HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL BOROUGH COUNCIL

Tuesday, 2 February 2010

at 3.00 pm

in Council Chamber
Civic Centre, Hartlepool

MEMBERS: HEALTH SCRUTINY FORUM:
Councillors Barker, Brash, S Cook, A Lilley, G Lilley, Plant, Sutheran, Worthy and Young

Resident Representatives:
Jean Kennedy and Linda Shields

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

   3.1 To confirm the minutes of the meeting held on 5 January 2010

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

   No items.

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

   No items.

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

   No items.

7. **ITEMS FOR DISCUSSION**

Scrutiny Investigation into 'Alcohol Abuse – Prevention and Treatment'

7.1 Evidence around 'Treatment Services'

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

(b) Presentation on Annual Needs Assessment / Treatment Plan – *Parenting Commissioner*;

(c) Evidence from the commissioners of Treatment Services - *Hartlepool Primary Care Trust*,

(d) Evidence from the deliverers of Treatment Services:-

(i) *Intrahealth*;
(ii) *Albert Centre*; and
(iii) *MIND*.

7.2 Evidence from the Joseph Rowntree Foundation – Covering Report – *Scrutiny Support Officer*

7.3 Six Monthly Monitoring Update of Agreed Health Scrutiny Forum's Recommendations – *Scrutiny Support Officer*

8. **ISSUES IDENTIFIED FROM FORWARD PLAN**

No items.

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

9.1 Tees Valley Health Scrutiny Joint Committee held on 11 January 2010 – *Scrutiny Support Officer*

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

ITEMS FOR INFORMATION

Date of Next Meeting:- Tuesday, 9 March 2010 at 3.00 pm in the Council Chamber, Civic Centre, Victoria Road, Hartlepool.

HEALTH SCRUTINY FORUM

MINUTES

5 January 2010

The meeting commenced at 3.00 pm in the Civic Centre, Hartlepool

Present:

Councillor: Jonathan Brash (In the Chair)

Councillors: Alison Lilley and Geoff Lilley.

In accordance with Council Procedure Rule 4.2 (ii), Councillor Carl Richardson was in attendance as substitute for Councillor Shaun Cook.

Officers: James Walsh, Scrutiny Support Officer
Angela Hunter, Principal Democratic Services Officer

Also present: Professor Dr Peter Kelly, Executive Director of Public Health, NHS Tees
Councillor Stephen Wallace, Chair of Hartlepool PCT
Carole Langrick, Director of Strategy / Deputy Chief Executive, North Tees & Hartlepool NHS Foundation Trust
Ali Wilson, Director of Health Systems and Estates Development, Hartlepool PCT
Jonathan Maloney, Assistant Director, Procurement & Contract Management (Acute Services), NHS Tees
Dr Alex Barlow, Practice Based Commissioning Chair, NHS Stockton

90. Apologies for Absence

Apologies for absence were received from Councillors Caroline Barker, Shaun Cook, Michelle Plant, Lilian Sutheran and resident representatives Linda Shields and Jean Kennedy.

91. Declarations of Interest by Members

None.

92. Minutes of the meeting held on 1 December 2009

Confirmed.

93. Matters Arising from the Minutes

(i) The Chair confirmed that the Acting Director of Health was collating the comparative information relating to the level of funding allocated by the PCT to drug and alcohol services and this would hopefully be provided before the next meeting of the Forum in February (minute 80 refers).

(ii) The Chair referred to minute 87 and the request by Members for clarification on the recent report published by the Dr Foster organisation in relation to mortality rates for hospitals. The Director of Strategy from Hartlepool and North Tees Foundation Trust (FT) was in attendance and informed Members that every hospital had an expected death rate and the Dr Foster report had been compiled by comparing data across all hospitals on the number of deaths expected in 2008-09. Prior to the report being published, the FT were aware of these figures and had looked in detail at how the figures were collated and recorded in conjunction with the Dr Foster organisation. Subsequently it was found that there were errors in the way the data had been initially recorded which had led to an artificially inflated actual death rate being produced. As a result of these findings, changes were made to how this information was recorded and the hospital rate was now proven to be in line with the expected rate.

In addition to the above, it was noted that in the north east a lot of people were receiving palliative care at home or in nursing homes and more often than not were admitted to hospital for their end of life pathway. Work was being undertaken with the Life Care Group to look at how services can be developed to ensure that people have the choice to remain in their place of care for their end of life pathway rather than being admitted to hospital.

(iii) Members were informed that the Chair, along with 12 other scrutiny chairs in the north east had signed a funding bid for research into health and equalities of ex-servicemen / women and their families. It was hoped that the result of the bid would be known by the end of January.

(iv) In relation to Greatham Health Centre, minute 89 refers, the Chair confirmed that a comprehensive response to the closure of the Greatham Health Centre was being prepared by the Director of Health Systems at the PCT and would be distributed to Members.

94. Any Other Business

A Member commented on the current weather conditions and freezing temperatures and was concerned for people on pre-payments meters especially families on benefits being unable to afford to top up their meters. The Executive Director of Public Health indicated that a more detailed

response would be provided by the Acting Director of Public Health but confirmed that the PCT and local authority were working together to reduce the number of people experiencing this kind of issue. Members were asked to note that although the NHS was not in a position to provide funding for meters, it was involved in a full range of funding initiatives including the provision of better insulation for homes and working with the Fire Authority to provide blankets for people where necessary.

95. Responses from Local NHS Bodies, the Council, Executive or Committees of the Council to Final Reports of this Forum

None.

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

None.

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

None.

98. Swine Flu Briefing – Covering Report (*Scrutiny Support Officer*

The Executive Director of Public Health was in attendance to provide Members with an update in relation to the current position with swine flu. Members were informed that daily briefings were held with the Acute Trust, the PCT and the Ambulance Service via telephone conference to ensure all organisations were aware of the current pressures on local hospitals. In addition to this, the Strategic Health Authority held a daily regional briefing, via telephone conference, with all lead representatives in the north east. There were also weekly meetings with all Directors within the regional Acute Trusts responsible for monitoring swine flu.

In relation to activity in the region, Members were informed that there were currently 27 people in the north east in hospitals with swine flu with 3 in critical care. The pressure that this was placing on local hospitals was negligible compared to the pressures brought about with the impact of the poor weather, ie falls and slips. The anti-viral medication for swine flu was being distributed from a collection centre at Thornaby although demand for this was currently very low. Methods of delivering this service via community pharmacies were currently being examined.

The immunisation programme for vulnerable people with underlying health conditions including children from 6 months and above and adults was nearing completion. The current programme was concentrating on nursing

and residential homes across Teesside which should be completed by the end of January 2010.

Members were asked to note that an immunisation programme for children 6 months to 5 years old was commencing this week. Finally, the Executive Director of Public Health confirmed that in relation to staff uptake of the immunisation programme, North Tees and Hartlepool FT were joint 2nd highest out of 23 FT with 52% of staff having received the vaccine.

In response to a query raised by a Member, the Executive Director of Public Health confirmed that there was a system in place to deliver the vaccine to people who had no other means of getting it, with some actually having been delivered on Christmas Day. The level of uptake of the immunisation was as well as anywhere in the north east of England and reassurance was given that there was no reason to be fearful of the injection as it was tried and tested as was the normal flu jab given at winter time.

Decision

The information provided by the Executive Director of Public Health was noted.

99. Momentum: Pathways to Healthcare – Progress report – covering report (*Scrutiny Support Officer*)

Members were informed that representatives from the Primary Care Trust (PCT) and Foundation Trust (FT) were in attendance to provide an update on the Momentum Programme. The Director of Strategic Development (FT) and the Director of Health Systems (PCT) gave a very detailed and comprehensive presentation which covered the background and approach of the programme including the development of community based facilities.

The presentation detailed the service delivery options for the following services:

- Accident and Emergency
- Outpatients
- Respiratory Conditions
- Diabetes
- Physiotherapy and Occupational Therapy

The service delivery options included the examination of extended working to provide treatment at a time convenient to patients and staff whilst ensuring that equipment and facilities were used more efficiently and were available as required. In addition to the above, it was noted that the Integrated Care Centre (ICC) in Park Road would provide a consolidation of urgent care as well as community services and integrated care.

The timetable for the completion of the new hospital was provided with the hospital expected to open in late spring 2015. Details of the proposed public transport services to be provided were included.

A discussion ensued which included the following issues.

(i) A Member commented on the community based facilities provided by the Rheumatology Department at Tees Street and questioned whether all the necessary facilities were available at this location. The Director of Strategic Development confirmed that in general appointments were screened to ensure that patients received treatment in locations where the necessary facilities were in place.
(ii) A Member commented that the key to the success of achieving the best treatment for patients involved close working with clinicians. The Director of Health System confirmed that great progress had already been made in this area through a full engagement with clinicians and general practitioners.
(iii) A Member questioned the level of publicity given to the 'breathe-easy' initiative and how it was ensured this was communicated to people. The Director of Health Systems indicated that this initiative was part of the community services provided and acknowledged that further publicity of the services available was being looked at.
(iv) The Director of Health Systems commented that there was a lot of care provided within the hospital environment through custom and practice that could be provided elsewhere. This would be achieved through education and training.
(v) A Member referred to the provision of cancer screening and the fact that the take up of this was not as high as it could be. The Practice Based Commissioning Chair indicated that the health screening provided by the local PCTs and health organisations was in line with Department of Health guidelines and beyond. He noted, however that the biggest impact on increasing awareness of cancer screening was through the publicity given to high profile celebrities who had been diagnosed with cancer.
(vi) With reference to the new hospital, a Member questioned if the provision of services from the hospital would be done on a phased approach. The Director of Strategic indicated that she would ensure a detailed response was provided for Members on this issue.

The representatives from the North Tees and Hartlepool Foundation Trust and Hartlepool Primary Care Trust were thanked for their informative presentation and for answering Members' questions.

Decision

(i) The presentation was noted.
(ii) That details of how services would be transferred to the new hospital be circulated to Members.

100. Consultant Referrals – Covering Report (*Scrutiny Support Officer*)

The Assistant Director, Procurement & Contract Management (Acute Services), NHS Tees was in attendance to provide evidence in relation to how the consultant to consultant (tertiary) referral process operated. A contractual agreement was in place between the Primary Care Trust and the Foundation Trust to cover tertiary referrals which operated as follows:

- If the consultant believes that additional treatment was required which related to the original referral, that patient would be referred directly to the appropriate consultant.
- If a patient had a pre-existing condition which had a material impact on the condition to which the original referral related, the consultant would refer that patient to an appropriate consultant to have that condition resolved before the treatment for the original referral took place.
- If a life threatening condition was identified that required urgent clinical attention, the consultant would refer the patient onto another consultant immediately.
- If an unrelated condition was identified, the patient was referred back to their GP to enable the GP to assess and appropriate treatment through their pivotal role in their patient's package of care.

In all cases, the consultant would keep the patient's GP informed as a matter of good practice.

The Assistant Director added that should a patient require urgent care, cancer treatment or there was the potential for the 18 week pathway to be exceeded, a consultant would refer the patient to the appropriate consultant immediately.

A discussion ensued which included the following issues.

(i) Should the patient be referred to the wrong consultant, does that consultant have to refer the patient back to their GP or can he direct them to the appropriate consultant? The Practice Based Commissioning Chair indicated that in this instance, the consultant should liaise with the GP to ascertain if the patient could be referred onto another specialist. The Director of Strategic Development confirmed that within the contract there was a defined limit to the amount of consultant to consultant referrals and this was monitored on a monthly basis by the PCT and FT.

(ii) A Member questioned the financial implications for GPs from consultant to consultant referrals. The Assistant Director confirmed that there were no financial implications for GPs from this although there were financial implications arising from the difference in primary and secondary care. However, the provision of care was driven by ensuring the patient had the most appropriate choice of treatment and how this was best provided.

(iii) A Member referred to a personal experience with a consultant referral and the Assistant Director asked if he could have more details of this outside of the meeting to enable a fuller examination of the facts.
(iv) It was suggested that a true reflection of how consultant referrals worked in practice would be best judged by asking patients about their experiences. Further information from the PCT and FT was also requested on how this was monitored to ensure the best use of this practice was in place. However, it was acknowledged that GP practices operated in many different ways and a lot of how a patient's treatment was delivered was dependent on this.
(v) It was acknowledged that the system as set out in theory was fair and in the best interests of patients but members questioned whether the operated this way in practice in all circumstances. It was agreed that further exploration of this point was needed.

The Chair commented that should any Members be affected by any of the issues discussed above, they could contact him and he would contact the FT and PCT to look at the issue further.

Decision

(i) The information provided by the PCT and FT was noted.
(ii) Further information on how the system of consultant and tertiary referrals was monitored to be provided at a future meeting of the Forum.
(iii) The proposal to seek the views of patients affected by tertiary referrals be further explored.

101. Care Quality Commission (*Scrutiny Support Officer*

Members were advised that in April 2009, the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection were replaced by the Care Quality Commission (CQC) who produced the document 'Voices into Action' in November 2009, a copy was attached at Appendix A. Members were informed that there was no requirement for the Forum to provide commentary this year but that contact would be forthcoming from the local CQC team, explaining how the Forum can provide information throughout the year.

However, the Chair sought Members' approval to submit a response to the CQC in relation to the working relationship with the FT and PCT. Any Members wishing to make comment should contact the Chair directly.

Decision

(i) The report was noted.
(ii) Members were asked to feed any comments in relation to the local authority's working relationship with the FT and PCT to the Chair directly with delegated authority given to the Chair to provide a

response to the CQC.

102. Tees Valley Health Scrutiny Joint Committee - Update (*Scrutiny Support Officer*

Members were informed that a meeting of the Tees Valley Health Scrutiny Joint Committee took place on 17 December 2009 where the following issues were discussed:

(i) Cancer Screening Services and Next Steps
(ii) Out of Hours Care Service Redesign
(iii) Swine Flu Briefing
(iv) Personal Health Budgets Pilot
(v) Stroke Services in Middlesbrough (for info)

The Chair confirmed that items (i) and (iv) would be examined in more detail at future meetings of this Forum.

Decision

The report was noted.

The meeting concluded at 5.47 pm

CHAIRMAN

HEALTH SCRUTINY FORUM

2 February 2010

Report of: Scrutiny Support Officer

Subject: ALCOHOL ABUSE - PREVENTION AND TREATMENT – TREATMENT SERVICES – COVERING REPORT

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1. PURPOSE OF THE REPORT

1.1 To provide Members with an introduction to the evidence gathering session around Treatment Services as part of this Forum's investigation into 'Alcohol Abuse – Prevention and Treatment'.

2. BACKGROUND INFORMATION

2.1 Members will recall that at the meeting of this Forum on 1 September 2009, the Terms of Reference and Potential Areas of Inquiry / Sources of Evidence were approved by the Forum for this scrutiny investigation into 'Alcohol Abuse – Prevention and Treatment'.

2.2 Subsequently at today's meeting a number of presentations will be received by Members of the Health Scrutiny Forum surrounding those organisations involved in Treatment Services aimed at helping those people suffering from alcohol abuse and misuse.

2.3 Detailed below are the organisations and representatives who have agreed to provide evidence on their involvement in Treatment Services:-

(a) **Parenting Commissioner** – providing a presentation on young people's substance misuse in relation to the requirement for the production of an Annual Needs Assessment / Treatment Plan;

(b) **Hartlepool Primary Care Trust** – providing evidence on their role as commissioners of the delivery of treatment services covered by the following organisations:-

(i) Intrahealth;
(ii) Albert Centre; and
(iii) MIND

Representatives of the providers listed under 2.3(a) (i)-(iii) will be in attendance at today's meeting to provide evidence on the work that they do. Members will note that attached at **Appendix A** to this report is MIND's Annual Report for 2008-09 and **Appendix B** is MIND's report from April-September 2009.

3. RECOMMENDATIONS

3.1 That Members note the content of this report and the presentations from the representatives detailed in section 2.3, seeking clarification on any relevant issues where felt appropriate.

Contact Officer:- James Walsh – Scrutiny Support Officer
Chief Executive's Department – Corporate Strategy
Hartlepool Borough Council
Telephone Number: 01429 523647
E-mail – james.walsh@hartlepool.gov.uk

BACKGROUND PAPERS

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

(i) Report of the Scrutiny Manager titled 'Scrutiny Investigation into 'Alcohol Abuse – Prevention and Treatment' – Scoping Report,' presented at the meeting of the Health Scrutiny Forum of 1 September 2009.

Hartlepool Mind Alcohol Project

Annual Report 2008-2009

The Hartlepool Mind Alcohol Project seeks to empower clients misusing alcohol to lead more productive, fulfilling, and enjoyable lives. It provides therapeutic involvement for clients across a broad spectrum of problematic drinking levels. These range from the relatively low level to the dependent, although the main focus of the project is on working with clients drinking in a hazardous or harmful manner. The project operates from the human givens ethos, assessing the unmet needs or misused resources of the client and seeking to assist them through a myriad of therapeutic interventions.

The project commenced its work in June 2008. This introduction was gradually phased in and by August the project was operating at capacity. Five key workers have been involved on a part-time basis to initiate the project, provide therapy in conjunction with clients, and to co-ordinate its running. These employees are Kyle Brooks, Vikki Dring, Cheryl Lake, Tom Livesey, and Stefan Wright. The roles have been those of the co-ordinator, therapist, recovery support worker and administrator. Kyle and Tom have been involved as therapists and co-ordinators, Stefan and Cheryl provided the recovery support work spine of therapy, and Vikki has provided the administration for the team. In addition to the alcohol project itself, clients have access to the full range of services available across Hartlepool Mind. As such, they may also participate in courses specific to their individual needs. An example of this might involve learning basic skills, if literacy had been identified as a stumbling block to their progress. A client might learn about sleep hygiene. This is a key tool in helping clients to tackle their addiction as many report that they misuse alcohol to help them to sleep. A process of initial and ongoing assessment enables the project to monitor the client's needs and seek suitable therapeutic activities to address them.

Over the past year, a referral and care pathway has been established to facilitate the development of alcohol treatment services in Hartlepool (see appendix attached.) This pathway provides a strategic map of services, ensuring that treatment is available to clients across the spectrum of alcohol misuse. The AUDIT tool is used to group alcohol misuse into four potential areas: safe drinking, where no harm is likely to ensue; hazardous use, where damage to the individual may occur; harmful levels, where damage is likely to occur; alcohol dependency, where the individual suffers physical withdrawals and may require a medical intervention to prevent harm. Hartlepool Mind has worked closely with partner organisations to ensure the smooth running of this pathway. Detailed cooperation in particular with the Albert Centre has enabled a flexible service to be delivered to this varied client group.

The ethos of the project is supported by the philosophical approach to practice inherent in human givens therapy. This approach stresses that each individual has a series of emotional needs. When met in balance they reflect wellbeing and guard against ill health. These needs include security, attention, a sense of autonomy, a sense of status and being valued, being stretched and challenged, privacy, emotional intimacy, and a sense of connection to wider community. This philosophy stresses the resources present in each individual to enable them to meet their needs. These include the ability to make rapport

with others, to discharge emotional arousal through dreams, a rational brain, a long-term memory, an observing self, the ability to match patterns in situations and with others, and an imagination. Clients accessing the alcohol project engage in an assessment, at which point the assessor will agree an unmet need, or needs with the client. The ensuing therapy may utilise the involvement of a recovery support worker, a therapist, or both as deemed appropriate by the client and the therapist at assessment. The client's treatment at Mind is reviewed on an ongoing basis. At the post-assessment referral stage a plan is provided for the subsequent worker, detailing the specific unmet need/s and therapeutic activities tailored to meet them. This approach provides clarity and structure to treatment for both the client and the team, increasing the likelihood of a successful therapeutic outcome.

Referrals

When the alcohol project was commissioned, it was envisaged that it would provide treatment to 100 clients over a calendar year. As mentioned above, the project started in June 2008, but was not at capacity until August. We have received 69 referrals in the nine month period of operation in 2008-09, ensuring that the project remains on track to see 100 clients within the first year of opening.

No. of referrals	69
Males referred	44 (64% of total)
Females referred	25 (36% of total)

We have received referrals from a wide range of sources. We are a street level project and can accept self referrals. This has proved to be our largest single incoming source , closely followed by those received from the Albert Centre.

Referral source	**No. of referrals received**
Self	19
Secondary Care	6
Primary Care	3
Arrest referral worker	10
Albert Centre	13
Probation	3
Internal referral	10
Other	5

Statistics/Outcomes

In order to monitor the outcomes of therapy, we have used the CORE evaluation tool and the AUDIT throughout the existence of the project. We have recently started to use PHQ9 forms to measure depression and GAD7 forms to assess anxiety issues, as well as using Treatment Outcomes Profile forms to provide statistical data. Core forms are completed at every session, whilst an AUDIT is completed on assessment and then at every other session. In order to provide meaningful therapeutic information, we have altered the AUDIT to gather data relevant to the month prior to completion. This enables the client to see progress that may have been made with regards to their drinking. GAD7 and PHQ9 forms are completed on an alternate basis with the AUDIT to ensure that we gather as much information as possible, without devoting too much time to paperwork in sessions. The TOP form is completed on assessment and then at ten week intervals to monitor progress.

Of the 69 referrals listed above, 57 entered treatment and engaged in at least one session. Of these 57, 20 either participated in one session only or did not complete core forms. As such these 20 clients have not been included in the table below, with obtained from CORE.

Average core decrease	6.4
Average core risk decrease	6.9
No. of clients showing improvement in emotional wellbeing	24 (65%)
No. of clients showing decline in emotional wellbeing	11 (30%)
No. of clients where emotional wellbeing remained the same	2 (5%)
No. of clients showing lower levels of risk	23 (62%)
No. of clients showing higher levels of risk	4 (11%)
No. of clients showing no change in risk	10 (27%)

In addition to obtaining CORE outcome data pertaining to mental health, the project has also used the AUDIT tool to assess levels of alcohol misuse. Data was collected for 43 clients, 29 of whom attended for more than one session and have subsequently been collated in the table below. The AUDIT was intended to be used as a tool to assess whether an individual might have an alcohol problem. We apply the tool as it is at our assessment, but use an

amended version at subsequent sessions. The altered form takes into account the client's drinking over the past month, providing a more accurate picture of their current drinking levels. It can also be used as a motivational tool, reflecting the progress that the client has made.

Average audit decrease	6.5
No. of clients showing decrease in audit score	27 (93%)
No. of clients showing increase in audit score	1 (3.5%)
No. of clients where audit score remained the same	1 (3.5%)

In addition to the quantitative data collected there has been a commitment on the part of the project to obtain qualitative evidence of the work undertaken. Several case studies have been produced to reflect the varied nature of the client group and the treatment provided and are available to interested parties.

Attendance data

Data has been obtained for client attendance, highlighting the progress made in establishing the project. The data below relates to the six-month period October 2008-March 2009.

	Therapy	**Recovery Support Work**	**Assessments**
Attended	92 (55%)	58 (59%)	17 (43%)
Did not attend	37 (22%)	30 (31%)	18 (45%)
Cancelled/rescheduled	39 (23%)	10 (10%)	5 (12%)

Training and development

Hartlepool Mind is committed to staff training needs and professional development. Staff have completed an array of training courses to ensure that the project can provide an excellent service to its client base. Staff training in 2008-09 has included a four-day workshop in solutions-focused therapy,

addictions workshops and seminars, many further seminars and workshops relating to human givens therapy, positive psychology, training in the mental health and mental capacity acts, child protection and mental health awareness.

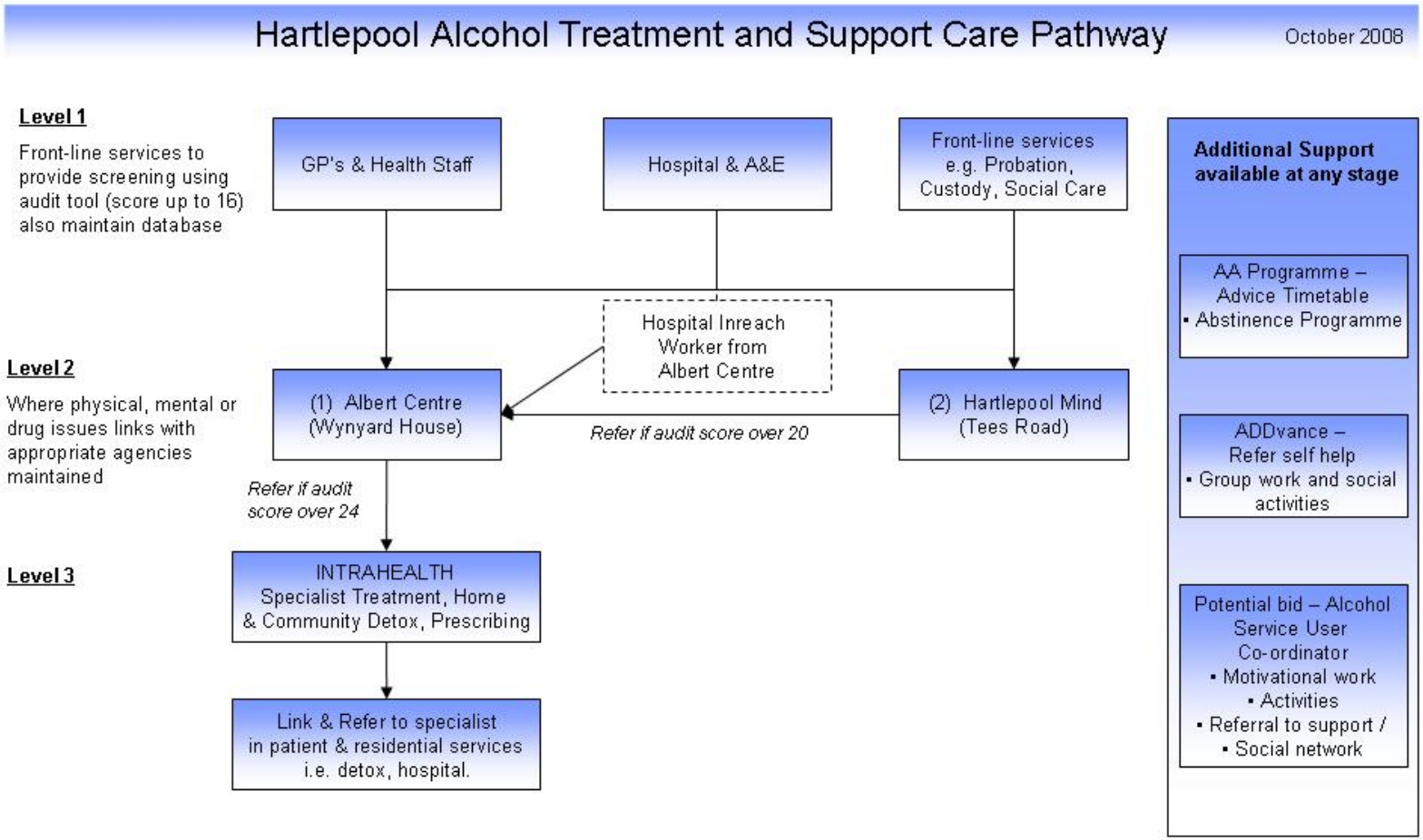
The coming year : 2009-2010

Funding has been secured for the project to continue to provide a quality service to its client group. We will continue to operate on a relatively small scale, with funding appropriate to 100 referrals. It is hoped that increased funding will be available in future years to provide a wider service, reflecting both the extent of alcohol misuse in the area and the successful outcomes obtained by the project.

The next year will see an equal commitment to training, with staff due to complete the human givens therapy certificate and diploma. Two days of training has been booked with Alcohol Concern covering brief alcohol interventions and advanced alcohol treatment for later this year. A further six days of training in the use of EMDR interventions has been arranged. It is hoped that some training may be undertaken, helping staff across the project to learn more about the practical application of CBT with this client group.

Conclusion

2008—09 has seen the establishment and development of the Hartlepool Mind Alcohol Project. The project has provided a much-needed, specialised input into the mental health needs of problematic drinkers and has seen great success over the past nine months. With funding secure for the next year, the project will continue to provide this service within Hartlepool, linking in with other service providers to ensure that the needs of a diverse and challenging client group continue to be addressed. The project has gathered evidence of the excellent outcomes obtained across its client work. We will continue to accumulate outcome-related evidence to inform our practice and to assess the quality of our work.



(1) Albert Centre - Severe dependency and dependency with complex needs (Audit Score 20-24) offer Comprehensive Assessment, Structured Counselling, Psychosocial Interventions (Motivational Interview, Solution Focused Therapies & Cognitive Behaviour Therapies)

(2) Hartlepool Mind – Harmful & hazardous drinkers (Audit Score 16-20) offer Comprehensive Assessment, Brief Intervention, Psychosocial Intervention (Motivational Interview, Solution Focused Therapies & Cognitive Behaviour Therapies) *Adopt a Human Givens approach.

All services Level 2 & 3 to discharge back to the referral agency for continued aftercare.

Safer Hartlepool

HARTLEPOOL MIND ALCOHOL PROJECT REPORT APRIL-SEPTEMBER 2009

Hartlepool Mind Alcohol Project Six-Monthly Report: April-September 2009

The Hartlepool Mind Alcohol Project seeks to empower clients to lead more productive, fulfilling, and enjoyable lives. It provides therapeutic involvement for clients across a broad spectrum of problematic drinking levels. Whilst these range from the relatively low level to the dependent, the main focus of the project is on working with clients drinking in a hazardous or harmful manner. The project operates from the Human Givens ethos, assessing the unmet needs or misused resources of the client and seeking to assist them through a variety of effective therapeutic interventions.

The Alcohol Project has been in operation for eighteen months. Funding is currently provided annually. Over the past six months, five members of staff have been employed on a part-time basis across the project: Vikki Dring and Claire Yeoman have worked as administrators; Tom Livesey has provided psychotherapeutic interventions and coordinated the project; Stefan Wright and Aimee Ruby have worked as clinical recovery support workers. In addition to the alcohol team itself, clients have access to the full range of services available across Hartlepool Mind. As such, they may also participate in courses and workshops specific to their individual needs. A client might learn basic skills, if literacy had been identified as a stumbling block to their progress, or about sleep hygiene if their sleep patterns are erratic. This is a key tool in helping clients to tackle their addiction as many report that they misuse alcohol to help them to sleep. A process of initial and ongoing assessment enables the project to monitor the client's needs and seek suitable therapeutic activities to address them.

As with all Hartlepool Mind services, the Alcohol Project is underpinned by the philosophical approach inherent to Human Givens therapy. This approach stresses the psychology that drives addictive behavior, viewing dependency as a subversion of the natural reward system in the brain. Mental health problems stem from the failure to meet emotional needs. By utilizing this framework, the project seeks to help the client to develop a clear structure and an explanation for their natural tendency towards addiction. The team works together with the client to create a map from which to plot an escape from their difficulties. Changes are planned with the organizing idea of seeking to achieve a life in which all emotional needs are met in balance.

A referral pathway across alcohol services in Hartlepool was established in 2008 (see appendix attached) and the past six months has seen a consolidation of multi-agency working. Hartlepool Mind has worked closely with The Albert Centre, Intrahealth, and Carrgomm to ensure that an holistic package of care is offered to town residents with alcohol-related issues. Mind is committed to involvement in the Alcohol Providers Group, the Alcohol Strategy Operations Group, and the Multi-agency Practice Group. These three task groups are focused on ensuring that all providers across the town are fully engaged in maintaining best practice in treatment, and that local, regional, and national strategic developments are implemented appropriately. Regular contact and discussion across these agencies ensures that clients' treatment is regularly monitored and discussed. Gaps are identified and resolved to provide the client with the best possible care from all services.

Referrals

As mentioned above, the project is funded annually, with an expectation that we work with one hundred referrals in that period. In the past six months we received sixty-three referrals and remain on track to meet our target number over the course of the 2009-2010 funding year. This suggests that the project is publicized appropriately and that referring agencies are aware of its availability.

Breakdown of referrals

No. of Referrals received	63
Males referred	42 (67%)
Females referred	21 (33%)

Referrals have been received from a wide range of sources. The majority has been referred by the Albert Centre, arrest referral workers, self-referrals, and internally by other Hartlepool Mind projects. This reflects the work undertaken to maintain close working relationships with other providers.

Referring Agency	**No. of referrals**
GP	3
Probation	1
Alcohol Outreach	1
Arrest Referral Worker	20 (32%)
Brooklyn	2
Internal	10 (16%)
Victim Support	1
The Albert Centre	8 (13%)
Job Centre	1
Harbour	1
PCP	2
CPN	1
PCT	1
Self	9 (14%)
DISC	1
Other	1

Statistics/Outcome measures

In order to monitor the outcomes of therapy, we have used the CORE[1] evaluation tool and the AUDIT throughout the existence of the project. We also use PHQ9[2] forms to measure depressive symptoms and GAD7[3] forms to assess anxiety to provide a full picture and to inform the direction of therapy. We complete Treatment Outcomes Profile (TOP) forms to provide the National Drug Treatment Monitoring System, a government statistics agency, with data about clients accessing treatment. CORE forms are completed at every session by the client, whilst an AUDIT[4] is completed on assessment and then at every other session. We have altered the AUDIT to gather data relevant to the month prior to completion. This provides therapeutically meaningful information, as it enables the client to see the progress made with regards to their drinking. GAD7 and PHQ9 forms are completed on an alternate basis with the AUDIT to ensure that we gather as much information as possible, without breaking rapport with the client in sessions. The TOP form is completed on assessment and then at eight-to-twelve week intervals to monitor progress and report data to the National Drug Treatment Monitoring System.

The data collected below highlights the work undertaken by the project. Clients who did not attend for assessment or who only presented for one session have not been included in these statistics.

Average CORE decrease	-5.7
Average CORE decrease in risk level	-5.3

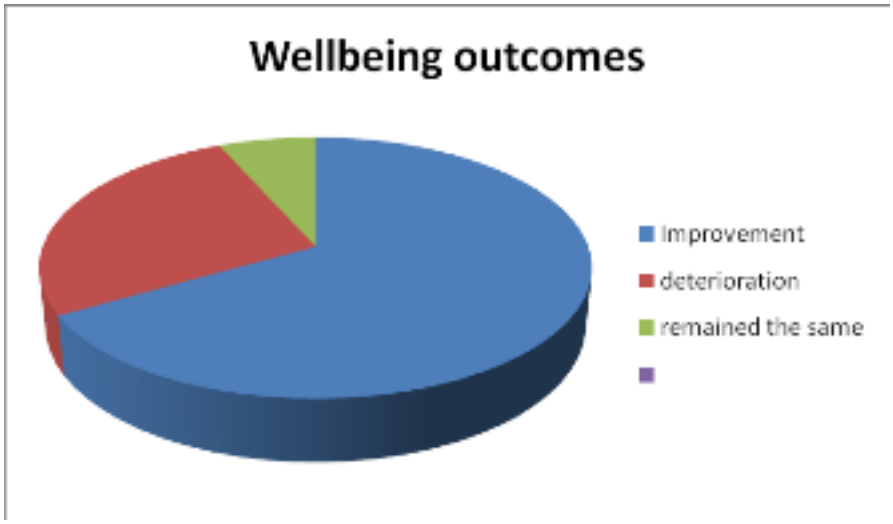
N=30

Clients showing improvement in emotional wellbeing	20/30 (66%)
Clients showing decline in emotional wellbeing	8/30 (27%)
Clients showing no alteration in emotional wellbeing	2/30 (7%)
Clients showing lower levels of risk	18/30 (60%)
Clients showing higher levels of risk	6/30 (20%)
Clients showing no alteration in risk level	6/30 (20%)

N=30

An alteration in CORE score of 5 in either direction suggests statistically reliable change, highlighting the success of the project in enabling clients to achieve positive outcomes in their mood. It is important to note that these forms are completed by the client directly, not by a therapist or support worker.

[1] Clinical Outcome Routine Evaluation
[2] Patient Health Questionnaire
[3] General Anxiety Disorder
[4] Alcohol Users Disorders Identification Test

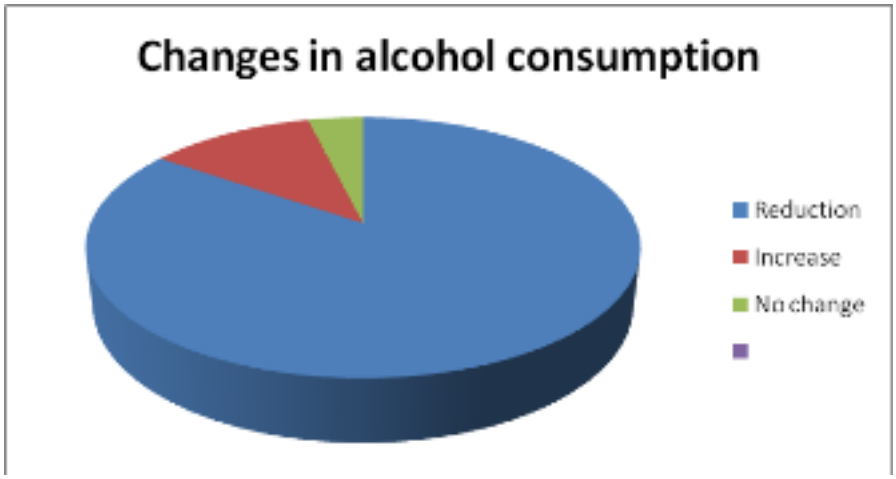


As stated above, we use an amended AUDIT questionnaire to track changes to the client's alcohol consumption throughout their engagement with Mind. This tool is divided into four categories based on where the client scores themselves. A score of 0-7 indicates sensible drinking, 8-15 suggests hazardous drinking, 16-19 harmful drinking, and a score of 20+ indicates possible dependence on alcohol.

Average AUDIT decrease	-9.2
Clients showing decrease in AUDIT score	22/26 (85%)
Clients showing increase in AUDIT score	3/26 (11%)
Clients where AUDIT score remained the same	1/26 (4%)

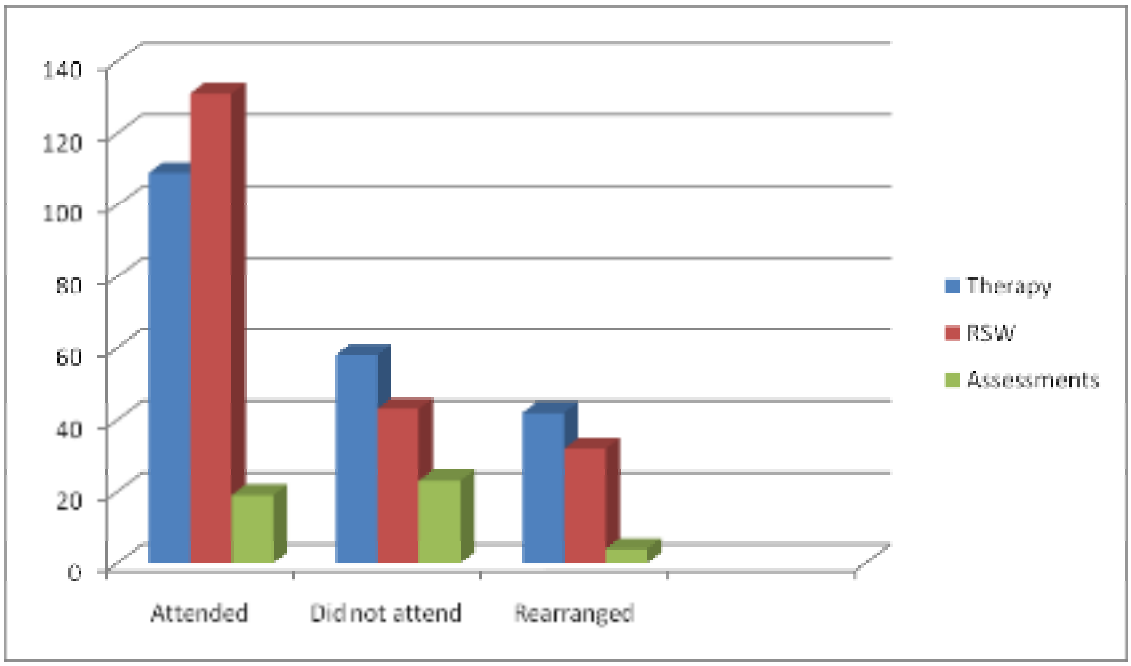
N=26

The above statistics confirm that clients are attaining a marked improvement in their drinking. The project is primarily funded to work with clients in the hazardous and harmful categories who would typically score between 8 and 19 on an AUDIT. By achieving the average reduction of 9.2 listed above, almost all clients in this category would either move into the sensible drinking group, or would be just outside it.



Attendance data

	Therapy	Recovery Support Work	Assessments
Attended	109 (52%)	131 (64%)	19 (41%)
Did not attend	58 (28%)	43 (21%)	23 (50%)
Cancelled/rescheduled	42 (20%)	32 (15%)	4 (9%)



Training and Development

The past six months has seen the continuation of our commitment to training and to professional development. The importance of the Human Givens ethos is reflected in the attendance of a wide number of seminars and workshops organized by Mindfields College. As with all Hartlepool Mind services, the Project Coordinator is working towards the postgraduate diploma in HG therapy. This is due to be completed by next June. In addition to this, both recovery support workers have completed four days of training in Motivational Interviewing at Leeds Addiction Unit.

The therapist has completed six days of training in EMDR, enabling the team to utilize an alternative treatment for clients suffering from trauma and low self-esteem. Training on Brief Interventions and Advanced Alcohol Awareness was facilitated by Alcohol Concern for twenty members of Hartlepool Mind, thereby increasing the knowledge and the skills base of the whole agency when dealing with alcohol-related issues.

The next six months: Aims, challenges and expectations

The main aims for the project are:

- To establish and develop a Specified Activity for clients with histories of alcohol-related offending. This will be undertaken in conjunction with the Albert Centre and development has been ongoing over the past three months. It is envisaged that this programme will be ready to receive referrals from probation in November. The facilitation of the course will increase demand on the project, as well as seeing an increase in self-referrals. Funding has been provided by the Safer Hartlepool Partnership for a specialist alcohol worker and an additional clinical recovery support worker. Both appointments have been made and are due to start in October. This programme will be a challenging one and will require the continuation of close working links with The Albert Centre and Probation. It will also see an alteration to the existing project ethos of voluntary involvement on the part of the client. This client group will be ordered to attend by the courts and we will need to monitor and review whether our existing services will complement their needs.
- To continue to provide an excellent service to clients with alcohol-related issues and to ensure that staff have the appropriate level of expertise to provide this. Two members of the team are due to attend four days of training in Interpersonal Therapy in October. Commitment remains ongoing to the Human Givens approach; the project coordinator is due to complete the Diploma by June 2010 and other members of staff will continue to attend workshops and seminars on relevant topics over the coming six months. One key area to improve on is the attendance of assessments. Closer working links with Arrest Referral might lead to improvement as attendance of appointments made from custody is extremely low. Six-month feedback data has showed that clients are maintaining the improvements made in therapy. The development of a relapse prevention course might help to conclude treatment with a clear set of goals and psycho-educative techniques to improve long-term outcomes still further.

- To obtain funding on a longer-term basis, ideally for at least three years to ensure that the project has a secure base. This is also included in the aims of the Alcohol Strategy Operational Group for Hartlepool, highlighting the importance of the Mind project within the town. The problems associated with alcohol misuse impact widely across all sectors of society. Longer term funding would represent recognition of the need to provide ongoing investment in treatment to reduce the effects of these issues.

Conclusion

The past six months has seen the project both consolidate and expand on the developments made in the previous year. We continue to exceed expectations in terms of referral numbers and maintain an excellent, holistic service to clients. This dedication to maintaining the highest standards and providing the best possible treatment is reflected in the training schedule for the coming six months. Our commitment to outcome measurement has yielded rich data to support the service and continues to inform therapy itself. Hartlepool Mind's involvement in the alcohol related offending programme has seen the team expand, increasing capacity. This will generate a series of new challenges, as we seek to remain faithful to our approach whilst moving into the criminal justice arena. The next six months promise to be exciting and invigorating, and the procurement of longer-term funding will enable Hartlepool Mind to provide a high-quality service to clients misusing alcohol over the coming years.

Young People's Substance Misuse John Robinson

- The Children's Trust Board is now responsible for tackling young people's substance misuse issues
- All Children's Trust Boards must complete and submit an Annual Needs Assessment/Treatment Plan.

Young People's Substance Misuse

- The Treatment Plan shows that Alcohol is the substance of choice for young people in Hartlepool with Cannabis second.
- We do not currently have issues with Class A drugs and young people
- Last year 108 young people accessed the specialist services and we are again looking at a similar figure this year.
- No young people have required residential treatment in 09/10.

Young People's Substance Misuse

- In 2009/10 the total budget spent on Specialist services was £288,824
- In 2010/11 identified funding is £200,000.
- In 2011/12 there will be a further reduction of at least £10,000
- How will the Trust Board respond to the budget pressures in this area?

Young People's Substance Misuse
Key Objectives

- We need to invest in tackling issues early and identifying young people who get involved in substance misuse?
- Integrate Specialist Service into local processes.
- Establish greater individual and corporate responsibilities for identifying and supporting young people with substance misuse issues.
- Develop intelligence led approaches to interventions.
- Review specialist service in relation to the current operational and financial context.
- Ensure all young people leaving specialist services are engaged with the integrated youth service.

Young People's Substance Misuse

1) That the Board agrees to submit "The Young People's Specialist Substance Misuse Treatment Plan 2010/11" document to the NTA.
2) That the board agrees to work with partners to ensure that services are resourced at a level commensurate with assessed need.
3) That the board agrees a process of governance that ensures a clear partnership between the Board and the Safer Hartlepool Partnership.
4) That Board members agree to allocate appropriately placed staff to form a specialist commissioning group that will support the development of substance misuse services for young people in Hartlepool.

Health Scrutiny Forum
2nd February 2010

Louise Wallace
Acting Director Public Health
Hartlepool NHS

Strategic Context
Commissioning Alcohol Treatment Services

- Reducing Harm caused by Alcohol is a national and local priority
    - Nationally requirement by the NHS in 5 year NHS Plan – 'From Good to Great' (2009)
    - Regionally – Regional Public Health Strategy 'Better Health, Fairer Health' (2007)
    - Locally -

      PCT commitment in Tees Strategy as part of World Class Commissioning

      Key Priority of Safer Hartlepool Partnership

- Mechanism for developing local Alcohol Strategy is the multi-agency Alcohol Strategy Group feeding into Joint Commissioning Group for Substance Misuse

- Comprehensive Area Assessment (CAA) in 2009 raised concerns in relation to commissioning alcohol treatment services resulting in a ‘red flag’

- Challenge is to ensure Alcohol Strategy and associated treatment plan is robust enough to address concerns of the CAA inspectors

- This will be taken forward through Safer Hartlepool Partnership to provide assurance to partner agencies that sufficient action is being taken as inspectors will require progress reports

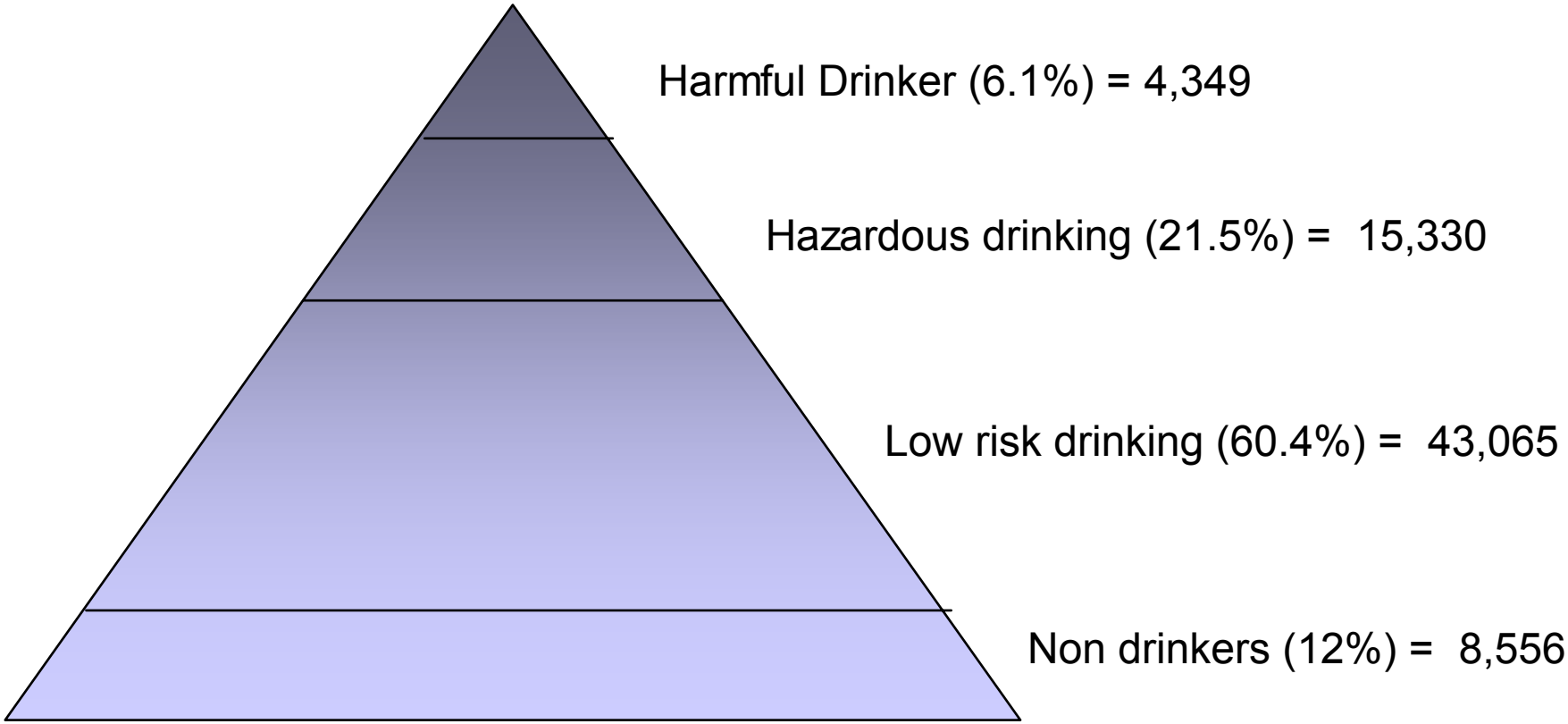
Health Scrutiny Forum
2nd February 2010

Chris Hart

Planning and Commissioning Manager
Safer Hartlepool Partnership

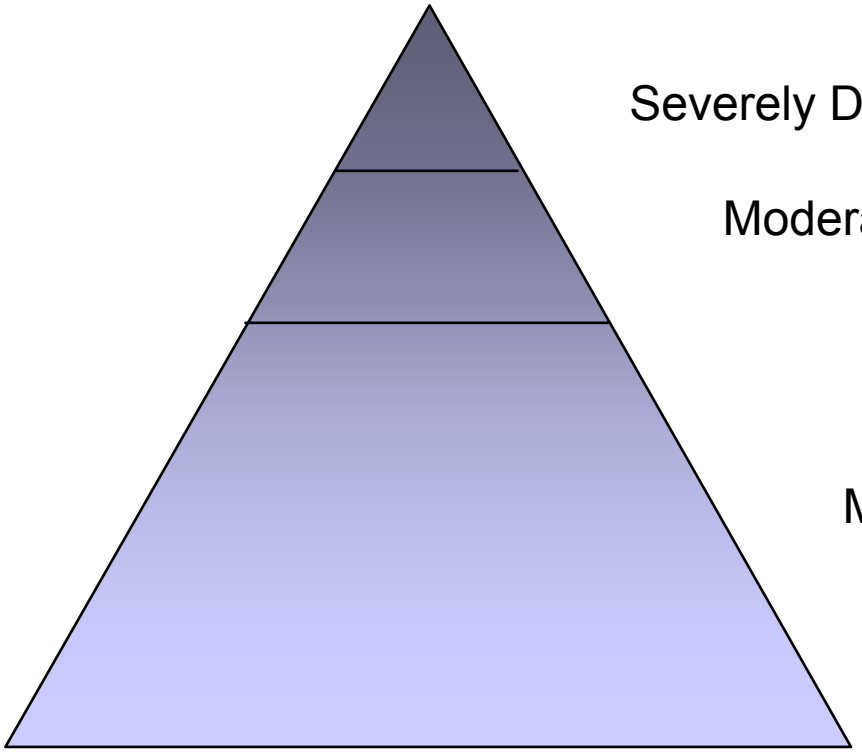
Estimates Hartlepool Drinking Behaviour

North West Public Health Observatory – Dec 008



Dependent Drinkers

Adult Psychiatric Morbidity Survey 2007



Severely Dependent (0.1%) = 71

Moderately Dependent (0.4%) = 285

Mildly dependent (6.7%) = 4,777

Models of Care for Alcohol Misusers

Dept of Health 2006

- Tier 1 screening, brief advice and referral. *For hazardous and harmful drinkers, best provided in non-alcoholic specialist settings. It usually takes the form of advice and other brief interventions*.

- Tier 2 open access services to reduce alcohol related harm *Aimed at hazardous and harmful drinkers who have not responded to advice and brief interventions.*

- Tier 3 community care planned treatment *Provided for moderately dependent drinkers provided by specialist services*

- Tier 4 residential/inpatient care plan treatment

  For severely dependent drinkers

Hartlepool Alcohol Treatment and Support Care Pathway

May 2009

Level 1

Front-line services to provide screening using audit tool and brief interventions (score up to 16) also maintain database

GP's & Health Staff

Hospital & A&E

Front-line services e.g. Probation, Custody, Social Care

Hospital Inreach Worker from Albert Centre to link discharge to community services

Level 2

Where there are physical, mental health or drug issues links with appropriate treatment agencies maintained

(1) Albert Centre (Wynyard Road) Audit Score 20-24

(2) Hartlepool Mind (Tees Road) Audit Score 16-20

Level 3

Specialist intervention to address physical dependency

(3) INTRAHEALTH (Wynyard Road) Audit Score 24+

Level 4

Specialist medical interventions

Link & Refer to specialist in patient & residential services i.e. detox, hospital.

Additional Support available at any stage

AA Programme – Advice Timetable
• Abstinence Programme

ADDvance – Refer self help
• Group work and social activities

Safe Voices – Family support And Hidden Harm

PINS –
• Family & carer self help

Service User Co-ordinator
• Motivational work
• Activities
• Referral to support
• Social network

Prevention & Education Workers – Campaigns, information & training

Carrgomm – Social landlord accommodation

(1) Albert Centre - Severe dependency and dependency with complex needs (Audit Score 20-24) offer Comprehensive Assessment, Structured Counselling, Psychosocial Interventions (Motivational Interview, Solution Focused Therapies & Cognitive Behaviour Therapies)

(2) Hartlepool Mind – Harmful & hazardous drinkers (Audit Score 16-20) offer Comprehensive Assessment, Brief Intervention, Psychosocial Intervention (Motivational Interview, Solution Focused Therapies & Cognitive Behaviour Therapies) *Adopt a Human Givens approach.

(3) Intrahealth – Specialist treatment, prescribing, home and community detox.

Safer Hartlepool

Hartlepool Treatment data

2008/09

- 588 specific alcohol related admissions to hospital
- 214 people into community treatment for alcohol misuse - 111 discharged
- Young people - 209 referred into Straight-line, 97 into HYPED

Additional Support Services

- Education, Campaigns and Events
- Alcohol Arrest Referral
- Specified Activities for Offenders
- Dual Diagnosis
- Hospital specialist services

Health Scrutiny
2nd February 2010

Dr. Paul McGoran

GPSI substance misuse/Medical Director

Intrahealth

Overview

- Present provision
  - Referral into service
  - Medical Interventions
  - Therapeutics

- Future/Discussion

Referral for medical assessment

- Audit score > 30
- AC colleague concerned
- Psychosocial interventions
- Specific medical interventions
- Medically assisted detoxification

Psychosocial Interventions

- Often reiteration
- Listening
- Explanation
- CBT
- More detail on self reduction
- Signposting
- No standard formula

Therapeutics

- Nutritional Support
  - Vitamin supplementation
  - Calorific supplementation

- Specific
  - Disulfiram
  - Acamprosate

- Other
  - Treatment of underlying or secondary conditions (Depression)
  - Naltrexone

- Key message….Medication has a very limited role in treating alcohol related disorders

Medically assisted detox

- Currently all treated as in patient

- Procedure

- Eligibility criteria
  - Motivated (largely qualitative). Team decision.
  - Committed to life of abstinence
  - Acute medical need
  - Must respect need for individuality so rigid “rules” should not apply
  - IH stats

Discussion

- What services were in place?
- What, if anything has changed?
- How can we improve?
  - Clinical effectiveness
  - Cost effectiveness
- Personal view re worthwhile further developments

Hartlepool Alcohol Treatment Services Working in Partnership

Health Scrutiny
2nd February 2010

Kevin Wilson

Chief Executive Officer
The Albert Centre

Hartlepool Alcohol Treatment and Support Care Pathway

November 2009

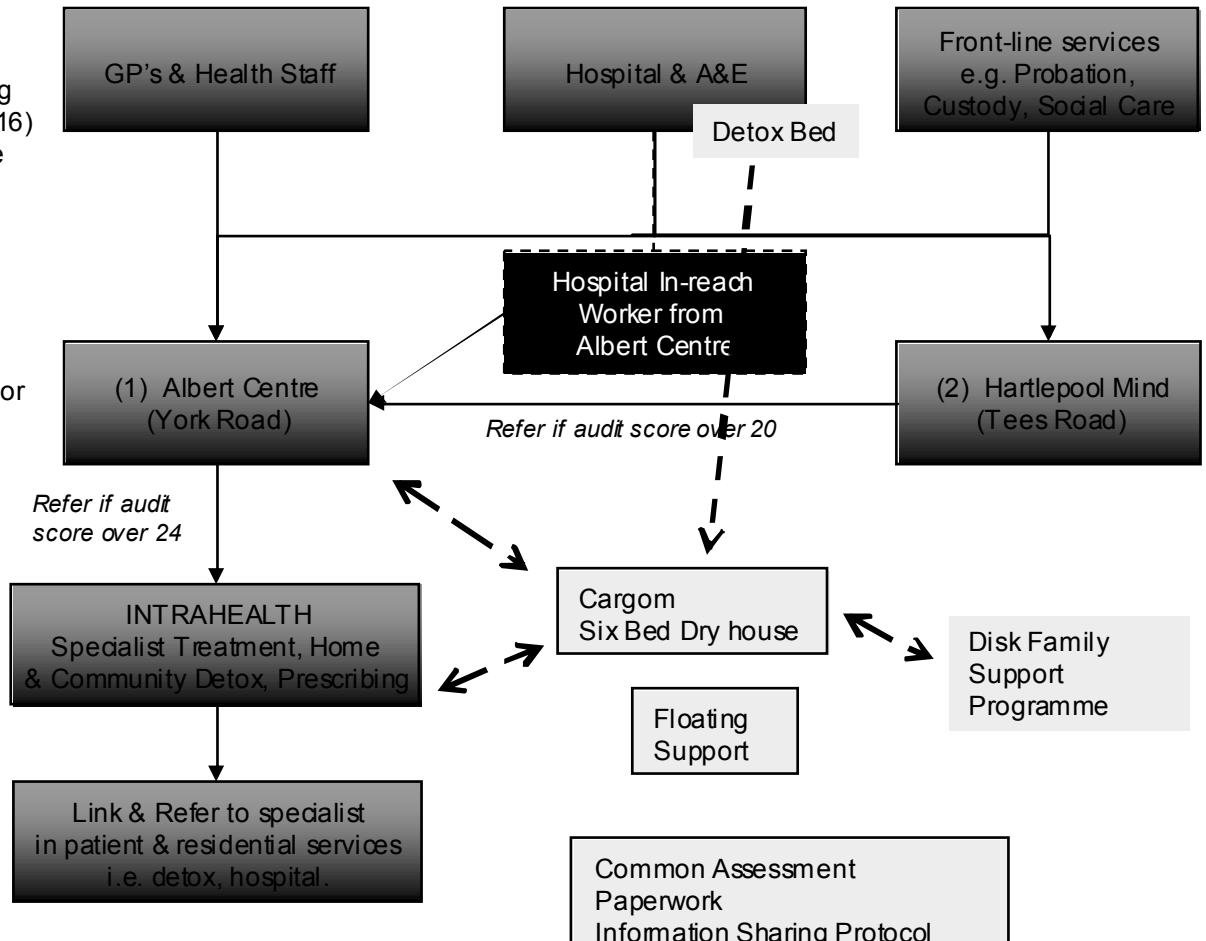
Level 1

Front-line services to provide screening using audit tool (score up to 16) also maintain database

Level 2

Where physical, mental or drug issues links with appropriate agencies maintained

Level 3



Additional Support available at any stage

AA Programme – Advice Timetable
- Abstinence Programme

ADDvance – Refer self help
- Group work and social activities

Alcohol Education & Aftercare Worker
- Activities
- Referral to support /
- Social network

Albert Centre - Severe dependency and dependency with complex needs (Audit Score 20-24) offer Comprehensive Assessment, Structured unselling, Psychosocial Interventions (Motivational Interview, Solution Focused Therapies & Cognitive Behaviour Therapies)

Hartlepool Mind – Harmful & hazardous drinkers (Audit Score 16-20) offer Comprehensive Assessment, Brief Intervention, Psychosocial ervention (Motivational Interview, Solution Focused Therapies & Cognitive Behaviour Therapies) *Adopt a Human Givens approach.

Aims of Albert Centre Alcohol Service

- **Access to a comprehensive range of services**
- **Coordination of care & communication across all agencies**
- **Avoid duplication of assessment and interventions**
- **Continuity of care throughout treatment**
- **Systematic and structured review and planning system**
- **Increase and maximise retention within treatment**
- **Minimise the risk of clients losing contact**
- **Prevent clients falling between services**
- **Re-engage clients who have dropped out of treatment**

2 x Alcohol Treatment Workers

- **Care coordination**
- **Psychosocial interventions**
  - **1-to-1 support**
  - **Motivational Interviewing (MI)**
  - **Group work**
  - **Complimentary therapies**
- **Specified Activities Programme based on the Cycle of Change:**
  - **Group work**
  - **Education**
  - **Alcohol & offending behaviour**
  - **1-to-1 sessions**

ALBERT CENTRE

mind
For better mental health

2 x Counsellors

An opportunity for clients to explore and understand issues that cause or contribute to their alcohol abuse, or hinder their recovery.

Care planned counselling

Reduction programmes

Relapse prevention techniques

Structured sessions

Planned review, ending and aftercare

Link in and see clients in GP Surgeries

1.5 x Assertive Outreach Workers

- In reach to hospital admissions
- Follow up DNAs
- Chaotic lifestyles
- Relapse intervention
- Crisis intervention
- Home assessments

1 x Aftercare

- Various Groups
- Relapse prevention
- Self-esteem & confidence building
- Social integration skills
- Support and advocacy

Hartlepool Mind Alcohol Project: An Introduction

Tom Livesey
Alcohol Project Co-ordinator

What are we?

- A community wellbeing service
- Recovery model of mental health
- Integrative approach
- Biopsychosocial
- Human Givens influenced
- Client outcome directed therapy

- Models of Care tier 2 and 3 interventions
- Pre-treatment, treatment, and aftercare
- Community involvement
- Work with dual diagnosis issues of interacting alcohol misuse and mental health

How do we fit into the strategy?

Who do we work with?

- Clients scoring 16-20 on AUDIT (flexible referral pathway)
- Hartlepool residents
- Specified activity clients, jointly with the Albert Centre

Case Study: 'Tina'

- Self-Referral.
- Joint work with the Albert Centre
- Assessed as dependent.
- Therapy to cope with depression.
- Recovery Support Work to address financial concerns and employment
- Left the service abstinent and in work.

HEALTH SCRUTINY FORUM

2 February 2010

Report of: Scrutiny Support Officer

Subject: ALCOHOL ABUSE - PREVENTION AND TREATMENT – EVIDENCE FROM THE JOSEPH ROWNTREE FOUNDATION – COVERING REPORT

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1. PURPOSE OF THE REPORT

1.1 To provide Members with evidence collated by the Joseph Rowntree Foundation into Young People and Alcohol.

2. BACKGROUND INFORMATION

2.1 Members will recall that at the meeting of this Forum on 1 December 2009, a presentation was received from the Parenting Commissioner entitled 'Young Persons Alcohol Misuse – Prevention'. During discussions Members were referred to the publication of a recent document by the Joseph Rowntree Foundation into Young People and Alcohol.

2.2 Subsequently attached as **Appendix A** to this report is a summary of the findings of the Joseph Rowntree Foundation' investigation into 'Children, Young People and Alcohol: How they learn and how to prevent excessive use"

3. RECOMMENDATIONS

3.1 That Members note the content of this report and the findings of the Joseph Rowntree Foundation attached as **Appendix A** to this report.

Contact Officer:- James Walsh – Scrutiny Support Officer
Chief Executive's Department – Corporate Strategy
Hartlepool Borough Council
Telephone Number: 01429 523647
E-mail – james.walsh@hartlepool.gov.uk

BACKGROUND PAPERS

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

(i) Joseph Rowntree Foundation (2009) *Children, Young People and Alcohol: How they learn and how to prevent excessive use*, Available from: http://www.jrf.org.uk/sites/files/jrf/children-and-alcohol-use.pdf [Accessed 13 January 2010]

Children, young people and alcohol: how they learn and how to prevent excessive use

Findings
Informing change

November 2009

Two linked research reviews examine: how young people acquire their knowledge, attitudes, expectations, and intentions about alcohol; and what interventions work best to prevent excessive use of alcohol.

Key points

- Key influences are:
  - family processes and structures;
  - while there is less consensus about the influence of peers, key processes include peer selection and mutual influence;
  - direct (advertising) and indirect (media representations, product placements, etc) marketing and cultural representations of alcohol;
  - country, ethnicity and race, religion, socio-economic status, and other cultural factors.
- Many of these ideas have been used to develop interventions. The most effective are those based on the family. These have generally worked on a number of aspects of family processes aimed at enhancing family bonding and relationships.
- Interventions based around altering peer influence can work too, although less well. Those linked with ones that also involve the family appear to work best.
- Despite a wealth of evidence that advertising and the media are dominating influences very few preventative interventions have been based on these ideas.
- The review concludes that what is needed is an integrated, planned and implemented community prevention system. Such a universal prevention programme needs to be started when children are young, not when families are starting to consider how to prevent teenage drinking.

The research
By Richard Velleman, University of Bath

JOSEPH ROWNTREE FOUNDATION

www.jrf.org.uk

Background

Children start to learn about alcohol from an extremely young age. They learn a great deal from general observation of the media and wider society. However, basic knowledge, attitudes, expectations and intentions are initially most influenced by their families – especially parents, but including others such as grandparents and siblings. Other important influences include peers, school, community, and religious and cultural influences.

Influences

Key family processes and structures have been shown to influence how young peoples' knowledge, attitudes and subsequent behaviour develop. It seems relatively clear that the family can continue to be a moderating influence throughout adolescence and even young adulthood, with parents usually also affecting long-term values.

There is increasing recognition that the influences of family and peers are interdependent. Rather than seeking to determine which has the greater influence, it may be more productive to examine how these two forces interact.

Overall, some processes protect young people, tending to slow down the risk that young people will initiate drinking earlier, and /or will move into heavier or more risky drinking styles; others tend to increase these risks. Each of these issues cannot be examined isolation.

As children grow, the primary influences usually change from parental influence towards societal as a whole then towards peer influence. However, parental and family factors hold huge sway over how much influence these other factors have, and at which stages they will start to predominate. As young people grow older, their involvement in their community also plays a prominent role in their relationship towards alcohol, again heavily influenced by parental (and later peer) factors.

Parenting style

Protective factors include: 'responsive parenting' (parents who expect a lot from their children and provide them with a sense of self-reliance); consistent child-management, balancing 'care' and control', with clear, consistent and enforced rules; high levels of parental supervision or monitoring; parental modelling of appropriate alcohol use; and clear and open communication of both expectations about alcohol use (or non-use) and potential disapproval if expectations are not met.

Family cohesion

Protective factors include: higher levels of family support and bonding (including eating together five or more times per week); a child liking or being satisfied with relationships with a parent; a child wanting to be like a parent; and a high level of family co-operation.

Sibling behaviour

Older siblings' willingness to use substances, and their actual substance use, are both robust predictors of later use by younger siblings.

Peers

There is less consensus about the influence of peers. What is clear is that it is not so much that young people are influenced by their peers but that they select like-minded peers leading to a process of mutual influence.

Marketing

Marketing and cultural representations of alcohol – whether direct (advertising) or indirect (media representations, product placements, etc) – exert a very significant influence on young people. Well-designed longitudinal studies show that marketing is a significant factor in the rise in young people's alcohol consumption. Not surprisingly, young people who see, hear and read more alcohol advertisements and endorsements are more likely to drink, and to drink more heavily, than their peers.

It is clear that the influence of the media is massive, in turn affecting the influence of parental and family relationships, especially with children where family controls are less apparent. It is generally accepted that:

- Frequent exposure to persuasive alcohol portrayals via a huge range of media has a major impact.
- The impact of these portrayals can be mediated by the parental and family factors reviewed above. In particular, parental reinforcement and counter-reinforcement of messages, open communication, parental monitoring, and clear rules can help to offset media influences.

Cultural factors

Other major influences are country, ethnicity and race, religion, socio-economic status, and other cultural factors. Examples include:

- An increasing *globalisation* of young people's drinking behaviour, with significant rises in binge drinking in many countries. The influence of family and peers is generally similar across countries.
- For *minority ethnic groups*, many of the same factors are equally important and independently associated with lower risk of regular drinking, including:
  - *family factors* such as: parental monitoring; perceived consequences; maintaining intimacy and connection to the family; family cohesion;

family supervision; low sibling willingness to use; parental attitudes toward their child's alcohol use; supervised provision of alcohol by parents and adult relatives and drinking with a parent (for older children); and greater levels of family social support;
  - *individual factors* such as: better decision-making skills; higher self-reliance; lower peer pressure susceptibility; more positive attitudes about school and prior school success; negative expectations of drinking, peer drinking and adult drinking;
  - *peer factors* such as having few friends who drink (this is generalised from USA research; very little research on these issues has been conducted elsewhere).
- *Religious identification* is a significant indicator of whether or not people drink, and is often more important than other cultural or social factors. For those who do drink, religious identification is also associated with less risky drinking.
- *Active religious involvement* or faith appears to have a protective effect on young people's drinking. Religious attendance seems to predict decreases in the quantity and frequency of alcohol use. Teenagers showing greater religious involvement and stronger religious values have a lower risk of alcohol use. Other studies have shown that religious attendance predicts decreases in the quantity and frequency of alcohol use even in the presence of peer, family, and school variables. However, these variables are of more importance than religious *salience* ('How important is your religion?') in relation to later decisions to use alcohol.
- Some studies suggest that familial, religious and peer influences are all closely correlated with *ethnicity*. Muslim young people mostly show lower levels of substance use, including drinking, coupled with higher levels of religious and familial, and lower levels of peer, involvement, compared with white, Black African and Black Caribbean young people (most of whom may be presumed to be either Christian or of no fixed or practicing religion).
- *Cultural norms* are important, as is 'place' or geographical location: the dynamics of neighbourhood and the ways in which the social history and linked physical characteristics of areas of residence may have a significant influence on how people drink alcohol.
- Other factors include taking part in *sport and other extra-curricular activities* (such as youth groups). Young people involved in these are less likely to have problems with alcohol or to be involved in risky drinking (binging, high frequency drinking, drinking outdoors); conversely, young people who do not become involved in such activities are more likely to initiate alcohol use early.

Interventions

Various prevention programmes focus on altering how children learn about and develop attitudes towards alcohol, reducing more general risk factors, or enhancing protective factors and developing resilience.

Evidence of effectiveness is best for interventions based on the family. These have generally worked on enhancing family relationships. This has included: skills training on parental support for children, parent-child communication, parental involvement, and parental monitoring and supervision; and practice in developing, discussing, and enforcing family policies on substance misuse.

Many family interventions are relatively complex, aiming to improve a wide range of family, parent-child and parenting behaviours. But one recent study suggested that the single most important thing that parents needed to do was to regularly and frequently eat dinner with their children (five times per week or more). This study suggested that this relatively simple intervention worked effectively to protect children not only from substance misuse, but also from poor school and academic performance, shown to be an independent factor related to many poor outcomes, including early substance misuse. It is likely that when families eat together most nights all the other important variables, such as family communication and family joint activity, also improve. It may be that persuading families to eat together could work as an important proxy for these other vital family factors – one that is far easier to encourage in the general population than retraining communication, rules, contingencies, and so on.

There is some (albeit less strong) evidence that interventions based on altering peer influence can work, by improving young people's skills to resist peer pressure or deal with life generally, or by training peers to become educators and attitude-formation leaders. The interventions that appear to work best are those interlinked with ones that also involve the family.

Although there is a wealth of evidence suggesting that advertising and the media are dominating influences on young people in this area, there have been very few preventative interventions based on these ideas.

Implications for future interventions

Despite the research evidence, parents do not have a strong sense of the importance of parental influence and modelling of behaviour on subsequent behaviour in their children. Of primary importance is educating parents about the effects of their own behaviour in influencing young people's use of alcohol (or drugs). Programmes need to equip parents with:

- parenting skills, helping parents to develop family cohesion, clear communication, high-quality supervision and the ability to resolve conflicts;
- substance-related skills, providing parents with accurate information and highlighting the need to model the attitudes and behaviour they wish to impart; and
- confidence skills, to enable parents to communicate with their children about alcohol and drugs.

The review concludes with suggestions for how a universal prevention programme might be developed and delivered. The core task is to replace the cultural norm of binging and other forms of drinking dangerously, with positive parental role models for sensible alcohol consumption.

Programmes need to:

- delay the onset of drinking, providing coherent messages about which age is appropriate for parents to introduce their children to alcohol;
- help parents to realise that it is a good thing to delay the onset of drinking and that there are things that they can do to achieve this;
- change children's and young people's norms about drinking;
- get parents to supervise young people's drinking when they do start;
- encourage parents to create a strong family life and family bonds, family values and family concern, family rules and family supervision, and a balance between family care and family control.

There are also wider issues about alcohol and its availability and affordability to children. Recommendations to start to deal with these include:

- an increased use of test purchasing and greater investment in policing underage sales;
- increased enforcement of immediate and severe penalties for those selling alcohol to young people;
- universal adoption of age checks for individuals purchasing alcohol who look under 21;
- advice to parents about monitoring the income and expenditure of children so that there is a better understanding about how much money children have and whether it is being spent appropriately.

Conclusions

The review concludes that what is needed is *an integrated, planned and implemented community prevention system*. This would draw lessons from a range of sources: effective parenting training programmes; organisational change programmes in schools, classroom organisation, management, and instructional strategies; classroom curricula for social and emotional competence promotion; multi-component programmes based in schools; community mobilisation; community/school policies; enforcement of laws relating to underage purchasing and selling alcohol to intoxicated people; altering community and cultural norms so that drunken behaviour is not tolerated (and certainly not encouraged); and how to effect planned policy changes with respect to price, availability and accessibility.

There is evidence from other countries that multi-component programmes can be very effective. However, there have been no research projects of sufficient power to test these ideas in a UK context.

About the project

This was a review of research and policy literature.

For more information

Fuller details are available in two linked reports, both by Richard Velleman: **Influences on how children and young people learn about and behave towards alcohol** and **Alcohol prevention programmes**. Both are available for free download from www.jrf.org.uk.

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Read more Findings at www.jrf.org.uk
Other formats available.
Tel: 01904 615905 email: info @jrf.org.uk

HEALTH SCRUTINY FORUM

2 February 2010

Report of: Scrutiny Support Officer

Subject: SIX MONTHLY MONITORING OF AGREED HEALTH SCRUTINY FORUM'S RECOMMENDATIONS

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1. PURPOSE OF REPORT

1.1 To provide Members with the six monthly progress made on the delivery of the agreed scrutiny recommendations of this Forum.

2. BACKGROUND INFORMATION

2.1 As Members will be aware, Scrutiny Co-ordinating Committee on the 21 November 2007 approved the introduction of an electronic database to monitor the delivery of agreed scrutiny recommendations since the 2005/06 Municipal Year. Approval was also given for the introduction of a standardised six monthly cycle for the submission of progress reports to each Scrutiny Forum.

2.2 The newly created electronic database, to be known as the Scrutiny Monitoring Database, will run along the same principles as the Authority's former Corporate Performance Management Database and in addition to provision of standardised six monthly monitoring reports, as detailed above, will provide the Scrutiny Co-ordinating Committee with a breakdown of progress against all Scrutiny Forums' recommendations on an Annual basis. The introduction of the new database will also provide the ability to produce 'real time' information of the progression of recommendations upon request.

2.3 In accordance with the agreed procedure, this report provides for Members information details of progress made against each of the investigations undertaken by the Forum. Attached as **Appendix A and Appendix C** is a Summary Report that breaks down progress made by investigations undertaken by the Health Scrutiny Forum and the Adult & Community Services & Health Scrutiny Forum respectively. Whilst **Appendix B and**

Appendix D provide a detailed explanation of progress made against each recommendation undertaken.

3. RECOMMENDATIONS

3.1 That progress against the Health Scrutiny Forum's (incorporating the former Adult and Community Services and Health Scrutiny Forum) agreed recommendations, since the 2005/06 Municipal Year, be noted and explored further where appropriate.

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BACKGROUND PAPERS

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

Scrutiny Enquiry Summary Report

Appendix A

Health Scrutiny Forum

Reaching Families in Need

G	Target achieved	2
	Rejected	1
A	Expect to achieve target	9

Scrutiny Recommendations (Not Completed) Monitoring Report

Appendix B

December 2009

Department: *

Division: *

Scrutiny: Health Scrutiny Forum

Scrutiny Enquiry: *

X	**Rejected**	**1**	8.3%
	Health Scrutiny Forum	1	
A	**Expect to achieve target**	**9**	75.0%
	Health Scrutiny Forum	9	
G	**Target achieved**	**2**	16.7%
	Health Scrutiny Forum	2	
	Total No. of Actions	**12**	

Scrutiny Recommendations (Not Completed) Monitoring Report

December 2009

Progress	Rec. No.	Recommendation	By When / Milestone	Update on progress	Lead Officer
SCRUTINY INVESTIGATION INTO: **HSF/08-9/1 REACHING FAMILIES IN NEED**					
Recommendation:					
HSF/08-9/1a	**That the local authority take the lead in providing a co-ordinated leadership approach across the different providers in order to facilitate a systematic approach to tackling health inequalities in the town, culminating in the creation of a Family In Need Strategy and specifically designated Executive Portfolio with responsibility for Social Inclusion.**				
A	HSF/08-9/1a(i)	The government has provided guidance regarding a "Think Family" initiative that we are developing in Hartlepool. This initiative will support this recommendation and will endeavour to lead a culture change in the way that our services are designed.	March 2011	Think Family Co-ordinator is now in post. Directors of Child and Adult Services is chair of the 'Think Family Steering Group'. Cross organisation social inclusion group is also in place to steer operationals aspects.	John Robinson
✓	HSF/08-9/1a(ii)	A specifically designated Executive Portfolio with responsibility for Social Inclusion is not to be created; however, the feasibility of including responsibilities within one of the existing Portfolio Holders remits is being explored.	September 2009		Stuart Drummond
Recommendation:					
HSF/08-9/1b	**That subject to the implementation of recommendation (a) above, the local authority, acting as strategic leader, enter into formal arrangements with partner organisations (i.e. Police, PCT, FT, Housing Hartlepool and the Voluntary Sector).**				
A	HSF/08-9/1b	The Think Family Reforms will be reported through the Children's Trust that includes all major stakeholders in this process.	March 2011	Expected to achieve target.	John Robinson

Scrutiny Recommendations (Not Completed) Monitoring Report

December 2009

Progress	Rec. No.	Recommendation	By When / Milestone	Update on progress	Lead Officer
SCRUTINY INVESTIGATION INTO: **HSF/08-9/1 REACHING FAMILIES IN NEED**					
Recommendation: **HSF/08-9/1c**		**That the FIP Project be expanded in light of its effectiveness thus far in targeting hard to reach families.**			
A	HSF/08-9/1c	The Family Intervention Project (FIP) is currently being developed as an integrated part of the Team around the School initiative. This service has been designed to enable new services to be bolted onto it and to adopt the FIP approach to assertive support.	December 2011	Service continues to develop with further opportunites being offered by government. Housing worker and 3 seperated parent workers have joined the team.	John Robinson
Recommendation: **HSF/08-9/1d**		**That the Connected Care Programme be rolled out across the town as a positive way of helping reach families that would not normally interact with either the council or engage with health services.**			
A	HSF/08-9/1d	The Connected Care pilot in Owton is undergoing an independent evaluation during 2009/10. Decisions regarding 'roll out' of the model need to be informed by the outcome of this evaluation. In the interim, opportunities to use the Connected Care approach elsewhere are being explored with Neighbourhood Forums and specific developments such as the extra care development at Orwell Walk.	March 2010	Expected to achieve target.	Phil Hornsby

Scrutiny Recommendations (Not Completed) Monitoring Report

December 2009

Progress	Rec. No.	Recommendation	By When / Milestone	Update on progress	Lead Officer
SCRUTINY INVESTIGATION INTO: **HSF/08-9/1 REACHING FAMILIES IN NEED**					
Recommendation:					
HSF/08-9/1e	**That the use of the model of intervention implemented through the FIP Project and Connected Care Project be explored as a basis for a more far reaching Families in Need Strategy, bringing together the activities of all partners / stakeholders with a dedicated Portfolio Holder taking the co-ordinating role.**				
A	HSF/08-9/1e	The FIP and connected Care steering groups will be asked to undertake a review of the projects and look at the learning that can be identified from both projects. This will form the basis of an event in March 2010 that will enable stakeholders to analyse and respond to the learning. This event will help frame the issues in preparation for a decision regarding a Families in Need strategy.	March 2010	Activities are underway within the Neighbourhood Action Plan areas	Denise Ogden
Recommendation:					
HSF/08-9/1g	**That in order to strengthen links and communication routes between agencies, the establishment of a co-ordinated, single point of contact for the referral of information and referrals from any source be explored (i.e. a 'one stop shop' telephone number or point of contact).**				
A	HSF/08-9/1g	We will explore current communication routes being developed by community safety, the Team Around the School Initiative and Family Information Service to further this action and provide a report to the Children's Trust and Cabinet.	March 2011	Initially this process is to be looked at by the Family Intervention Project Steering Group. A YCAP database is being developed and a police officer has joined the TAPs team to look at some of the issues.	John Robinson

Scrutiny Recommendations (Not Completed) Monitoring Report

December 2009

Progress	Rec. No.	Recommendation	By When / Milestone	Update on progress	Lead Officer
SCRUTINY INVESTIGATION INTO: HSF/08-9/1 REACHING FAMILIES IN NEED					
Recommendation:					
HSF/08-9/1h		**That the feasibility of introducing a similar way of gathering and sharing data in Hartlepool, as has been implemented by Westminster Council (i.e. a Multi-Agency Information Desk) be explored.**			
A	HSF/08-9/1h	We will investigate this issue as part of the development of the Common Assessment Framework linked in with the Children's Trust, the Local Safeguarding Children Board and the Safer Hartlepool Partnership. These developments will need to take account of the current sub regional agreements that are in place.	March 2011	The Parent Commissioner attended a seminar on the Westminster model and has received all policy and operational documents, these will be considered as part of the development of Integrated Services.	John Robinson
Recommendation:					
HSF/08-9/1i		**That ways of providing and promoting programmes that are not badged as being run by official bodies, including those run by the Voluntary Sector, should be explored as a way of reaching families that are reluctant to engage the Council, PCT, FT or other partner bodies.**			
A	HSF/08-9/1i	(i)We will continue to develop our commissioning and procurement process to ensure that they are accessible to third sector organisations. (ii) We will continue to involve a wide range of stakeholders in the development of services and in particular involve local community based groups to provide services that are not perceived as stigmatising by users.	March 2011	Proposals to ensure that the commissioning and procurement process children's services are more accessible to third sector organisations are being developed. It is anticipated that a report will be submitted to the Portfolio Holder for Children's Services early in 2010. Children's Services continue to involve stakeholders in the development of services and the 3rd Sector have been contracted to provide outreach to vulnerable families on behalf of SureStart Children's Centres.	Ian Merritt

Scrutiny Recommendations (Not Completed) Monitoring Report

December 2009

Progress	Rec. No.	Recommendation	By When / Milestone	Update on progress	Lead Officer
SCRUTINY INVESTIGATION INTO: **HSF/08-9/1 REACHING FAMILIES IN NEED**					
Recommendation:					
	HSF/08-9/1j	**That a system be put in place to ensure that where new public buildings / facilities are constructed (i.e. the new health centre) the inclusion of a place where advice / assistance and other integrated services can be provided is explored.**			
A	HSF/08-9/1j(i)	A generic facility for providing advice and assistance will be available in new integrated health centres.	May 2010	The new Hartlepool integrated health centre will be operational from May 2010.	Joanne Dobson

Scrutiny Enquiry Summary Report

Appendix A

Adult & Community Services & Health Scrutiny Forum

Pandemic Influenza - 'Contingency Planning'

G	Target achieved	1

Access to GP Services

G	Target achieved	48

Social Prescribing

N	No longer deliverable	1
G	Target achieved	12

Withdrawal of Emergency Care Practitioners Service at Wynyard Road

G	Target achieved	2
A	Expect to achieve target	1

Scrutiny Recommendations (Not Completed) Monitoring Report

Appendix B

December 2009

Department: *

Division: *

Scrutiny: Adult & Community Services & Health Scrutiny Forum

Scrutiny Enquiry: *

N	**No longer deliverable**	**1**	1.5%
	Adult & Community Services & Health Scrutiny Forum	1	
A	**Expect to achieve target**	**1**	1.5%
	Adult & Community Services & Health Scrutiny Forum	1	
G	**Target achieved**	**63**	96.9%
	Adult & Community Services & Health Scrutiny Forum	63	
Total No. of Actions		**65**	

Scrutiny Recommendations (Not Completed) Monitoring Report

December 2009

Progress	Rec. No.	Recommendation	By When / Milestone	Update on progress	Lead Officer
SCRUTINY INVESTIGATION INTO: **ACS/06-7/3 SOCIAL PRESCRIBING**					
Recommendation:					
	ACS/06-7/3c	**As part of this process, detailed consideration should be given during the 2007/08 year to re-allocating funds to the MIND and other social prescribing services from existing activities that service users found less helpful and acceptable.**			
N	ACS/06-7/3c	This recommendation is specifically linked to NDC funding and we do not allocate these funds.	June 2007	Unable to progress. HBC doesn't allocate NDC funding. However, the PCT has allocated significant funding to be administered by HVDA to support voluntary organisations (in the region of 250 -300k). These resources cover core costs as well as specific funding for projects such as social prescribing (as this is specifically linked in to the Public Health Strategy as a recommendation). MIND has received a significant amount of this funding and has also been allocated some voluntary sector core cost funding by the PCT.	*

Scrutiny Recommendations (Not Completed) Monitoring Report

December 2009

Progress	Rec. No.	Recommendation	By When / Milestone	Update on progress	Lead Officer
SCRUTINY INVESTIGATION INTO: **ACS/06-7/4 WITHDRAWAL OF EMERGENCY CARE PRACTITIONERS SERVICE AT WYNYARD ROAD**					
Recommendation:					
	ACS/06-7/4c	**That the creation of a formal set of protocols on consultation be debated between the PCT and the Forum to:- (i) Promote the real improvements in health services in Hartlepool; and (ii) Foster the improved links with Hartlepool PCT, that have developed in the intervening period between the closure of the ECP Service at Wynyard Road and the conclusion of this Forum's investigation.**			
A	ACS/06-7/4c	Draft proposals have been shared. This is being progressed by the PCT and Scrutiny Chairs.	January 2010	Draft proposals have been shared. This is being progressed by the PCT and Scrutiny Chair. (Original Deadline: December 2009)	Ali Wilson

HEALTH SCRUTINY FORUM

2 February 2010

Report of: Scrutiny Support Officer

Subject: TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE - UPDATE

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1. PURPOSE OF THE REPORT

1.1 To inform Members of issues discussed at meetings of the Tees Valley Health Scrutiny Joint Committee held since the last meeting of the Health Scrutiny Forum on 5 January 2010.

2. BACKGROUND INFORMATION

2.1 A summary is provided below of the issues discussed at a recent Tees Valley Health Scrutiny Joint Committee Meeting held on 11 January 2010. Further information on these issues is available from the Scrutiny Support Officer and where appropriate clarification can be sought from Hartlepool's Tees Valley Health Scrutiny Joint Committee representatives who are present at today's meeting:-

(i) Cancer Screening Across the Tees Valley – Draft Final Report: Members agreed the conclusions and recommendations that featured in the draft final report into Cancer Screening Across the Tees Valley. It is planned that all the Tees Valley Health Scrutiny Forums / Committees will receive a copy of the full report, once minor amendments have been finalised to the report.

(ii) Tees Valley Health Scrutiny Joint Committee – Scrutiny Work Programme 2010: Members agreed to look at issues for future investigation at the 'half-way' stage of the Committee's Work Programme for 2009/10. Members noted that a working group was concurrently looking at NEAS capacity issues and that future meetings of the TVHSJC would look into the Oral Health Strategy, as well as keeping a watching brief on Sexual Health Services and the Personal Health Budget Pilot. Members agreed that due to the changing management structure for NHS Tees, the Chief Executive should be invited to a future meeting of the Committee and that

a report on Mental Health be received by Members before the end of the 2009/10 Municipal Year.

2.2 Full copies of these reports are available from the Scrutiny office should Members wish to obtain them.

3. RECOMMENDATION

3.1 That Members note the content of the report and outline any possible comments in relation to the issues discussed which they would like the Chair to relay back to the Joint Committee on their behalf.

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BACKGROUND PAPERS

No background papers were used in the preparation of this report