure will double. Our plan is to widen our interventions to include courses for parents of children with Autism, ADHD, parents of teenagers and parents with significant mental health difficulties.

Delivering a better start in life

This, like the rest of public health, is a collaborative effort. Some of the indicators of child health were covered in chapter 1. Here are some illustrative factors in greater detail.

Healthy weight and healthy diets

According to an annual survey conducted across the country by Sport England, 81% of 15 year olds in Hartlepool spend at least seven hours a day, on average, sitting down. This is the highest (ie worst) level in the whole of England. But for those who are active, a different finding emerges: Hartlepool has the 5th highest (ie best) level in the North-East region (15.2%), and is above both the regional and England average.

The National Child Measurement Programme looks at the height and weight (body mass index, BMI) of children aged four to five, and again aged 10-11, in order to assess the levels of obesity within those populations.

When this is applied across England, the prevalence of excess weight in Reception is roughly one in five and at Year 6 is roughly one in three. When this is applied to Hartlepool, the prevalence of excess weight in Reception increases to roughly one in four, with the prevalence in Year 6 remaining at one in three.

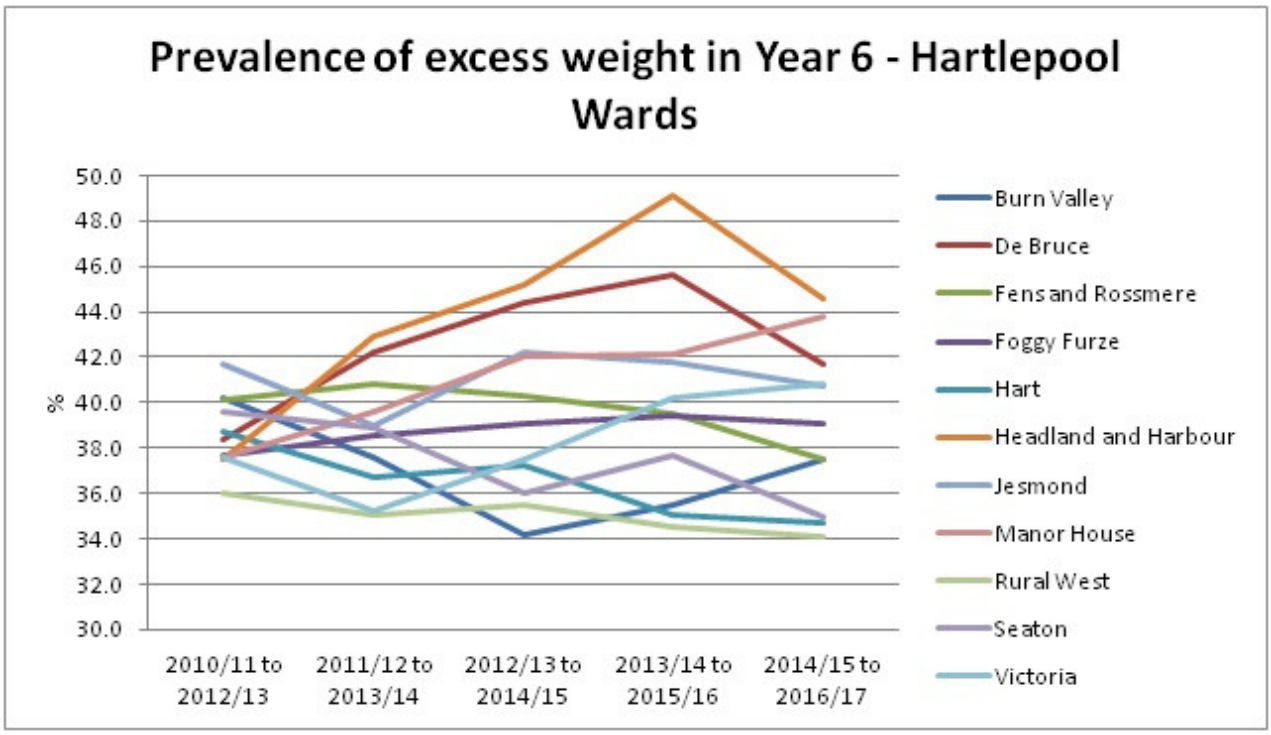
Trends are not looking good in the pre-school stage. Hartlepool's excess weight prevalence at school entry is at an eight year high both in terms of proportion of the Hartlepool population and the gap between Hartlepool's prevalence and the England average.

When prevalence of excess weight at age 10-11 is examined, the picture for Hartlepool becomes slightly better. At this stage Hartlepool's prevalence of 36.8% is below the North-East regional average of 37.3%, and the gap between Hartlepool and the England average has never been narrower. Hartlepool's prevalence figure for Year 6 is at a seven year low, which is good, and has decreased year on year for two years.

Taken together, it appears that adverse trend before primary school is being turned around a bit at school. This is to be applauded, but more could be done.

If we start to examine the differences within Hartlepool itself, we can see that, at ward level for 10-11 year olds, for excess weight, the difference between the best performing wards and the worst performing wards has increased.

In the last four years the difference between the highest prevalence ward and the lowest prevalence ward has nearly doubled. This shows that geographical factors are having a larger impact on a child's chances of excess weight in Year 6 than they were four years ago.



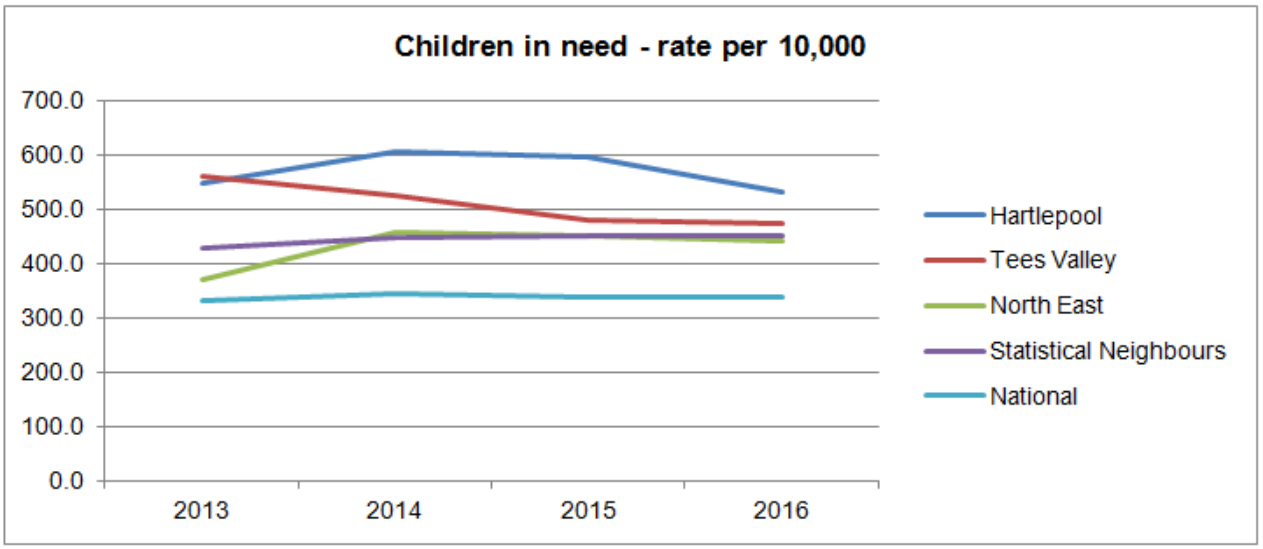
However at five years old (Reception) age this geographical factor is of less importance, as the difference between the highest and lowest prevalence wards has actually decreased by 0.7%.

If we look at other lifestyle indicators linked to obesity then a consistent picture emerges. Hartlepool has the largest proportion of 15 year olds with at least seven hours sedentary time per day in the whole of England, and also has only four out of ten 15 year olds eating five portions of fruit or vegetables a day, which is in the bottom quarter for performance in England. This highlights that the lifestyle trends captured at Reception and Year 6 are continuing into teenage years and beyond, with excess weight in Hartlepool's adult population at 70.1%, more than 10% above the England average.

In summary, we have a legacy of poor diets and inactive lifestyles, in childhood and adult life, which affect the less affluent areas of Hartlepool disproportionately and widen the health gap. At the moment the trend is not good in the pre-school years but there are signs that things improve during the primary school years. The challenge is to promote that trend through more children and their families eating more healthily and getting more activity.

Children in need

A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled.



There has been a decrease in the number of children in need: the rate per 10,000 population decreased from 596.6 in 2015 to 531.0 in 2016. This is still significantly higher than the national figure of 337.7.

2016 attainment results

A child's educational attainment is closely correlated with his or her length and quality of life after school.

Foundation stage: of those children who were children in need, 30.2% achieved a 'good level of development' by the end of the Foundation stage compared with 68.4% of all pupils in Hartlepool and 69.3% of all pupils nationally. This highlights that by the end of the Foundation Stage the attainment gap between children in need and their peers is 38.2% and children in need are required to make greater than average progress in order to narrow the gap.

Phonics screening Year 1: of those children who were in need, 61% met the expected standard compared to 85% for all Hartlepool pupils.

Key Stage 1: of those children who were in need, 51.5% achieved the expected standard in Reading compared with 73% for all Hartlepool pupils; 42.4% in Writing compared with 65% for all Hartlepool pupils; and 36.4% in Maths compared with 71% for all Hartlepool pupils.

Key Stage 2: of those children who were in need, 36% achieved the expected standard in Writing compared with 76.1% for all pupils in Hartlepool schools; 43% in Maths compared with 71.6% for all pupils in Hartlepool schools; 43% in Spelling, and Punctuation and Grammar compared with 74% for all pupils in Hartlepool schools.

Key Stage 4: of those children who were in need, 17.2% achieved 5+ A*-C including English and Maths compared with 47.6% for all Hartlepool pupils.

The good news is that all stages, achievement for Hartlepool's children in need is close to or exceeded that of children in need in England as a whole.

Youth offending

New referrals to the Youth Justice System

The table shows the number of referrals made to the Youth Justice Service (YJS) from various sources over the period 2015-2018. Note that the number of referrals does not refer to the number of individuals as some received more than one referral.

	2015/16	2016/17	2017/18
Total referrals	320	271	222

Analysis of youth-related anti-social behaviour for the 2017 Safer Hartlepool Partnership Strategic Assessment revealed that more than 600 individuals were involved in more than 1,200 incidents during the reporting period.

48 individuals were recorded as being involved in five or more incidents in this year with the highest number perpetrated by any one individual being 38 incidents. The average age of repeat perpetrators in this year was 13 years and nine months.

During this assessment period, it is also evident that anti-social behaviour is a precursor to criminal behaviour. Many Prolific and Priority Offenders were known to the police and local authority as perpetrators of anti-social behaviour in their early teenage years.

A review of evidence by the Local Government Association (LGA) found robust evidence for a link between experiencing family violence and subsequent participation in youth offending. The more risk factors, for example adverse childhood experiences (ACEs) experienced by young people, the greater the likelihood of participation in youth offending.

Risk factors influencing the link between family violence and youth offending

Individual factors	Family factors	Community factors
Low social competency Experience of depression Failure at school Experiences of family violence that start in or persist into adolescence Substance abuse	Running away from home	Delinquent peers Verbal and physical abuse with peers

The LGA review also highlighted that there are a number of protective factors that reduce the risk that young people exposed to family violence will go on to offend; and, equally, a range of risk factors which increase this likelihood. These are shown in Tables 1 and 2 below:

Protective factors influencing the link between family violence and youth offending

Individual factors	Family factors	Community factors
High self-esteem	Good sibling relationships High quality relationships with supportive adults	Good peer relationships Safe school environment

Looked after children

There has been a significant increase in the number of looked after children since 2015. The majority of wards in Hartlepool have seen an increase in the number of children taken into care. Victoria Ward has seen the largest increase (52%).

Children who return home from care are the largest single group of children who cease to be looked after. Research shows that careful assessment of needs, evidence of improvements in parenting capacity, slow and well managed return home and the provision of services to support children and their families after the return home were associated with a positive experience of reunification which lasted.

Foundation Stage: of those children who were looked after for at least 12 months, 20% achieved a 'Good Level of Development' by the end of the Foundation Stage compared with 68.4% of pupils in Hartlepool. This highlights that by the end of the Foundation Stage the attainment gap between children looked after and their peers is 48.4% and children looked after are required to make greater than average progress in order to narrow the gap.

Key Stage 4: of those children who were looked after for at least 12 months, 16.7% achieved 5+ A*-C including English and Maths compared with 47.6% for all Hartlepool pupils and 13.6% for looked after pupils nationally. It is encouraging to see that looked-after children do better at school than the national average, but there is still a big gap from those who are not in this high level of need.

Childhood vaccinations

Hartlepool's vaccination coverage rate for the measles, mumps and rubella (MMR) vaccine is below the 95% coverage target for both the first dose and the second dose.

This will affect the overall "herd" immunity of Hartlepool, making the vaccinations less effective as a means of controlling outbreaks of these illnesses. The coverage rate for the first dose, in the 2016/17 data, is 89.6%. This is below both the England average of 91.6% and the North-East regional average of 94.9%. Hartlepool's coverage rate is at a four year low.

For the second dose Hartlepool has a population coverage of 88.7%. This is higher than the England average of 87.6% but lower than the regional average of 92.4%. Hartlepool's coverage rate is down on the 2015/16 rate of 91.3%. Both the first dose and the second dose coverage rates for Hartlepool are the lowest in the North-East.

If we look at the rates within Hartlepool, neither show a big difference between the least deprived and the most deprived, with a swing of 1.3% for the first dose and 1.5% for the second dose.

The coverage rate for the combined whooping cough, diphtheria, tetanus, polio and Haemophilus influenzae type b has been consistently above the 95% mark for five years, giving Hartlepool a robust protection across its young population for these diseases. The current coverage of 95.8% is higher than the national average of 95.1%.

Vaccination rates for the human papillomavirus (HPV) vaccine (to protect against cervical cancer) have fallen year on year across the three available reporting periods, 2014/15 to 2016/17. Hartlepool had a population coverage of 93.6% in 2014/15. This has fallen year on year, and is now 85.0% in 2016/17. This has seen Hartlepool fall from having population coverage higher than the England and regional averages, to having coverage 2.2% lower than the England average and 4.8% lower than the regional average. This is a challenging trend for Hartlepool and our public health nursing services.

Infant mortality

Hartlepool's infant mortality rate (deaths under 1 year of age), is at its highest level for seven years. After peaking with an infant mortality rate of 7.1 per 1000 in 2006-08, Hartlepool had seen five years of general decline in its infant mortality rate, down to 2.7 per 1000. However since this point there has been a gradual increase year on year, up to 4.4 per 1000 in 2014-16.

The difference between the most deprived areas and the least deprived is stark. The most deprived tenth of our population has an infant mortality rate of 5.9 per 1000, which is more than twice the size of the least deprived tenth, which has a rate of 2.8 per 1000. Actual numbers are very small.

Stillbirths have fallen for the past four years.

Injuries

The five most common unintentional injuries leading to a hospital admission are falls, injuries caused by humans or animals, injuries from being hit, crushed or cut, burns and scalds, and poisoning. Hartlepool's emergency admission rate for falls is above that of both the North-East and England averages. Figures are better for burns and scalds: Hartlepool is considerably below both the England and North-East rates, at around 21 cases per 100,000 population.

Hartlepool's rate of accidental poisoning from medicines for under 4s has fallen from 193.0 to 145.2 per 100,000 population. This is now similar to the North-East average of 145.8, but still some way higher than the England average of 101.5. However the gap between Hartlepool and England is narrowing.

The numbers of children killed or seriously injured on the roads in Hartlepool has recovered back to its 2008-10 level of 21 per 100,000, after peaking at 34 in 2011/13. Hartlepool has remained statistically similar to the North-East for the entirety of the 7 year reporting period and has only been statistically worse than England once in this period.

Young people and substance misuse

The national drug treatment monitoring system (NDTMS) looks at the performance and level of need regarding substance misuse in England. The 2017/18 NDTMS figures for young people in Hartlepool show that numbers in treatment are down by 24% from 107 in 2016/17 to 81 in 2017/18. Successful completions of substance misuse treatment have increased from 65% to 85% in the same period. Young people’s substance use in Hartlepool is predominantly cannabis and alcohol, with 80% of young people in treatment citing cannabis and 46% citing alcohol. The next largest substance of use is cocaine which was used by 7% of young people. This is similar to the national picture, where alcohol is cited by 88% and cannabis by 47%.

Five per cent of Hartlepool’s children in treatment for substance misuse are under the age of 13 years old, which compared with two percent nationally. Those Hartlepool service users under 13 cited alcohol, cannabis and benzodiazepines as their substance of misuse. In keeping with national trends, drug and alcohol misuse is falling slightly and starting later.

Low-income families

When comparing Hartlepool with the region, Hartlepool has the second highest rate of under 16s in low income families in the North-East. Only Middlesbrough, which has the highest rate in the whole of England, is above Hartlepool in the regional comparators.

The approach to best start in life can be summarised in the words of a familiar song:

The Greatest Love Of All (Lyrics by Michael Masse and Linda Creed, sung by Whitney Houston)

"I believe that children are our future;
Teach them well and let them lead the way.
Show them all the beauty they possess inside;
Give them a sense of pride.
Let the children's laughter remind us how we used to be."

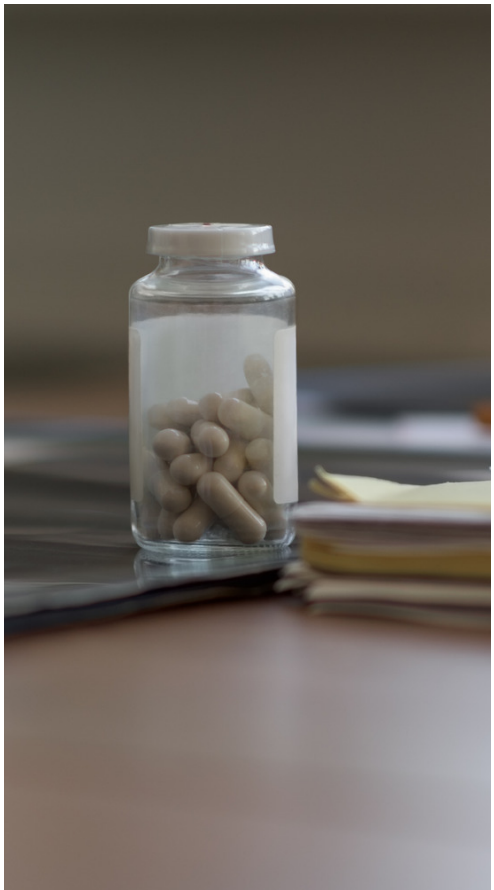
CHAPTER 3

A fresh look at Drugs and Alcohol Services

Background

Hartlepool has one of the highest death rates from drug misuse, and from alcohol-related liver disease, in the North-East region. The Council recognises substance misuse as a major factor in child neglect, domestic violence, acquisitive crime, antisocial behaviour and children being taken into care. The total cost to the local economy and caring services is around £6 million per year.

Nearly half of opiate users and high-level alcohol consumers drop out of treatment between assessment and the first therapy session and others don't seek help at all. There is a particular gap in provision for those not yet sufficiently motivated to achieve abstinence, and a marked generational cycle of misuse that is proving difficult to break.



A year ago the Council decided to bring the psychosocial therapy element of service in-house, leaving the clinical prescribing element in a contract with Addaction.

A series of unexpected leadership gaps and lack of service specification in the former have left the service as a whole without the clarity and unity of purpose intended. The contract with the latter is approaching time-expiration.

Hartlepool's Health and Wellbeing Board asked for a "needs assessment" to be conducted during 2018 and from that to produce this specification and engage in a dialogue with potential clinical providers to secure a new pattern of service. That assessment has been completed and a new service specification has been drawn up, for implementation during 2019.

Several needs were uncovered, of which some are summarised below.

A need to refresh the service outcomes:

- Reduce intoxication-related harm, and addiction-related harm such as: injuries, skin and vein infections, blood-borne viruses, smoking, sexual health, dental health, mental health, overdose and premature mortality.
- Reduce levels of use.
- Improve access to services.
- Reduce inequalities in use of services.
- Improve retention rates in therapy.
- Improve success rates.
- Reduce antisocial behaviours, crime and re-offending rates.
- Increase employment, volunteering and training rates ("something useful to do").
- Safeguarding of children and vulnerable adults in the household.
- Reduce incidence of domestic violence.

The need for a fresh approach to commissioning and contracting. Commissioning is a Council responsibility but will be conducted collaboratively with service users and providers. It was seen as helpful to regard this as "co-mission-ing" – an essentially collaborative endeavour based on common purpose. The lead commissioner will be supported by a governance board, chaired by the commissioner, with the main providers, partners and representatives of users as members.

The need for strong leadership. This will be a single service, under a single overall leader, trained and experienced in the role. It is envisaged that this leader will be a Council employee, accountable to the Director of Adults and Community Services. He or she will lead an in-house team focussing on key worker social support and psychological/behavioural support with the primary addictions. The service leader will oversee performance of the clinical services which will be brought in under a refreshed contract. The service leader will be a member of, and supported by, the Hartlepool Drug and Alcohol Harm Reduction Group, part of the Safer Hartlepool Partnership.

The need for flexibility, ambition and imagination. We want to promote a learning and evaluative culture, including willingness to adopt new models of care within the contract resource envelope – for example to explore the legal permissions and practicalities for prescribing and administering opiates in clinically supervised surroundings. It is recognised that as the evidence base, policy and practice evolve the Council, as commissioner, will need to have a sufficiently flexible agreement with its provider(s) to accommodate best practice within the resources available.

The need for much greater emphasis on prevention and early intervention – Hartlepool is embarking on becoming an "ACE-aware" town (Adverse Childhood Events) with attempts to prevent the "toxic trio" of drug and alcohol misuse, domestic violence, and mental ill-health through prevention of ACEs and to mitigate their adverse effects if they have arisen. This emphasis on prevention will include efforts to improve awareness and remove the stigma of addiction, and draw on the assets of recovered service users.

The need for whole-person care – we wish to see a "key worker" or small team providing continuity of care and building trust over the span of recovery from the first assessment through to discharge, starting with immediate needs of shelter, food and clothing, and moving on to medical, dental, sexual and mental health needs as well as addressing the addictive behaviours and prescribing. This includes "making every contact count" with respect to healthy lifestyle changes and finding service users "something useful to do." We wish to minimise the number of onward referrals to other services, preferring an in-reach of relevant services in a "one-stop-shop" model, with facilities to match.

The need for whole-household and family support – particular attention needs to given to safeguarding of children and vulnerable adults in the household, with closer ties to the Council's 0-19 public health nursing (currently provided in-house). For example, we would seek assurances that every service user's household in which there is a child under 16 receives a home visit by the public health nursing team, and that no-one is prescribed methadone to use at home if there is a child present. Greater connection with the Council's activity and creative offers, including outdoors, will be encouraged.

The need for a service model and specification based on pathways - Pathways start and end at a point where an individual is addiction-free and achieving their full potential. Although steps in the pathway may be provided by different agencies or in different locations, it is important that all staff, and all service users, should feel that they are part of one service and one pathway, with continuity of care throughout.
The need for clinical assessment and treatment with facilities and information technology fit for purpose.

Those individuals with coexisting mental health and addiction issues (dual diagnosis) have greater needs and this forms part of the assessment and response. Close working relationships with Mental Health Services are essential to address the needs of individuals presenting with a dual diagnosis. Our service model is for this to be provided on the same site (an in-reach mental health service) with joint sessions. We wish to discuss with potential providers how they would achieve this.

Harm minimisation will need to incorporate needle exchange, wound care, sexual health advice, blood-borne virus (BBV) and HIV management and dental health. Experience from local GPs and service providers is that sepsis (infection) in the legs is common and leads to higher rates of leg amputation or life-threatening septicaemia (blood poisoning).

Aftercare packages should be embedded within the treatment plan which may include psychosocial support. Aftercare could be addressed by working alongside advocacy services in the community with strong links to a mutual aid group.

Residential detoxification and rehabilitation, as at present but preferably on a larger scale, would require a suitably home-like but clinically equipped rehabilitation facility.

Liaison with criminal justice - The service will seek to provide continuity of care if a client enters prison, leaves prison, and/or is under a court order or the probation service, and this is another role of the key worker. Such key workers will work with police and other partners with identified prolific and other priority offenders. At strategic level we are re-launching the Hartlepool Drugs and Alcohol Harm Reduction Partnership, with refreshed terms of reference and membership, under the auspices of the Safer Hartlepool Partnership. The Service Leader will participate in this group and the Drug Related Death (DRD) reviews, and actions which follow from them.

Assessing the need has been a major thrust of this year’s public health work.

CHAPTER 4

What do we mean by "prevention"?

Background

During my brief tenure as Interim Director of Public Health I have had the privilege of many conversations about “prevention.” Those conversations have included elected Council members, senior planners and commissioners in the Council and NHS, people who work in our services and people who use our services.

There has been considerable coverage of prevention issues in the local press, especially the Hartlepool Mail, and occasionally in the local broadcast media and national press. During the 2018 World Cup soccer competition we succeeded in persuading ASDA in all its stores nationally not to sell a T-shirt with the slogan “Win or lose, let's booze”, and this Christmas they have decided not to sell a novelty wine glass that holds a full bottle of wine. These are welcome trends.

So, what do we mean by “prevention”? To those with a health service responsibility, prevention usually means the avoidance of disease such as diabetes, cancer or stroke.

“Primary prevention” means stopping the disease in the first place and includes public health measures like healthy eating, physical activity, avoidance of smoking and drinking alcohol sensibly.

“Secondary prevention” means catching diseases early, often before symptoms appear, for example through breast, bowel and cervical cancer screening.

“Tertiary prevention” applies once a disease is established but helps prevent relapses or further damage, such as rehabilitation after a stroke.

That is the disease model of prevention. By analogy it can apply to conditions such as joblessness, domestic violence or poor educational attainment. Other aspects of prevention are “personal responsibility”, “independent living” and “resilience to adversity.” These have featured in conversations too. There is no “one size fit all”, but are we being assertive enough? An area I have found controversial in conversations with caring professionals is the degree to which should we encourage and support individuals to exert greater control and responsibility over their own wellbeing. (Parents recognise this with their children as “tough love”).

Is it better to offer a hand-out or a hand-up? How do we avoid the unintended consequence of promoting dependency, while at the same time not pushing too much responsibility too soon? The objectives are to obtain a sustained improvement in personal wellbeing, greater resilience and reduced demands on the caring agencies.

The reality is that both the Council and the NHS are swamped with demands which are rising and unaffordable, yet so much of that demand is driven by remediable causes which people themselves can address if they have the right help and incentives. The key to unlocking the dilemma is prevention. But how?

The New Economics Forum in Manchester has promulgated “Five ways to wellbeing” (see box). These are gaining momentum in local authorities and the NHS and now frequently appear in policy documents. By finding activities that cover all five “ways”, it is possible to produce sustained improvement in personal health and wellbeing and reduced calls on caring services. I would suggest adding a sixth way, which is “be creative” because there is a strong evidence base for the role of the arts in personal and community development. All these ways to wellbeing can address primary, secondary and tertiary prevention discussed above.

How can we afford to invest in "prevention" in a climate of austerity?

Money is not the only resource, and statutory agencies are not the only providers. If traditional sources of capital and revenue are running low, we should draw more explicitly on social capital and revenue – for example through volunteers, charities, and benefactors. And we should not just look at the “inputs” side of the equation – the money, staff, buildings, time, expertise, commitment and so on, but also the outcomes – improved health, wellbeing, independence and reduced inequalities. Rather than refer to “costs” and “cuts” we should refer to “investment” and “disinvestment” because that language prompts us to reflect on the returns we should expect.

The five ways to wellbeing

Be active: get out and about – even standing and walking are better than sitting
Take notice: be mindful of your surroundings, pause to take an interest in the wider world, take a break from your own troubles
Learn: keep your brain active by exploring new knowledge and taking up new interests
Connect: stay in touch with family and friends and make new friends – loneliness can seriously impair quality and length of life
Contribute: it is a boost to self-esteem and self-worth to know you are making a difference and doing something useful, perhaps for the environment or for another person
(And the sixth “way” for Hartlepool – be creative: find new ways to express yourself and fulfil your potential, for example through painting, writing, music, dance, photography or gardening**.)**

Allied to this idea of social capital is the concept of “social prescribing” – referring people who could benefit from a change in lifestyle in ways which are engaging and sustainable – instead of relying solely on a medical model of pills and clinical interventions. This notion has progressed well beyond a promising idea; it is now a well-studied and evaluated evidenced-based option.

Many of the social prescribing models involve volunteers or volunteering in some capacity and can be considerably cheaper (and more cost-effective) than clinical alternatives. The Council has a role, for example through neighbourhood regeneration, allotments, physical activity, arts, and outdoor green spaces, to greatly increase the social prescribing offer. A social prescription should be the first option, in suitable individuals, before referral to more expensive and more risky pills and hospital visits in many common presentations, such as mild depression, early type two diabetes, high blood pressure and raised cholesterol. If we go down this route we need to keep evaluation in place to track outcomes and value.

If we, across all partners in health and wellbeing, are to shift the focus of our attention from reactive care to proactive prevention we need a sea-change in incentives, investment and how we view success. We should not look at individuals and populations in terms of their needs alone but also in terms of their abilities. For years, reports like this have looked at inequalities in health and the strong association with material deprivation. But benefits and services which address material poverty alone will not reduce inequality: we need to address poverty of opportunity, poverty of aspiration, poverty of good role models and poverty of hope.

Myth-busting

Perhaps the reason that we are not further ahead with prevention is that we don’t really believe in it? Here are some common myths, and how to bust them.

“Prevention takes years to have effect, yet alone release savings.” Not true. Take quitting smoking for example. Within a day there is a measurable fall in exhaled carbon monoxide – which means the blood (and an unborn baby for a pregnant mother) is getting an immediate benefit.

Within a week the pulse is measurably slower – which means the heart is under less strain. Within a month there is a measurable fall in blood pressure and the risk of stroke and kidney disease is falling. And within a year there is a measurable decrease in visits to the doctor or hospital with exacerbations of chronic bronchitis and heart disease. There are long term benefits too, which are a bonus to the ex-smokers and the caring services as well.

“If one organisation invests, another reaps the rewards”. This is true to an extent. The argument goes: “Why should the Council invest in health promotion if the NHS reaps the financial reward?” But there are usually swings and roundabouts, where each organisation helps the other when it addresses prevention, and joined-up strategies for investment in prevention should promote collaboration and working at sufficiently large scale.

“Prevention of one condition such as heart disease just stores up problems from another like dementia later.” Not true. The thrust of prevention is to prolong healthy active life. Most lifestyle interventions reduce risks for a wide range of physical and mental conditions.

“Prevention is nannying and individuals should make their own life choices.” The part about individual choice is true, but proper prevention increases personal autonomy by providing information and healthier choices. And sometimes we do have to be nannied, for example the lives saved from seat belt legislation, food safety standards enforcement, and banning smoking in public places.

A good example of local prevention in action is the EPEC project covered in chapter 2: addressing the root causes of poor health, poor life chances and unjustifiable inequalities by helping individuals help themselves and their neighbours.

It is encouraging to see the emphasis that the NHS sustainable transformation plan (now evolving into integrated care systems and integrated care partnerships) is placing on the issue of prevention, and we look forward to the fully costed version of the local integrated partnership and the quantification of investment in prevention.

It is also encouraging to see reports such as that by the Royal College of Physicians into smoking cessation (“Hiding in plain sight: treating tobacco dependency in the NHS, June 2018, which alerts its own members to their responsibilities. It includes this recommendation on page 227: “It is therefore in the specific specialty interests of all clinicians, as well as the health interests of their patients, to ascertain and treat tobacco dependence. There is no justification for failing to do so. A rational approach for England would be to move responsibility for smoking interventions back into the NHS.”

CHAPTER 5

Stewardship of the Public Health Grant

In 2012 the Health and Social Care Act brought the public health function, team and budget out of the NHS and into local authorities. Implementation began in 2013. The grant for public health was “ring-fenced” and local authorities must account each year for how it is deployed.

There is considerable freedom, within the ring-fence, to define what is and is not public health, though certain areas are described in the legislation and must be covered to some degree.

“Public health is the science and art of prolonging life, promoting health and preventing disease, through organised efforts of society” (Sir Donald Acheson, former Chief Medical Officer for England)

“Science reassures: art disturbs” (Georges Braque, artist)

Over time in Hartlepool the public health staff and their budget have been increasingly embedded in other directorates. It can be argued that everything a Council does is related in some way to health and wellbeing so there is justification for this approach so long as governance of standards and outcomes is maintained.

In order to keep track of the public health grant, the staff employed from it, the activities generated by it, and its outcomes achieved, a set of “service level agreements” has been agreed between the director of public health and each of the other directors or assistant directors who manage the budget. For information, these are summarised in the table on the next page.

The balance of the public health grant = £347,278. It was spent on the core public health offer: the Director and Deputy Director of Public Health, two senior public health practitioners and a data analyst, plus their associated costs for their direct public health activities.

Where did the public health grant go in 2017/18?

DIRECTORATE/ DIVISION	PROGRAMME/PURPOSE	BUDGET (£)
Children and families (52 funded staff over all programmes)	Health visiting & school nursing	1,566,000
	Early intervention	950,000
	Children's centres	650,000
	Family poverty initiatives	250,000
	Intensive response team	150,000
	Other staff costs (eg training)	22,000
	Non-recurring reserves	516,000
	TOTAL	4,104,331
Joint commissioning (3 funded staff over all programmes)	Substance misuse contracts - clinical & prescribing	1,279,782
	Sexual health contract	622,282
	Health checks	58,000
	Healthy start vitamins	10,000
	TOTAL	1,970,064
Adults and community (37 funded staff over all programmes)	In-house drugs & alcohol services	981,980
	Sports and recreation	277,785
	Community Hubs	144,355
	Mental health	150,000
	Older people	94,000
	Falls service	90,000
	Health promotion resource library	27,762
	Non-recurring reserves	171,286
	TOTAL	2,066,168
Neighbourhoods & Regeneration (All funds from reserves - N.R)	Public protection & admin support	77,259
	Allotments	50,000
	Consumer services	16,900
	TOTAL	144,159
Finance & Policy	Finance & audit	40,500
	Human resources	29,000
	Strategy	23,000
	Communications & marketing	20,000
	Information technology	12,000
	Legal services	7,000
	Non-recurring from reserves	22,000
	TOTAL	132,000
TOTAL CONTRIBUTION OF PUBLIC HEALTH GRANT TO OTHER DIRCTORATES		**8,416,722**

Given the dispersed nature of the public health workforce and new lines of managerial accountability, the directorate of public health has introduced monthly lunchtime seminars on topics of public health interest to allow staff from any background to become familiar and stay up to date with public health practice. The first three topics were health promotion, health economics and screening for diseases, respectively.

Public health outcomes (including inequalities) are scrutinised by the Audit and Governance Committee with respect to the Council's objectives, and by the Health and Wellbeing Board with respect to partnership objectives. Chapter 1 of this report covered some of these outcomes. Both meetings are held in public and attracted constructive coverage in the local press.

Through that medium some important messages and discussion points reached a wider local audience. Topics covered by the Hartlepool Mail this year, for example, following meetings of these two bodies, include: teenage pregnancy; "five a day" fruit and vegetables; breast feeding; gaps in life expectancy; sensible drinking; drugs and childhood obesity. That coverage illustrates the breadth of the challenge but also the degree of public interest and engagement.

Coping with cuts

In 2018/19 we are expecting a cut in our grant from Public Health England of £228,000. In discussion with the Corporate Management Team, and then following approval from the Finance and Policy Committee, the approach to disinvestment was as follows.

We looked at the five main areas of public health activity: public health nursing (0-19 years old); drugs and alcohol services; healthy weight and healthy lives activities; sexual health services and smoking cessation services. Rather than take a proportionate reduction from all of them, irrespective of value to our corporate objectives and return on investment, we decided to identify the programme with least value and take the cut from that.

In order to assess the contribution of these public health programmes to our corporate objectives, we came up with 11 criteria by which to assess the programmes. Since not every criterion carried equal weight, we allocated a weighting score (adding up to 100) for each. Those criteria, and the weightings we gave them, are listed as follows.

Weighted criteria for prioritising disinvestment (or new investment) in public health programmes

CRITERIA	WEIGHTING (ADDS UP TO 100)
Benefit is felt by many people rather than a few	15
Benefit is large and lasts a long time	15
It helps reduce inequalities in health or wellbeing	15
It empowers people/communities to sustain health & wellbeing, for example education, skills, job opportunities	10
It improves efficient use of resources, including "invest to save"	10
It reduces demand on other Council services	10
It reduces demand on other partners (eg NHS)	5
There is an alternative if the Council no longer provides	5
It has public support and protects the Council's reputation	5
It does not damage the environment or sustainability	5
The evidence for the criteria above is strong	5

Having applied these criteria to the public health programmes, one service emerged with a clearly lower score and discussions are in hand with that contracted provider to achieve the necessary level of savings.

Tough choices on funding priorities are an inevitable part of budget management, and particularly stark during periods of austerity. On the positive side, we believe we are deploying the resources we do have as efficiently and transparently as possible, and we are looking just as hard at outcomes as we are at inputs.

Summary: the pursuit of efficiency

The pursuit of efficiency is an ethical imperative for all who work in publicly funded services because at the end of the day it is the public who pay for any efficiency and the currency in which they pay is not just their taxes but in missed life chances, avoidable inequalities, needless distress and even dying before their time.

CHAPTER 6

Concluding challenges: austerity, inequality and empowerment.

Austerity

Austerity is both a challenge and an opportunity.

Are the public sector cuts leading to hardship and detriment to health and wellbeing? Yes.
If we had more resources could we use them to improve health and wellbeing? Undoubtedly.
Are we using every bit of resource currently to its best advantage? Probably not. Therein lies a challenge that we can do something about.

As regards the public health function, austerity drives us to look more closely at value for money and creative thinking about new ways of working – often in partnerships – to deliver the desired outcomes within the resources entrusted to us. In some service areas we know the costs but not the value. We are becoming expert in doing things right ("technical efficiency") but are we doing the right things ("allocative efficiency".)

When we have to take money out of programmes (or in rare instances increase investment in programmes) we need to be explicit with ourselves and others about how those choices are made.

To make our decisions more open, inclusive and robust, we need to draw on disciplines such as epidemiology (the nature and scale of the problems), effectiveness (scrutinising the evidence base), economics (relating inputs to outcomes), evaluation (checking that stated objectives are being met) and ethics (being clear about value judgements).

Hartlepool Borough Council might want to take stock of this skill set and maybe fill any gaps by partnership with the education sector and universities. Other partners in health and wellbeing might want to share the cost since they face the same needs.

At the very least it would be constructive if Hartlepool Borough Council had an agreed list of criteria, perhaps similar to those listed in chapter 5, by which officers could prepare decisions for public scrutiny.

Inequality

This report draws attention to many areas of inequality – some getting wider – where evidence from other boroughs with similar population profiles and affluence appear to be getting better results. Reducing these avoidable gaps is, and must continue to be, a priority objective for all Hartlepool Council programmes, with even greater scrutiny of the "inequalities" section in papers that come to committees.
We will never eliminate inequalities because every individual has a unique genetic endowment and life experience (for example we never have every baby born at the same weight, everybody experiencing the same diseases and accidents, everybody choosing the same occupation and earning exactly the same wage, and everybody dying at exactly the same age, and so on). But we can reduce unfair and avoidable inequalities.
Some of the current inequalities mapped out in this report are in relation to material deprivation, and the correlations are very strong. This does not mean that money alone is the cause or the solution. Just as important as inequality in material wealth are inequalities in opportunity, inequalities in aspiration, inequalities in positive role models, inequalities in hope, and so on. These are areas that we certainly can address, without waiting for new money to materialise.

Empowerment

Hartlepool's greatest resource is its people. Without waiting for the economic upturn we can get on with recognising and developing individuals and community assets. For the local NHS in general, especially but not exclusively general practitioners and pharmacists, there could be a greater emphasis on empowering patients to take greater control over lifestyle choices, to making a "social prescription" the first offer more often, and thereby freeing the hospitals to do what only they can do and do best. Part of the Council's task, including all those programmes funded by the public health grant, should support a wider social prescription offer and make healthier choices easier choices.

Helping all Hartlepool's children away from adverse childhood events, and its older citizens to adopt the five "ways to wellbeing" suggested in chapter 4, (or six, if we include creativity) would be very significant steps towards a healthier Hartlepool, with fewer inequalities, and release resources for those who need it most and cannot help themselves.

"It is better to light a candle than curse the darkness"

(Anonymous proverb)

HARTLEPOOL BOROUGH COUNCIL

If you wish to comment on this report, or ask questions arising from it, please contact:

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