HEALTH AND WELLBEING BOARD AGENDA

HARTLEPOOL BOROUGH COUNCIL

Monday 28th October 2013

at 10.00am

in Committee Room B

MEMBERS: HEALTH AND WELLBEING BOARD

Prescribed Members:

Elected Members, Hartlepool Borough Council – Councillor C Akers-Belcher (substitute Councillor Richardson), Councillor Hall, Councillor G Lilley and Councillor Simmons
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group (2) – Dr Pagni and Alison Wilson
Director of Public Health, Hartlepool Borough Council (1); - Louise Wallace
Director of Child and Adult Services, Hartlepool Borough Council (1) – Gill Alexander
Representatives of Healthwatch (2). Margaret Wrenn and Stephen Thomas

Other Members:

Chief Executive, Hartlepool Borough Council (1) – Dave Stubbs
Director of Regeneration and Neighbourhoods, Hartlepool Borough Council (1) – Denise Ogden
Representative of the NHS England (1) – Caroline Thurlbeck
Representative of Hartlepool Voluntary & Community Sector (1) – Tracy Woodhall
Representative of Tees Esk and Wear Valley NHS Trust (1) – Martin Barkley
Representative of North Tees and Hartlepool NHS Foundation Trust – Alan Foster
Representative of North East Ambulance NHS Trust (1) – Nicola Fairless
Representative of Cleveland Fire Brigade (1) – Ian McHugh

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

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

3.1 To confirm the minutes of the meeting held on 16th September 2013 *(attached)*

4. ITEMS REQUIRING DECISION

None

5. ITEMS FOR INFORMATION

5.1 Maintaining and Developing the Joint Strategic Needs Assessment (JSNA) Proposal for 2013 Onwards (*Director of Public Health)*
5.2 Reviewing the Sustainable Community Strategy for Hartlepool *(Director of Public Health)*
5.3 Making the Difference: the Role of Social Care Services in Supporting Vulnerable Offenders (*Director of Offender Management, Durham Tees Valley Probation Trust*)
5.4 Summer and Winter Preparedness Plan *(Director of Public Health)*
5.5 Referral to the Audit and Governance Committee – Autism (*Audit and Governance Committee)*
5.6 Referral from Children's Services Committee regarding Speech and Language Therapy (*Children's Services Committee*)
5.7 Presentation - SEND Reforms and the Pathfinder

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

10. **ITEMS FOR INFORMATION**

Date of next meeting – Monday 9th December 2013 at 10.00am in Committee Room B

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

16 September 2013

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

Present:

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

Prescribed Members:
Elected Members, Hartlepool Borough Council, Councillors Simmons and Ainslie (substitute for Councillor Hall)
Representing Hartlepool and Stockton-on-Tees Clinical Commissioning Group; Dr Pagni and Ali Wilson
Representing Director of Child and Adult Services, Jill Harrison, Assistant Director (Adult Services)
Director of Public Health, Hartlepool Borough Council, Louise Wallace
Representatives of Healthwatch, Margaret Wrenn
Other Members:
Chief Executive, Hartlepool Borough Council; Dave Stubbs
Director of Regeneration and Neighbourhoods, Hartlepool Borough Council, Denise Ogden
Representative of the NHS England; Caroline Thurlbeck
Representative of Hartlepool Voluntary & Community Sector, Tracy Woodall
Representative of Tees Esk and Wear Valley NHS Trust, David Brown (substitute for Martin Barkley)
Representative of Cleveland Fire Authority, Ian McHugh
Representative of North East Ambulance Service, Nicola Fairless

Also in attendance:-

Dr Phillipa Walters, Tees Valley Public Health Shared Service
Jill Simpson, Durham, Darlington and Tees Area Team

Officers: Steve Hilton, Public Relations Officer
Richard Starrs, Strategy and Performance Officer
Amanda Whitaker, Democratic Services Team
Andy Graham, Public Health Registrar

26. Apologies for Absence

Councillor C Akers-Belcher, Leader, Hartlepool Borough Council
Councillor Hall, Hartlepool Borough Council
Representatives of Healthwatch, Stephen Thomas

Representative of North Tees and Hartlepool NHS Foundation Trust; Alan Foster
Councillor Fisher, Chair, Audit and Governance Committee (Observer)

27. Declarations of interest by Members

None

28. Minutes

The minutes of the meeting of the Health and Wellbeing Board held on 5 August 2013 were confirmed.

29. Funding Transfer from NHS England to Social Care – 2013/14 (*Assistant Director, Adult Services, Hartlepool Borough Council and Chief Officer, Hartlepool and Stockton-on-Tees Clinical Commissioning Group*)

The report sought the Board's approval for the use of the Funding Transfer from NHS England to Social Care 2013/14. The Board was advised that in 2011/12, the NHS Operating Framework had identified NHS funding for social care. Over £600m had been allocated to Primary Care Trusts who were required to transfer the funding to their Local Authorities via an agreement under section 256 of the 2006 NHS Act (a s256 agreement) to invest in social care services which also had a health benefit. This funding had been initially identified for 2011/12 and 2012/13. The funding allocated for Hartlepool for 2011/12 and 2012/13 was £1,219,000. In line with the guidance issued by the Department of Health, the Local Authority and PCT worked together to develop a plan for how this funding would be used. This was monitored through a North of Tees Reablement Steering Group which met regularly to monitor progress and evaluate performance information. The Plan had been circulated as an appendix.

A letter from the Department for Communities and Local Government and the Department of Health to Chairs of Health and Wellbeing Boards and Directors of Adult Social Services on 26 June 2013 had confirmed that this funding would remain in place until March 2016, with a significant increase in funding anticipated in 2015/16 as the letter announced a £3.8 billion pool of funding to promote the integration of health and social care services. The letter explained what this meant for adult social care and also advised Chairs of Health and Wellbeing Boards and Directors of Adult Social Services that it would enable 'investment in prevention and early intervention'. The funding allocated for Hartlepool for 2013/14 was £1,793,604 which was an increase of £574,604 on funding received in previous years.

Representatives from the Local Authority, Clinical Commissioning Group and

Area Team had worked together to review the plan covering 2011/12 and 2012/13 and to identify priorities for the use of the additional funding for 2013/14. The proposals for use of the funding met the requirement for investment in adult social care with health benefits and would make a positive difference to social care services and outcomes for people using services. It was proposed that the additional funding for 2013/14 be used to maintain services that support people to remain independent in the community (including extra care, respite, domiciliary care and personal budgets) where the Local Authority currently had budget pressures and would be required to cut services without this investment. The plan for use of the funding for 2013/14 had been circulated at Appendix 2. A draft s256 agreement had been prepared by NHS England's Durham, Darlington & Tees Area Team and would be finalised and signed by the Area Team and the Local Authority following approval of the plan. The draft agreement had been circulated also to members of the Board.

Decision

The Board approved the plan for use of the Funding Transfer from NHS England to Social Care 2013/14.

30. Improving A&E Performance and Winter Planning

(*Chief Officer, Hartlepool and Stockton on Tees Clinical Commissioning Group*)

The report provided the Board with an update in relation to National expectations and requirements for delivery of the 95% operational standard for A&E performance and the approach to winter planning 2013/14 as set out in the key paper – *Improving A&E Performance* (Gateway 00062 – Appendix A) issued by NHS England. The report summarised the work being undertaken to ensure delivery of effective optimal Urgent Care entering into the challenging winter period. The Board was assured that it was intended to continue to robustly assess and review all Urgent Care Services to ensure that demand could be met efficiently and would continue to collaborate with all key stakeholders involved within the Urgent Care agenda.

Decision

The report was received by the Board.

31. Feedback from Health and Wellbeing Board Sub Groups (*Director of Public Health*)

The report informed the Board of the progress of establishing the three sub groups supporting the work of the Board. The terms of reference for the

Board described three sub groups reporting to the Board with responsibility for overseeing the implementation of the Health and Well Being Strategy and associated action plan. At the Health and Well Being Board meeting on 5th August 2013, the chairs of the sub groups had been identified and had been requested to establish initial meetings of these groups by September 2013:

The Board was advised that the Health and Well Being Strategy Action Plan has been reviewed and appendix 1 suggested which sub groups take responsibility for overseeing specific elements of the action plan.

The Director of Public Health advised the Board that a report would be submitted to a future meeting of the Board which would provide information on performance for each of the Groups. A report would be submitted also to the Council's Audit and Governance Committee.

Decision

The Board noted the progress that had been made in establishing the sub groups and the allocation of actions from the Health and Well Being Strategy Action Plan across the three groups.

32. Pharmaceutical Needs Assessment (*Dr Phillipa Walters, Tees Valley Public Health Shared Service)*

The report set out the responsibilities relating to the Pharmaceutical Needs Assessment for Hartlepool. The Board was advised that each Health and Wellbeing Board (HWB) had a number of responsibilities which included the publishing of a Pharmaceutical Needs Assessment by 1 April 2015. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 set out the minimum requirements for the first Pharmaceutical Needs Assessment (PNA) produced under this duty. Health and Wellbeing Boards would be required to undertake a consultation on their first PNA for a minimum of 60 days and the Regulations listed those persons and organisations that had to be consulted. In accordance with the 2013 Regulations, the Health and Wellbeing Board was now responsible for the latest PNA published by the former PCT (NHS Hartlepool). As the inherited PNA was already being used by NHS England and the duty had been placed upon the Board to ensure that the PNA was robust and up to date, the Board was advised of the systems which would be required to be put in place in conjunction with the Tees Valley Public Health Shared Service

Decision

That the report be noted.

33. Feedback from Regional Meeting of Health and Wellbeing Board Chairs Network (*Chair*)

The report provided feedback to the Board from the regional meeting of the Chairs of Health and Well Being Boards held on Monday 9th September 2013 (documents for which had been circulated to members of the Board). The report set out the items which had been discussed and actions which had been agreed at the meeting.

The Chair highlighted that Investment in tobacco by Local Authority Pension Funds had been a key item of discussion. Following those discussions, it had been agreed to further develop the paper discussed at meeting and present it to leaders and mayors across the North East with a view to collective action to withdraw from such investments, explore how other areas have approached this issue who have withdrawn from such investments and to alert representatives on the Teesside pension Fund of this issue.

Members of the Board discussed issues arising from investment in tobacco. Following on from those discussions, the impact of excessive consumption of alcohol both in terms of the health of an individual but also the impact on society, families and children was highlighted. Engagement with the alcohol industry was, therefore, considered also to be an issue.

Decision

That Board noted the content of the report and

34. Presentation – NHS Structures

Further to minute 24 of the meeting of the Board held on 5 August 2013, the Board received a presentation which outlined the context of NHS reforms and the rationale for that reform together with Policy issues set against economic context.

The presentation covered details including the roles and functions of Area Teams, Clinical Commissioning Groups, Public Health Departments and Healthwatch. Board Members who represented the identified organisations contributed to the presentation and provided information which supported the issues which had been highlighted in the presentation.

Decision

The Board noted the presentation and the Chairman expressed his appreciation of the contributions of Board Members in updating the Board to allow greater understanding of NHS structures.

35. Presentation – A Call to Action – Working in Partnership with Health and Wellbeing Boards

The Board received a presentation which introduced the national NHS England 'A Call to Action' initiative and which set out the rationale, process and timelines associated with the initiative together with the role of the Health and Wellbeing Board in the context of the initiative.

Board Members noted that the delivery of local engagement activity would take place throughout September 2013 and October 2013 with national engagement activity from September 2013 to January 2014. There was recognition that there was an opportunity for this national initiative to work on a local basis. It was highlighted that the Board had agreed a joint communication and engagement strategy which could form the basis for progressing this initiative. Referring to the timescales which had been presented, Board Members wanted to ensure meaningful dialogue was undertaken and highlighted therefore that dialogue would have to be used as a template for ongoing discussions. Board Members discussed also how the initiative would complement work which had been undertaken already.

The role of the Council's Audit and Governance Committee was highlighted together with the potential involvement of the Council's Neighbourhood Forums and the Safer Hartlepool Partnership.

Decision

The presentation was noted.

36. Any Other Items which the Chairman Considers are Urgent

It was noted that the next meeting of the Board would be held on 28 October at 10 a.m.

CHAIR

HEALTH AND WELLBEING BOARD

Monday 28th October 2013

Report of: Director of Public Health

Subject: **MAINTAINING AND DEVELOPING THE JOINT STRATEGIC NEEDS ASSESSMENT (JSNA): PROPOSALS FOR 2013 ONWARDS**

1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 NON KEY

2. PURPOSE OF REPORT

2.1 The purpose of this briefing is to outline the process for maintaining and developing the JSNA, in order to make the JSNA an integrated way of working in helping to improve local health and wellbeing

3. BACKGROUND

3.1 All local authorities and clinical commissioning groups have a statutory duty to have a Joint Strategic Needs Assessment (JSNA) that is part of the commissioning process for health improvement and wellbeing. The JSNA for Hartlepool is now based on an interactive website that is accessible to all.

3.2 A summary of the current JSNA commissioning intentions and unmet needs has been published. Hartlepool Borough Council, Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG), the NHS Area Team and other partners are able to use this list particularly for consideration of any joint commissioning and service planning.

4. REQUIREMENTS FOR JSNA MAINTENANCE AND DEVELOPMENT

4.1 The effectiveness of the JSNA for supporting continuous improvement in population health and wellbeing requires a process for maintenance and development. The process needs to be practical and efficient not only for JSNA Topic Leads but also for the core staff of the Tees Valley Public Health Shared Service (TVPHSS). Working with Topic Leads, the TVPHSS staff members manage the website infrastructure and the quality assurance of content on behalf of the Tees Valley Directors of Public Health. They also provide related intelligence in a common format and standard.

4.2 As a minimum, the process for maintenance and development needs to:

1. Ensure that Topic Leads keep existing topics up to date;
2. Improve existing topic content in breadth and depth where required;
3. Extend the facility to benchmark, segment and forecast population needs;
4. Agree criteria for potential for the inclusion of new topics;
5. Demonstrate how policy and practice is influenced by JSNA processes;
6. Communicate with others about priorities for better population health;
7. Market the JSNA as a local gateway to resources and expertise; and
8. Encourage wider use of facts and evidence to inform decisions at all levels.

4.3 ***Practical support for the process***

4.4 To ensure that these needs are handled systematically – but allowing for locality flexibility – the proposals for practical support of the process are as follows:

- Arranging sessions for Topic Leads: Sessions for Topic Leads will be arranged as needed. These sessions will allow content to be reviewed systematically to improve quality and to address missing content. For this process to be effective, one topic will be considered at a time in a series of meetings where the Topic Leads for all localities in Tees Valley will be invited to share experience, knowledge and learning. In general, the highest quality of current content is discernible for topics where local knowledge and experience has been shared between localities. The Public Health Intelligence Service will co-ordinate these meetings and offer whatever facilitation Topic Leads require. The timing and order of the topic reviews will be published at the end of September 2013. It is likely that priority will need to be given to topics where the current content needs significant improvement or where unexpected inconsistencies between localities are most evident.

- Publishing an updated topic guide: An updated written guide for Topic Leads will be published. This will include joint learning and experience derived from the process of website content development to date.

- Agreeing 'triggers' for appropriate maintenance of the JSNA: Possible triggers for JSNA maintenance are when:

    - Significant policy change occurs either nationally or locally;

- Significant new intelligence including data emerges that requires consideration of more or different intervention(s);
- Commissioning priorities have been implemented or modified or abandoned;
- Significant service developments are proposed or implemented; and
- New unmet need arises as a consequence of changes in risks or services.

4.5 A Scrutiny review or inquiry into a particular issue may also stimulate further analysis of the evidence / data, leading to further information that can contribute to the JSNA.

Such triggers should prompt an update in the appropriate topic section(s). The date that website content is uploaded is included in each topic session and a date that content should be reviewed in the absence of a specific 'trigger' will be included.

4.6 Ensuring continuous development of the JSNA:

In the unlikely event that there were no such triggers, each topic still needs regular review. The frequency of 'regular' review needs to take account of various issues including commissioning processes, the nature of change in the topic or service or population and the expertise of Topic Leads working in partnership with colleagues. Although the JSNA is not an annual business plan, an annual review would seem sensible. Such a review should be embedded in existing structures and processes (such as policy meetings or inter-agency meetings) to minimise the need for additional processes.

5. RECOMMENDATIONS

5.1 The Health and Well Being Board note the content of this report and the process for maintaining and developing JSNA.

6. REASONS FOR RECOMMENDATIONS

6.1 The Health and Social Care Act 2013 requires local Authorities and Clinical Commissioning Groups to have undertaken a Joint Strategic Needs Assessment.

7. CONTACT OFFICER

7.1 Louise Wallace
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HEALTH AND WELLBEING BOARD

28th October 2013

Report of: Director of Public Health

Subject: REVIEWING THE SUSTAINABLE COMMUNITY STRATEGY FOR HARTLEPOOL

1. PURPOSE OF REPORT

1.1 To present the Health and Wellbeing Board with the first draft of the new Sustainable Community Strategy document.

2. BACKGROUND

2.1 The Council has a statutory duty to prepare a Sustainable Community Strategy (SCS) for the Borough. The previous SCS was adopted 5 years ago in 2008 and therefore needs to be reviewed to ensure that it remains relevant, reflects local circumstances and responds to national changes.

3.2 Three options for reviewing the SCS were presented to Finance and Policy Committee on the 31st May 2013. The Committee agreed with the recommendation for Option 3 '*A change in approach with a downsized Community Strategy focussing on other key strategies to provide the detail*.'

3.3 This option builds on the previous SCS by maintaining the existing long term vision for Hartlepool but enables the priorities for the next five years to be more focused in light of the change in resources, organisational structures and the issues facing the Borough at the present time.

3.4 Therefore the new SCS will be greatly downsized and will compliment other key strategies and plans for the Borough for example the Health and Wellbeing Strategy, Housing Strategy, Economic Regeneration Strategy and the Community Safety Plan.

3. PROPOSALS

3.1 The first draft of the proposed SCS is attached as Appendix 1. This has been developed by officers within the Council and includes the following sections:

- Vision & longer term aims (taken from the existing SCS)
- Priorities for the next 5 years (identified by officers within the Council)
- How we'll achieve those priorities and how we'll measure our success

- How we'll work in partnership
- Our principles of working (taken from the existing SCS)
- What our delivery plans are i.e. which strategies and action plans will help us achieve our vision.

4. NEXT STEPS

4.1 Consultation on the Strategy has ran through the summer during which time we contacted statutory consultees to submit their views, the document has also be made available Elected Members, Town and Parish Councils and the Voluntary and Community Sector to gain their views. Consultation with the public has include questionnaires available in all libraries and other Council buildings open to the public together with online consultation for which we have received over 700 responses which we are currently analysing.

4.2 In terms of Health priorities Sports England have responded to raise their concerns at the lack of a priority to increase physical activity amongst residents of Hartlepool.

4.2 The results of the consultation on the first draft will be considered and used to inform the next draft of the Strategy along with the results of the Hartlepool Household Survey and any other relevant information that emerges during that time.

5.3 The second draft of the Strategy will be produced and will be presented to Finance and Policy Committee in November. A further two week consultation will then be undertaken before the final draft of the SCS is produced for consideration by Finance and Policy Committee before being taking to Council for adoption in February 2014.

6. LEGAL CONSIDERATIONS

6.1 The Council has a statutory duty to have a Sustainable Community Strategy.

7. RECOMMENDATIONS

7.1 That the Health and Wellbeing Board note the first draft of the Strategy and provide any feedback to the Performance and Partnerships team at Hartlepool Borough Council.

7. BACKGROUND PAPERS

7.1 Hartlepool's Ambition, Community Strategy & Neighbourhood Renewal Strategy, 2008-2020.

Report to Finance and Policy Committee 31st May Reviewing the Sustainable Community Strategy for Hartlepool.

Report to Finance and Policy Committee 26th July Reviewing the Sustainable Community Strategy for Hartlepool.

8. CONTACT OFFICER

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Hartlepool's Ambition

The Sustainable Community Strategy for Hartlepool

2014 – 2020

Foreword

In 2008 the Hartlepool Partnership launched the Sustainable Community Strategy which set out the future vision for the Borough in 2020. Since then we have made a lot of progress to turn that vision into reality; crime has fallen, people are living longer, primary and secondary educational attainment is improving and there has been significant investment in the Borough's housing stock, business areas and environment. However, a number of challenges have presented themselves since 2008 globally, nationally and locally with huge financial, economic and demographic challenges now facing us. We know that areas such as unemployment, health inequalities and poverty remain serious issues and we want to ensure that we continue to focus on areas were we can have the biggest impact. We will endeavour to continue to improve the lives of people who live and work in Hartlepool and the physical infrastructure so that people want to live and work here and businesses want to invest.

In spite of the impact of national decisions locally this Sustainable Community Strategy reiterates our commitment to our long term ambition for Hartlepool. We have reshaped our partnership to meet the challenges ahead and focus our efforts on what really matters. This document sets out our priorities for the next five years and how we will continue to work together to meet our aspirations for the community of Hartlepool.

Councillor Christopher Akers-Belcher

Leader of Hartlepool Borough Council and Chair of the Hartlepool Strategic Partners Group

What do we want to achieve?

This Sustainable Community Strategy sets out our long-term ambition for the economic, social and environmental wellbeing of Hartlepool. It builds upon the ambition and aspirations set out in 2008 and sets out our priorities for the next 5 years.

Our long-term ambition, as agreed in 2008, remains relevant today:

Hartlepool will be an ambitious, healthy, respectful, inclusive, thriving and outward-looking community, in an attractive and safe environment, where everyone is able to realise their potential.

We also remain committed to making improvements across the 8 themes of:

- Jobs and the Economy
- Lifelong Learning & Skills
- Health and Wellbeing
- Community Safety
- Environment
- Housing
- Culture & Leisure
- Strengthening Communities

We have agreed a number of key strategies and plans that set out the detail of how we will achieve our long-term ambition. These are reviewed more frequently than the Sustainable Community Strategy and provide an accurate and timely picture of how we aim to deliver against our long-term ambition:

- Child Poverty Strategy
- Children and Young People's Plan
- Community Safety Plan
- Council Plan
- Economic Regeneration Strategy
- Hartlepool Voluntary and Community Sector Strategy
- Health and Wellbeing Strategy
- Housing Strategy
- Local Transport Plan
- Tees Valley Joint Waste Management Strategy
- The plans and strategies which together comprise the Development Plan
- Vision for Adult Social Care in Hartlepool
- Youth Justice Strategic Plan

We regularly monitor the progress made against each of these plans and we use this to assess whether we are on track to achieve our long-term ambition.

What are our priorities for the next 5 years?

We have identified a number of key priorities for Hartlepool which will be our main focus for improvement over the next 5 years. This does not mean that we will stop making progress against the other themes we have identified as that will continue through the strategies and plans that we already have in place. Our priorities for the next 5 years are:

Increased business and jobs

- Regenerate key sites and attract investment.
- Improve business infrastructure.
- Support business growth.
- Develop an enterprising culture.
- Develop a competitive workforce.

Reduced poverty

- Ensure that children that live in poverty are safe.
- Increase the parental employment rate.
- Improve skills levels in parents and children.
- Support families to maximise their entitlements.
- Prevent those at risk from falling into poverty.
- Where it is evident that a family is experiencing poverty take action to mitigate its effect.

Healthier people

- People live longer healthier lives.
- Strengthen ill health prevention.
- Protect the health of the population.
- Improve early detection of illness.
- Adults with health and social care needs are supported to maintain maximum independence.
- Vulnerable adults are safeguarded and supported while having choice and control about how their outcomes are achieved.

Better housing

- Delivering new homes, contributing to sustainable communities.
- Improving existing homes, supporting sustainable communities.
- Meeting the specific housing needs, this includes homeless households, older people, people with disabilities, and the black and minority ethnic community.

Safer stronger neighbourhoods

- Reduce crime and repeat victimisation.
- Create confident, strong, and safe communities.
- Reduce offending and re-offending.
- Reduce the harm caused by drug and alcohol misuse.

Giving every child the best start in life

- Deliver effective early intervention services for children, young people and families.
- Ensure all children can live safely.
- Provide effective support for looked after children.
- Deliver new approaches for children and young people with special educational needs and disabilities.
- Ensure schools provide the highest quality education for all children.

How will we know if we are on track to achieve our ambition?

Alongside our priorities we have identified some key measures of success that we will monitor to see if we are on track to achieving our ambition. Through the various parts of the Hartlepool Partnership we will closely manage our performance to ensure success.

Increased business and jobs

What we are going to do:

- Deliver the Economic Regeneration Strategy 2011-2021.
- Deliver the Seaton Carew Master Plan.
- Development of the Enterprise Zone initiative.
- Development of the Innovation and Skills Quarter.
- Attract economic investment to key employment sites such as the port area at Hartlepool Docks and Southern Business Zone.
- Secure investment in key development sites such as Jackson's Landing and Mill House area.
- Implement the Retail Revival Strategy.
- Deliver the Hartlepool Youth Investment Project.

How we will measure success:

- Number of new jobs created.
- Number of new businesses on Enterprise Zones.
- Level of investment in key regeneration sites.
- New business registrations.
- Level of self-employment.
- Level of overall employment.

Healthier people

What we are going to do:

- Prevention and early detection of cancer.
- Promote the healthy heart check programme.
- Focus on prevention and effective treatment of respiratory disease.
- Reduce smoking prevalence.
- Reduce alcohol related harm.
- Promote healthy weight healthy lives.
- Focus on the prevention and effective treatment of sexual transmitted infections.
- Reduce the harm caused by drugs and alcohol.
- Support people to live independently in their own homes
- Support carers to maintain their caring role
- Continue to promote independence and facilitate recovery for people with mental health needs
- Implement the National Dementia Strategy in Hartlepool.
- Safeguard vulnerable adults,

How we will measure success:

- Male and female life expectancy.
- Under 75 mortality from cancer and Cardio Vascular Disease.
- Teenage pregnancy rate.
- Rate of sexually transmitted infections.
- Smoking prevalence.
- Childhood obesity rates and modelled adult obesity estimates.
- Breast feeding initiation rate and breastfeeding rate at 6-8 weeks.

- Proportion of substance misusers going into effective treatment and proportion who successfully complete treatment and represent back into treatment within 6 months.
- Rate of alcohol related harm admissions to hospital.
- Percentage of Social Care clients receiving Self Directed Support
- Carers receiving needs assessment or review and a specific carer's service, or advice and information
- People supported to live independently through social services (all adults, per 100,000 population)
- Delayed Transfers of Care
- Adults with learning disabilities in settled accommodation
- Adults in contact with secondary mental health services in employment
- Access to equipment and telecare: users with telecare equipment
- % of people who received intermediate care or reablement package on discharge from hospital who remain at home 91 days after discharge

Safer stronger neighbourhoods

What we are going to do:

- Tackle acquisitive crime - domestic burglary and theft.
- Tackle domestic violence and abuse.
- Support victims and reduce the risk of victimisation.
- Address substance misuse through a combination of prevention, control and treatment services.
- Protect and support vulnerable victims and communities including victims of hate crime.
- Improve public reassurance and fear of crime by actively communicating, engaging and working with local communities.
- Continue to address anti-social behaviour at a neighbourhood level through effective multi-agency working.
- Tackle offending and re-offending behaviour through a combination of prevention, diversion and enforcement activity underpinned by a strong multiagency approach.

How we will measure success:

- Overall crime rate per 1,000 population.
- Number of repeat incidents of domestic violence/abuse.
- Perception of people using or dealing drugs in the community.
- Perceptions of anti-social behaviour.
- Perceptions of drunk or rowdy behaviour as a problem.
- Anti-social behaviour incident rate per 1,000 population.
- Deliberate fires per 1,000 population.
- Hate incidents/crimes per 1,000 population.
- Reoffending rate for young offenders.
- First time entrants into the youth justice system.
- Reoffending rate of Prolific and Priority Offenders.
- Number of troubled families engaged and results claimed.

Reduced poverty

What we are going to do:

- Encourage schools to use their pupil premium to target interventions with disadvantaged children that improve their attainment and increase their rates of progress in English and mathematics.
- First Contact and Support Hub to offer information, advice and guidance to support families to maximise their income.
- Implement universal pathway plus in disadvantages hotspots to ensure that families are supported at the earliest opportunity.
- Link Think Families/Think Communities customers onto employment initiatives such as the Work Programme.
- Develop the Family Wise project to engage and support long term unemployed parents to move closer to the labour market.
- Develop the Going Forward Together project to engage and support young people who are at risk of becoming 'Not in Education, Employment or Training' (NEET) in the long term.

How we will measure success:

- Number of children in poverty.
- Proportion of children living in workless households.
- Gap between the 20% lowest performing children and the rest at age 5.
- Number of families needing crisis support.
- Employment Rate.
- Youth Employment Rate.
- Number of Adults on Working Age Benefits.
- Level of participation of young people (16-18) in further learning.

Giving every child the best start in life

What we are going to do:

- Ensure effective and efficient safeguarding procedures are in place and are followed to protect all children and young people.
- Review and strengthen the Early Intervention Strategy.
- Ensure children and young people are supported at the earliest opportunity to help prevent them entering into care.
- Ensure all looked after children are supported effectively as they grow into adults through access to appropriate placements, high quality education and healthy lifestyles.
- Deliver the Special Educational Needs Pathfinder.
- Work with all schools to improve educational attainment through practical support and guidance.

How we will measure success:

- Number of common assessments completed.
- Number of Children in Need.
- Number of children subject to a Child Protection Plan.
- Number of children re-referred to social care.
- Number of Looked After Children and percentage of Looked After Children placed for adoption within 12 months of the decision that they should be placed for adoption.
- Number of accidental injuries to children.
- School absences and school exclusions.
- Gap between the 20% lowest performing children and the rest aged 5 years old.
- Gap between children eligible for Free School Meals and the rest at Key Stage 2 and Key Stage 4.
- Number of children achieving 5 A*-C GCSEs including English and Maths.
- All schools to have an Ofsted judgement of Good or Outstanding.

Better housing

What we are going to do:

- Provision of new build affordable accommodation across the town and the provision of new homes on regeneration sites.
- Improvement of housing conditions, reductions of empty homes and good management across tenures.
- Address the impact of welfare reform on tenancy sustainability across tenures and on demand for the rented sector.
- Meet the specific housing needs of vulnerable groups across communities.

How we will measure success:

- Affordable homes delivered (gross).
- Number of new homes built on regeneration schemes.
- Number of properties where identified Housing Health and Safety Rating System (HHSRS) Category 1 and actionable Category 2 hazards are dealt with through formal or informal enforcement action.
- Numbers of properties improved through the grants or loans schemes
- Number of long term (over 6 months) empty homes brought back into use.
- Number of households where homelessness has been prevented through local authority action.
- Average waiting time for a disabled facilities grant to be completed.
- Percentage of applicants on the Choice Based Letting (CBL) Housing register indicating they are from a minority ethnic origin.

How we will work together to achieve our ambition?

Only through working together in partnership will we be able to achieve our ambition for Hartlepool. Our collective effort is needed to ensure that we can deliver against our priorities and make real change happen.

Through decisions taken nationally there is less public money available to help us achieve our ambition. This means that we will need to think differently about how we deliver and use new approaches to create lasting change within the Borough. We will need to work even closer as partners, sharing and pooling our resources, financial, physical and human, to make sure we use them to best effect. We will also need to build on our relationships with local voluntary and community groups and businesses as well as forging new relationships with those who can help us to achieve our ambition.

In Hartlepool we already have in place a number of formal partnership arrangements and these will continue to develop so that we are best placed to take advantage of opportunities as they arise. The Hartlepool Partnership is the banner under which all of the partnerships in Hartlepool come together: There are also a number of sub groups operating below the partnerships shown below. One of these is the Children's Strategic Partnership which feeds into the Health and Wellbeing Board.

Together these partnerships will be responsible for ensuring that we make progress on our priorities over the next 5 years and achieve our long-term ambition.

Our principles

In delivering the Sustainable Community Strategy vision, we will strive to apply the following principles:

Effective decision making and communication
Communicating openly and honestly with the community in Hartlepool and being publicly accountable for our decisions. Decision-making will be rigorous and transparent and decisions will be based upon the best information available at the time.

Effective partnership working
Working together as equals to deliver sustainable communities within Hartlepool, having a clear understanding of shared decision-making, risks, responsibilities and accountabilities.

Efficient partnership working
Increasing efficiency and achieving value for money through improved procurement, financial reporting and management. Delivering high quality local services and making the most of the resources available including people, money, property, data and information.

Acting with integrity
Acting with honesty, selflessness, objectivity and trust, declaring interests and dealing with truth and completeness.

Ensure widest possible involvement and inclusion
All parts of the community regardless of where they live, or their gender, race, ethnicity, disability, religion, sexual orientation, family and other circumstances, language, national or social origins, age or any other status, are encouraged to be involved at all stages in the development, delivery and monitoring of this strategy.

Demonstrating leadership and influence
Leading by example with enthusiasm in delivering the strategy by applying these principles and using influence to encourage other partners and providers locally, regionally and nationally to do the same.

Effective performance management
Actively managing the delivery of the strategy by providing clear, robust and reliable information for monitoring purposes, establishing clear lines of accountability, managing risk, reporting by exception, and, when performance is not on track, taking action to address this.

Developing skills and knowledge
Developing our own capacity and skills to improve performance, whilst providing opportunities for the community to improve their skills, capacity and life chances.

Contributing to sustainable development
Considering economic, social and environmental goals equally and in an integrated way ensuring the long term and global aspects of strategy and decision making are considered.

HEALTH AND WELLBEING BOARD

28th October 2013

HARTLEPOOL BOROUGH COUNCIL

Report of: Director of Offender Management Durham Tees Valley Probation Trust

Subject: MAKING THE DIFFERENCE : THE ROLE OF SOCIAL CARE SERVICES IN SUPPORTING VULNERABLE OFFENDERS

1. PURPOSE OF REPORT

1.1 To inform the Health and Wellbeing Board in respect of the role of Social Care Services in supporting vulnerable offenders who live in Hartlepool in the light of the report 'Making the Difference'; the role of Adult Social Care Services in supporting Vulnerable Offenders (Appendix 1)

1.2 To link this report with the Reducing Reoffending Strategy for Hartlepool that adopts an 'Offender Centric' approach to reducing reoffending and the broader harm caused to communities.

1.3 To discuss and agree potential actions identified within the report

2. BACKGROUND

2.1 Many of the people who offend most frequently are also some of the most vulnerable people in our communities . The role of adult social care in supporting these individuals has been little recognised , yet these services are in a unique position to offer leadership to local efforts to improve the lives of vulnerable citizens and their families.

2.2 Social care can make a difference in three main ways

- By influencing local strategies to support people with multiple needs
- By forming partnerships with other services to meet multiple needs more efficiently
- By offering personalised social care support based on a person's unique needs

2.3 While resources are currently constrained in adult social care departments coordinating effective and personalised support for people with personalised

needs, especially those at risk of offending and offenders represents good value for money improving the lives of an often ignored group of people

2.4 Adults with multiple needs often have a combination of mental health problems, personality disorder, learning disabilities, development disorders such as autism, and behavioural and communication difficulties . There is also growing evidence of high rates of neurodisabilty and acquired brain injury in the population of young offenders

2.5 The paper points out that what works well for people with multiple needs is the 'interconnectedness between improving health and social care outcomes for those in contact with the criminal justice system and other government priorities, particularly reducing reoffending '(Bradley 2009)

2.6 As members of health and Wellbeing Boards, directors of adult social services and lead members are ideally placed to raise the profile of people with multiple needs, especially those at risk of offending and offenders and encourage the development of more integrated support

3. PROPOSALS

3.1 It is important that adult social care services review their interaction with vulnerable offenders to ensure that multiple needs are met at the earliest opportunity . The 'protective factors' against reoffending are frequently those areas of life with which people with multiple needs struggle and in which early relatively low level intervention can make a difference .

3.2 Social Care has a major contribution to make in the seven resettlement pathways for offenders for example ,housing , finance , benefits and debt and the children and families of offenders . The importance of identifying lead professional roles to work with offenders is necessary to ensure needs are identified support given and the best possible opportunities to support a crime free life

4. RECOMMENDATIONS

5.1 Prioritising vulnerable offenders at both strategic and operational level within adult social care must be considered by the Health and Wellbeing Board and lead members to ensure the needs are met of the vulnerable offenders with multiple needs in Hartlepool .

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PRISON REFORM TRUST

directors of adass adult social services

Centre for Mental Health

REVOLVING DOORS AGENCY

Making the Difference:

the role of adult social care services in supporting vulnerable offenders

- 39% of adult offenders under supervision in one probation area had a current mental illness; 49% had a history of mental health problems (Brooker et al, 2011)
- 75% of adult prisoners have a dual diagnosis of mental health problems and substance misuse (Offender Health Research Network, 2009)
- 7% of adult prisoners have an IQ below 70 and a further 25% have an IQ in the range 70-79 (Mottram, 2007); it is generally acknowledged that between 5 and 10% of the offender population has a learning disability
- 15% of newly sentenced prisoners reported being homeless before custody; 37% said they would need help finding somewhere to live when released; 60% said that having a place to live would help them stop reoffending (Ministry of Justice, 2012)
- 40% of young people in custody have previously been homeless (YJB, 2007)
- 43% of children and young people on community orders have emotional and mental health needs (Healthcare Commission, 2009)
- 25% of children and young people who offend have an IQ below 70 (Harrington & Bailey, 2005), and 60% have communication difficulties (Bryan, Freer and Furlong, 2007).

Foreword

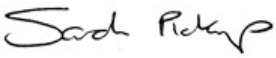
Every community is affected by crime and the harm it causes. Many of the people who offend most frequently are also some of the most vulnerable people in our communities who need support from a number of different local agencies.

The role of adult social care in supporting these individuals has been little recognised. Yet as directors and lead members of adult social care services we are in a unique position to offer leadership to local efforts to improve the lives of our most vulnerable citizens and their families.

Our role goes beyond that of commissioning and providing social care. We can help to build partnerships between local services, creating coherence where currently there is duplication and confusion. We can bring people together to identify where our local services are doing well and where improvement is needed. And we can lead the way in preventing offending and reoffending by improving people's life chances, their hopes for the future and their place in our communities.

All local authorities face major challenges in managing demand for our services while taking on important new roles in securing wellbeing for our communities.

Being attentive to the needs of our most vulnerable citizens of all ages is not an optional extra for adult social care services. It is fundamental to why we exist. We see people in their wholeness, not as problems, diagnoses or nuisances. We help people to be more independent, flourishing in their lives and contributing to their communities. Our leadership can bring about great change and this briefing paper offers insights and ideas to help us to achieve it, whatever the unique needs and circumstances of our local areas.



Sarah Pickup
President, ADASS

Summary

This briefing paper for directors of adult social services and lead members draws together current information about young people and adults with multiple needs in contact with the criminal justice system.

Adult social care has an important, and often overlooked, role in supporting people with multiple needs who offend to desist from crime and lead independent, fulfilling lives in their communities.

People with multiple needs are not always clearly identified in public service information systems. For example, when personal needs are assessed separately for different services, individuals often fall below eligibility thresholds for each service even though their total need is high. Failure to respond to multiple needs has been shown to lead to greatly increased costs to the local public sector over both the short and the longer term (Anderson and Cairns, 2011).

Directors of adult social services and lead members can be the cornerstones of improved support to people with multiple needs in, or on the edge of, the criminal justice system.

Social care can make a difference in three main ways:

- by influencing local strategies to support people with multiple needs
- by forming partnerships with other services to meet multiple needs more efficiently
- by offering personalised social care support based on a person's unique needs.

Recent developments in health and social care policy emphasise early intervention, supporting recovery and choice, promoting independence and strengthening local partnerships across public services, including criminal justice.

While resources are currently constrained in adult social care departments, coordinating effective and personalised support for people with multiple needs, especially those at risk of offending and offenders, represents good value for money. It should achieve efficiencies in local public sector spending as well as improving the lives of an often ignored group of people.

How social care can make the difference

Strategy:

1. Ensure data concerning people with multiple needs, especially those at risk of offending and offenders, are reflected in Joint Strategic Needs Assessments and given sufficient prominence in Joint Health and Wellbeing Strategies

Partnership:

2. Encourage collaborative working at the strategic level with a range of partners, such as Police and Crime Commissioners, Probation Trusts and the NHS National Commissioning Board
3. Use aligned or pooled budgets, for example Community Budgets, to achieve better value for money from different streams of funding for people with multiple needs
4. Offer social care expertise to other local services, including housing, Integrated Offender Management and liaison and diversion services

Support:

5. Provide information, advice and guidance to people with multiple needs through intensive support, using link workers and vulnerable adults teams
6. Work with local liaison and diversion services to help assess and meet multiple needs as people enter the criminal justice system, and with prison staff as prisoners with multiple needs prepare to leave prison
7. Work with criminal justice agencies to ensure the safeguarding needs of vulnerable suspects, defendants, offenders and prisoners are recognised and met.

People with multiple needs

Adults with multiple needs often have a combination of mental health problems, including personality disorder; learning disabilities; developmental disorders such as autism, and behavioural and communication difficulties. There is growing evidence of high rates of neurodisability (Hughes et al, 2012) and acquired brain injury (Williams, 2012) in the population of young offenders, and no reason to suppose that the underlying conditions disappear in adulthood. People with multiple needs frequently have difficulties with substance misuse, physical health, housing and relationships.

Multiple needs in young people are often compounded by their youth and developmental immaturity. Entering the criminal justice system can be especially difficult for young people already negotiating the transition between children's and adult health and social care services. A recent inspection of transition arrangements for young people who offend found failures to identify the particular and multiple needs of this group and to initiate coherent planning for transfer to adult services, including continuation of support and interventions (Criminal Justice Joint Inspection, 2012).

Evidence shows that while young people in the transition to adulthood (16-17 years) and young adults (18-24 years) are the most likely age group to commit a criminal offence, with the right intervention and support, they are also the most likely to desist from offending and 'grow out of crime' (Transition to Adulthood Alliance, 2012).

Profile of people who offend

Adult offenders:

- 39% of adult offenders under supervision in one probation area had a current mental illness; 49% had a history of mental health problems (Brooker et al, 2011)
- 75% of adult prisoners have a dual diagnosis of mental health problems and substance misuse (Offender Health Research Network, 2009)
- 7% of adult prisoners have an IQ below 70 and a further 25% have an IQ in the range 70-79 (Mottram, 2007); it is generally acknowledged that between 5 and 10% of the offender population has a learning disability
- 15% of newly sentenced prisoners reported being homeless before custody; 37% said they would need help finding somewhere to live when released; 60% said that having a place to live would help them stop reoffending (Ministry of Justice, 2012)
- Prisoners who reported being homeless before custody were more likely to be reconvicted upon release than prisoners who didn't report being homeless – 79% compared to 47% in the first year after release (Ministry of Justice, 2012)

Children and young people (10 – 17 years):

- Looked after children are over-represented in the youth justice system: 22% of children aged under 14 years were living in care at the time of their arrest, and a further 6% were on the child protection register; this compares with around 1% of children within the general population who are in the care of the local authority (DCSF, 2009)
- 43% of children and young people on community orders have emotional and mental health needs (Healthcare Commission, 2009)
- 25% of children and young people who offend have an IQ below 70 (Harrington & Bailey, 2005), and 60% have communication difficulties (Bryan, Freer and Furlong, 2007)
- 40% of young people in custody have previously been homeless (YJB, 2007).

What works for people with multiple needs?

Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system was clear that social care is a key player in improving justice:

> *What is apparent is the interconnectedness between improving health and social care outcomes for those in contact with the criminal justice system and other government priorities, particularly reducing reoffending (Bradley, 2009).*

Social care has a key role in reducing offending and reoffending. It has a major contribution to make in each of the 'seven resettlement pathways for offenders' (Gojkovic et al, 2011) including, for example, housing; finance, benefits and debt; and the children and families of offenders. There is growing evidence that supporting desistance from crime has much in common with the Recovery approach in mental health. Each are about building strengths through, for example, fostering positive social bonds, securing stable accommodation and meaningful occupation, and addressing health needs. They emphasise the importance of enabling people to have choice and control in their lives, with a greater sense of hope for the future and opportunities to build a better life (Shepherd, Boardman and Slade, 2008)

The 'protective factors' against reoffending are frequently those areas of life with which people with multiple needs struggle and in which early, relatively low level, intervention can make a difference. Rather than create novel interventions, the key is often to apply recognised good practice, using a variety of means to identify and engage with a group that is often excluded from mainstream services.

Effective responses to tackling multiple needs usually include a lead professional role, such as a link worker, who builds a trusting relationship and supports the individual to get access to the range of services they need. It is essential, however, that such arrangements are supported by robust partnership arrangements – often involving pooled or aligned budgets – able to bring together lead professionals from the different services that people need.

Supporting people with multiple needs

1. Self advocacy:

The Elfrida Society receives funding from adult social care to support people with learning disabilities. Activities for members include:

- learning skills for independent living
- access to education, employment and health
- opportunities to get involved in stakeholder engagement work, such as responding to consultations and providing training, which they have undertaken for the police and council services.

Members report increased self-esteem, confidence in speaking up, and the ability to make better decisions and choices about their lives.

(Material provided by the Elfrida Society)

2. Combined step-down and preventive services:
Walsall's Adult Social Care Operating Model includes moving people placed in residential or inpatient care to independent community based living. The model provides step down support to sustainable community living as an alternative to residential care, and preventive services for people who are vulnerable but not 'Fair Access to Care Services' eligible.

A social care provider, KeyRing, was commissioned to establish networks that combined 'step down' support for 26 people and preventive support for another 51 people regarded as vulnerable and liable to crises, which could require costly support. Evaluation after one year showed that the model was delivering savings against the original costs while also mitigating risks such as homelessness, abuse and mental health crises.

Joe, a beneficiary of Walsall's Adult Social Care Operating Model, was diagnosed with paranoid schizophrenia. He had substance misuse problems and had spent time in prison, an assessment and treatment unit and residential care. He moved into a flat with support from KeyRing. The support worker visits Joe once a week to help him with correspondence, bills and keeping appointments. The support worker encourages Joe to socialise, reminds him to take his medication and liaises closely with mental health services. Joe is sustaining his tenancy and now cooks for another member of the network. He is proud about this and how he has learned to be independent. He also recognises the importance of taking his medication and says he feels 'much better for it.'
(Material provided by KeyRing, http://www.keyring.org/home, and taken from Alder, 2012)

3. Early Intervention:
The Warrington New Directions service provides integrated, early intervention involving more than 25 local agencies and health and social care services to meet the needs of adults in contact with the police. Service users may be offenders or victims who are deemed to be at risk or in distress. Although many service users have multiple and complex needs they are unlikely to meet the criteria for access to mainstream support. Social workers linked to the New Directions service offer a needs assessment, which includes physical and mental health, social networks, housing and benefits. They provide brief interventions and help service users to make and keep appointments to address needs arising from their assessment.

An evaluation of service users in contact with the Warrington New Directions service revealed that 74% of those assessed had experienced mental health problems, and 42% had self-harmed; 50% per cent had problems with housing; 45% had problems with alcohol; 45% had financial difficulties; and around 60% had a history of offending.

4. Intensive support for women
Anawim women's centre in Balsall Heath, Birmingham, is a day centre for vulnerable women. It acts as a one-stop shop into services for women with multiple and complex needs, such as substance misuse, poverty, homelessness and domestic violence. Almost 30 different services are available through Anawim, providing much needed support to vulnerable women on issues such as drugs and alcohol, housing and healthy and safe relationships. The centre provides food, clothes, social activities, educational classes and a creche for children whilst the women participate in activities.

Anawim is increasingly receiving referrals of women offenders who have been sentenced by the courts to undertake unpaid work or a specified activity at the centre.

Working in partnership

Social care support involves more than the provision of direct services. It means working creatively at the interface between social care and other local services, both to support those who are eligible for social care support and those who are currently below the threshold but whose needs could escalate to 'substantial' or 'critical' level.

Advice and support from social care to other agencies, including voluntary and community organisations, can help them to improve their 'offers' to people who do not meet Fair Access to Care Services (FACS) criteria (Fox, 2012). For example, collaboration with Integrated Offender Management and with liaison and diversion services brings social care skills and knowledge to bear on the complex difficulties experienced by many vulnerable suspects, defendants and offenders. This could involve information and awareness training, co-working and advice 'surgeries'. Local authorities may also fund voluntary organisations providing relevant expertise and support, for example, self-advocacy, mentoring and supported employment.

Some local authorities have continued to identify 'Supporting People' monies as a distinct funding stream, usually within adult social care. Providing support to people with housing-related support needs to sustain their tenancy can play a valuable protective role in helping to promote independence and reduce reoffending. This in turn has shown to result in savings to the public purse, including a small net benefit to adult social care (Ashton & Hempenstall, 2009).

People leaving prison report difficulties in preparing for release. They need coordinated and consistent support with the basic needs of life such as a home, a job, healthcare and relationships (Byng et al, 2012). Starting the process of assessment and planning prior to release from prison, including the provision of information and advice, can make a significant difference to ensuring successful resettlement in the community (Edgar, et al, 2012).

The Housing First approach

The Housing First approach to housing and supporting people with complex needs was developed first in the United States and is now being adapted by some providers in the UK.

Its key principle is to place people who have been homeless and have drug or alcohol problems in permanent accommodation without first requiring them to undergo treatment. Most existing services for this group move people through a number of stages of hostel and supported accommodation before offering independent tenancy.

Evidence from the US suggests that Housing First clients have significantly higher rates of tenancy retention than those supported through a 'treatment first' approach. There was no significant difference between the two approaches in mental health symptoms, quality of life or drug and alcohol problems.

Turning Point Scotland has begun a three-year pilot project of the Housing First approach. Residents are given permanent tenancies in dispersed sites with round-the-clock floating support and peer support workers who help build residents' trust and engagement with local services (Scott, 2012).

A four-year US study comparing Housing First and Treatment First approaches found that the per capita cost of the Housing First programme was around half that of Treatment First programmes (Padgett et al 2006).

Local strategic leadership

In addition to their role as a commissioner and coordinator of care and support, local authorities can use wider powers to create safer and stronger communities to help ensure that people with multiple needs in, or on the edge of, the criminal justice system are included in initiatives to improve wellbeing and quality of life.

Every local authority is involved in a number of overlapping partnerships, such as Community Safety, Integrated Offender Management, Troubled Families, Safeguarding Adults, and Health and Wellbeing Boards. These all offer an opportunity to coordinate efforts to improve outcomes for individuals and the communities in which they live. As members of Health and Wellbeing Boards, directors of adult social services and lead members are ideally placed to raise the profile of people with multiple needs, especially those at risk of offending and offenders, and encourage the development of more integrated support:

> *...the need to tailor a package of measures for an individual will require close liaison to ensure the joining-up of services, e.g. housing, social services, benefits and education around individual offender needs (LGA, 2005).*

Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) offer an important opportunity for local authorities to draw together a range of local organisations to support people with multiple needs and to overcome their invisibility in some mainstream services.

The implementation framework for 'No health without mental health' (HM Government, 2012) encourages the use of options such as Community Budgets to improve the quality and efficiency of support for people with multiple needs. Similarly, the NHS Mandate recognises the need for improved partnership working between the NHS and a range of agencies to achieve shared aims including:

> *...developing better healthcare services for offenders and people in the criminal justice system which are integrated between custody and the community, including through development of liaison and diversion services (Department of Health, 2012a).*

Community budgets

Four Community Budget pilots in Essex, London, Manchester and Cheshire are reviewing local public expenditure to see how it is being spent and whether it can be put to better use. In London, the Tri-borough partnership (Westminster, Kensington and Chelsea, and Hammersmith and Fulham) included a focus on reducing reoffending.

The pilot found that over £4 million/year was spent by the three boroughs alone on offenders. Half of those given short prison sentences were likely to reoffend within a year. This same group represents 9% of all offenders but two-thirds of all prison admissions and releases.

A bespoke service is being established that will co-ordinate help by offering a single point of assessment and management across all three boroughs.

This will include:

- early assessment
- support based on likelihood of reoffending and motivation to change
- an 'end to end' key worker
- a personalised action plan, including consequences for non-compliance.

Different ways of working are being explored that have the potential to reduce costs and reoffending. For example, releasing prisoners mid-week instead of on a Friday afternoon means that key council services are open and can provide immediate support.

The pilot has a target of reducing re-offending by 10% and reducing direct spending, with an estimate of wider economic benefits over five years amounting to £25 million.

http://transact.westminster.gov.uk/docstores/publications_store/the_future_of_public_services.pdf

New opportunities to meet multiple needs

> *Early intervention, social investment, payment by results, multi-agency delivery – these should be the watchwords for every government department, local authority and private or voluntary sector provider in the coming years (HM Government, 2012).*

There is an increasing convergence in both policy and practice between social care and criminal justice. This can create new opportunities to improve support for offenders with multiple needs, and those at risk of offending, and their families.

Of particular relevance is the draft Care and Support Bill, which includes a duty for social care services to co-operate with criminal justice agencies and encourages a greater focus for adult social care on early intervention and promoting independence (Department of Health, 2012b). The Law Commission has also been investigating ways of improving social care provision in prisons (Law Commission, 2011).

There is growing awareness in the criminal justice system of the value of social care. The National Offender Management Service (NOMS) has appointed Health and Wellbeing Co-Commissioning regional leads and its commissioning intentions document seeks to strengthen engagement with social care in respect of both offenders and their families (NOMS, 2012).

There is increasing emphasis in criminal justice policy on effective community sentencing. Offenders with multiple needs in receipt of a community order are likely to need support with compliance, for example in keeping appointments, understanding exclusions, avoiding risky people and situations, and intensive supervision has been shown to reduce reoffending rates (Ministry of Justice, 2011). As a result, there is growing interest in, and recognition of, the importance of advice and support from social care in working with vulnerable suspects, defendants and offenders by, for example, Integrated Offender Management schemes, liaison and diversion services and Probation Trusts.

While it is difficult to predict the impact Police and Crime Commissioners (PCC) might have on local communities, what is clear is the relevance of the local community safety fund, which PCCs can use in collaboration with partner agencies to tackle drugs and crime, reduce re-offending and improve community safety.

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HEALTH AND WELLBEING BOARD

28th October 2013

Report of: Director of Public Health

Subject: Summer and Winter Preparedness Plan

1. TYPE OF DECISION/APPLICABLE CATEGORY

NON KEY

2. PURPOSE OF REPORT

2.1 The purpose of this report is to introduce to the Health and Well Being Board the Summer and Winter Preparedness Plan for County Durham and Tees Valley.

3. BACKGROUND

3.1 This plan has been produced by NHS England's Durham Darlington and Tees Area Team (DDTAT) on behalf of the Local Health Resilience Forum (LHRP). It has been developed from the plan produced for Cleveland's Local Resilience Forum (LRF) in 2012. It is intended as the summer and winter plan for the Durham and Darlington LRF and Cleveland LRF.

3.2 Following consultation the plan was signed off by the LHRP on 6 August 2013.

3.3 The plan is informed through reference to the NHS England Heatwave Plan for 2013 and Cold Weather Plan for England 2011. References to levels are references to the trigger levels contained in those plans. The plan has been produced to provide a coordinated multi-agency response to the varying levels and does not therefore remove individual agency responsibilities to maintain their own plans in accordance with the National documents.

4. KEY ISSUES

4.1 Extreme weather can have a significant impact on health and well being. Changing weather patterns have had a significant impact on the way multi-agency partners plan and respond to adverse weather events. Pre planning has helped reduce the impact of past weather related incidents, but future planning will need to include working with environmentalists and engineers

to look at climate change and the impact on matters from new builds to sea defences.

4.2 The plan recognises the four alert levels for both summer and winter and provides advice for action by agencies or groups. Unlike previous plans where actions were not given as directions to agencies or groups, this plan does so when a Level 1 alert is issued. This is the preparedness state and the purpose of the plan is to ensure that those with a duty to prepare are in fact doing so.

4.3 Governance of adherence to the actions within the plan at Level 1 falls to DDTAT who will seek evidence that the work is being undertaken. This will be reported to the LHRP and to wider interested parties, e.g. Health and Wellbeing Boards.

5. RECOMMENDATIONS

5.1 Members of the Board are asked to note the Summer and Winter Preparedness Plan.

6. REASONS FOR RECOMMENDATIONS

6.1 To ensure the Board is aware of the plan as extreme weather can have a significant impact on health ad well being.

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Summer and Winter Preparedness Document

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Document control

Title	Summer and Winter Preparedness Plan
Date/Version	June 2013 / V 1.0
Author	Andy Summerbell, Head of EPRR Durham Darlington and Tees Area Team
Date endorsed by DDT LHRP	6th August 2013
Date to CDD LRF Chief Officer Group	To be presented 29th November 2013
Date to Cleveland LRF Chief Officer Group	To be presented 17th September 2013
Circulation	All members of the LHRP and LRFs. All Area Team on-call officers.
Review Period	Annually by the LHRP Health and Social Care Sub Group or sooner in response to changes in national guidance or organisational responsibilities.
Last Reviewed	Version 1
Exercise Period	TBC
Last Exercised	This plan is based on the NHS England's Heatwave Plan for England 2013 and Cold Weather Plan for England 2011.

1. Introduction

This plan has been produced by the NHS England's Durham Darlington and Tees Area Team (DDTAT) on behalf of the Local Health Resilience Forum (LHRP). It has been developed from the plan produced for Cleveland's Local Resilience Forum (LRF) by Sally Johnston (NHS England) in 2012. It is intended as the summer and winter plan for the Durham and Darlington LRF and Cleveland LRF.

The plan is informed through reference to the NHS England Heatwave Plan for 2013 and Cold Weather Plan for England 2011. References to levels are references to the trigger levels contained in those plans. This plan has been produced to provide a coordinated multi-agency response to the varying levels and does not therefore remove individual agency responsibilities to maintain their own plans in accordance with the national documents.

This plan should be read in conjunction with the LRF Escalation Plan attached at appendix A.

Changing weather patterns have had a significant impact on the way multi-agency partners plan and respond to adverse weather events. Pre planning has helped reduce the impact of past weather related incidents, but future planning will need to include working with environmentalists and engineers to look at climate change and the impact on matters from new builds to sea defences.

Utilisation of the Joint Strategic Needs Assessment identifies the health, environmental and social needs within communities and future planning requirements to create strong, safe and prosperous communities.

Summer and winter preparedness is a constant challenge with hot and wet summers to cold and icy winters. This document supports multi-agency working, and organisational internal arrangements to planning and response phases.

2. Summer preparedness

Climate change means heatwaves are likely to become more common in the UK. By the 2080s, it is predicted that an event similar to that experienced in France and Central Europe in 2003 will happen every year.

In Northern France in August 2003, unprecedented high day and night-time temperatures for a period of two weeks resulted in 15,000 excess deaths. The vast majority of these were among older people. Excess deaths are not just deaths of those who would have died anyway in the next few weeks or months due to illness or old age. The evidence is strong that these summer deaths are indeed 'extra' and the result of heat-related conditions.

England that year there were over 2,000 'excess deaths' over the 10-day heatwave period which lasted from 4–13 August 2003, compared to the previous five years over the same period. In 2006 we had a significant heatwave (when it was estimated that there were about 680 excess deaths compared to similar periods in previous years). In 2009 there were approximately 300 excess summer deaths during a heatwave compared to similar periods in previous years.

Certain types of environment may exacerbate the risk from extreme heat, such as accommodation in top floor flats, lack of air conditioning or work places producing heat, such as foundries and bakeries.

During extremely hot weather, there is a risk of developing heat exhaustion and heatstroke. Heatstroke can develop if the symptoms of heat exhaustion are left untreated. It can also occur suddenly and without warning. Heatstroke can result in organ failure, brain damage or death.

Groups at risk

There are certain groups that are particularly at risk during a heatwave.

These include:

- Older people, especially those over 75 years old and/or living on their own;
- Babies and young children, especially under four years old;
- People suffering from mental ill health, those with dementia, and those who rely on help from other people to manage day-to-day activities;
- People taking certain types of medication;
- People suffering from chronic ill health including heart conditions, diabetes, respiratory or renal insufficiency
- People with an already raised temperature from an infection;
- People using psychoactive drugs, including alcohol or illicit drugs;
- People who are bed-bound;
- People who have previously experienced problems in adapting to extreme heat.
- Individuals living in urban areas and south facing top floor flats
- Individuals who are homeless

Heat Health Alert Levels

Level 1 – Heatwave summer preparedness and long term planning

Summer preparedness runs from **1 June to 15 September** when a Level 1 alert will be issued. During the summer months, social and healthcare services need to ensure that awareness and background preparedness are maintained by implementing the measures set out in the Heatwave Plan. Long-term planning includes year-round joint working to reduce the impact of climate change and ensure maximum adaptation to reduce harm from heatwave. This involves influencing urban planning to keep housing, workplaces, transport systems and the built environment cool and energy efficient.

Level 2 – Heatwave is forecast - Alert and Readiness

This is triggered as soon as the Met Office forecasts that there is a 60% chance of temperatures being high enough on at least two consecutive days to have significant effects on health. This will normally occur 2-3 days before the event is expected. As death rates rise soon after temperatures increase, with many deaths occurring in the first two days, this is an important stage to ensure readiness and swift action to reduce harm from a potential heatwave.

Level 3 – Heatwave Action

This is triggered as soon as the Met Office confirms that threshold temperatures have been reached in any one National Severe Weather warning Service (NSWWS) region or more. This stage requires specific actions targeted at high-risk groups.

Level 4 – Major Incident - Emergency Response

This is reached when a heatwave is so severe or prolonged that its effects extend outside the health and social care systems including power and water shortages or where the integrity of the health and social care systems are threatened. At this level illness and death may occur among the fit and healthy, and not just in high risk groups this will require a multi-sector response at national and regional levels.

The decision to go to a Level 4 is made at national level and will be taken in light of a cross – Government assessment of the weather conditions, coordinated by the Civil Contingencies Secretariat (Cabinet Office).

3. Winter preparedness

In recent years winters have had significant periods of severe and sustained cold weather. Mortality rates rise by 19% in the winter months in England. This equates to an average of 27,000 'excess' winter deaths or about 1,560 more people per week dying between December and March compared with the rest of the year.

At-risk groups

Examples of sub-categories, as well as living conditions, and health conditions which may place people at risk:-

- Over 75 years old
- Frail
- Pre-existing cardiovascular or respiratory illnesses and other chronic medical conditions
- Severe mental illness
- Dementia
- Learning difficulties
- Arthritis, limited mobility or otherwise at risk of falls
- Young children
- Living in deprived circumstances
- Living in homes with mould
- Fuel poverty (needing to spend 10% or more of household income on heating home)
- Elderly people living on their own
- Homeless or people sleeping rough
- Other marginalised groups

Fuel Poverty

Affordable warmth is the ability to achieve sufficient warmth within the home. The lack of affordable warmth is known as 'fuel poverty'. A fuel poor household is one that cannot afford to keep adequately warm at reasonable cost. The most widely accepted definition is a household that needs to spend more than 10% of its income to heat the home to an adequate standard of warmth. A level of warmth consistent with health and wellbeing is 21°C in main living areas and 18°C in other areas for healthy adult households.

Importantly the definition focuses on what people need to spend rather than what they actually spend on heating. This is because fuel poor households have to balance the need for fuel and other essentials, so often cannot afford to heat their homes properly. Fuel poverty is clearly linked to general poverty and deprivation and is firmly associated with:

- low income and debt;
- poor household insulation and ventilation standards;
- inefficient or expensive heating systems;
- lack of access or availability of affordable fuel and/or tariff options;
- under-occupation of homes/ size of homes; and, householder behaviour.

In addition, other factors must be considered as contributing to fuel poverty. Certain households have a greater requirement for heat and hot water than the average household because they may be spending longer periods of time at home. This might include those households which include pensioners, those with long-term illnesses or disabilities, the unemployed and households with young children. These households tend to be on lower incomes, although not necessarily on benefit, and at the same time may have less access to capital to improve their situation through improvements to their homes or appliances. In terms of fuel poverty these households are deemed vulnerable and almost half of all households in the UK fall into this category.

The links between fuel poverty, poor housing and ill health are well established. Cold homes may exacerbate problems associated with cardiovascular illness and the onset of stroke or heart attacks, while damp and poorly ventilated homes are associated with a range of respiratory and allergic conditions such as bronchitis, pneumonia, asthma etc. Cold homes may also impact on conditions such as rheumatism or arthritis and may affect those people with poor mobility, thus increasing the risk of falls and other household Living in cold, damp and poorly ventilated homes is not only uncomfortable but may also be stressful in itself.

Accidents impact negatively on the mental health of householders. This may be compounded by anxiety about high bills, fuel debt or other fuel poverty related factors. The educational attainment of school age children may also be affected if they do not have a warm space to study and are forced to share general living space or need to take time off from school due to cold-related illnesses. Householders who are permanently sick or disabled and unable to work may require their heating to be on more than employed householders as they are likely to spend more time at home; this means their fuel bills will be higher while their incomes may be lower and thus these households are more likely to be in fuel poverty.

Prevention

There are ways to reduce winter deaths by raising public awareness and triggering actions in the NHS, Social Care and other community organisations to support vulnerable people who have health, housing or economic circumstances that increase their risk; working with multi-agency partners to identify needs of individuals and communities to agree strategies and timely preventative measures to reduce harm and winter mortality.

These can include the following:

- Good communication campaigns around flu vaccinations
- Promotion and improved access to free, impartial and accurate energy efficiency advice, grants and discount schemes;
- Improving affordable warmth though income maximisation and money advice
- Improving health and well being

- Working towards energy efficient properties i.e. insulation of properties.
- Working with communities including support groups families and relatives to highlight individuals / vulnerabilities and work with them to reduce the impact.

Winter Planning

The Met Office's National Severe Weather Warning Service provides warning to relevant organisations about a range of high impact winter weather events, including heavy rain, heavy snow, strong winds, fog and widespread ice. This service operates all year round across the UK.

The Cold Weather Alert service enhances this by recognising the potential impact of cold weather on health and triggering a co-ordinated response. Depending on the severity, duration and geographical spread of severely cold weather conditions, a series of escalating alerts will be issued up to a major incident

This service will run in England from **1 November to 31 March.**

Severe cold weather and cold weather service alerts – definitions

Cold weather alerts are issued by the Met Office on basis of the following weather events:

- Low temperatures
- Widespread ice and
- Heavy snow.

Often low temperatures criteria are coincident with ice and/or snow. However, sometimes one event may occur without the other.

Definitions

Heavy snow–defined as snow falling at a rate of at least 2 cm per hour or more, expected for at least two hours. Geographic extent is not considered, and sometimes the event can be quite localised, but the Met Office will always try to indicate in the bulletin the areas that are affected.

Widespread ice–defined as when rain falls on to surfaces with temperatures at or below zero; or condensation occurs on surfaces at or below zero; or already wet surfaces fall to or below zero. The ice is usually clear and difficult to distinguish from a wet surface. It usually forms in sheets. Warnings are issued when any depth of ice is expected over a widespread area. Warnings will also be issued after snowfall, when compacted snow is expected to cause a risk of ice.

Widespread – indicates that icy surfaces will be found extensively over the area as defined in the Met Office bulletin. The Met Office issues all these alerts down to county level, so either of the warnings above could be issued even if only one county was likely to be affected.
The Met Office will issue alerts up to Cold Weather Alert Level 3, whilst a Level 4 alert would be issued following cross-Government consultation, in response to a particularly severe winter weather event.

The Cold Weather Alert levels

Level 1: Winter preparedness– Level 1 is in force throughout the winter from 1st November to 31st March, with the seasonal flu vaccination programme starting on 1 October.

Level 2: Alert and readiness– Level 2 is declared when the Met Office forecasts a 60% risk of severe winter weather in one or more defined geographical area in the days that follow. This usually occurs two to three days ahead of the event. A Level 2 alert would be issued when a mean temperature of 2°C is predicted for at least 48 hours, with 60% confidence, and/or widespread ice and heavy snow is forecast, with the same confidence.

Level 3: Severe weather action–a Level 3 alert is issued when the weather described in Level 2 actually occurs, It indicates that severe winter weather is now occurring, and is expected to impact on people's health and on Health Services.

Level 4: Major incident– a Level 4 alert indicates that many parts of the country are experiencing exceptionally severe winter weather and the conditions are affecting critical services. Such weather conditions are likely to have significant impacts not only on health, but also on other sectors and critical infrastructure. A cross-Governmental response may be required.

Appendix A

LEVEL 1- PREPARDNESS	ACTION Multi-agency partners	Communities	Individuals
	➢ Assurance that partners are delivering the following actions at Level 1 (LHRP) ➢ Register for Heat-Health Watch Alerts (All) ➢ Register for National Severe Weather Warning Service (All) ➢ Identifying vulnerabilities through Joint Strategic Needs Assessments (JSNA)(HWB) ➢ Identification of vulnerable landscape/environments (LA) ➢ Increase of green spaces within communities (LA) ➢ Consideration should be given to choice of location and structures on new builds and re-development. (LA) ➢ Work with private housing and landlords to promote energy efficient properties (LA) ➢ Develop multi-agency steering groups to deliver the climate change initiatives (LA) ➢ Working with Highways and Transport agencies to identify key transport networks/links to be maintained during severe weather (LA and HA) ➢ Identification of vulnerable individuals/communities (LA and LHRP)	➢ Working with community managers to develop a Community Action Plan to identify vulnerable neighbours during cold weather and heatwave, ensure that pavements and public walkways are cleared of snow and ice in the local community. This might include identifying local resources (snow clearing equipment and stocks of grit and salt) and rotas of willing volunteers to keep the community safe during inclement weather and to check on vulnerable or frail neighbours. ➢ Get in touch with other groups who will be holding workshops or directing members/clients to benefits advice. ➢ Communicate with communities on all issues via newsletter face to face community groups, Facebook, Twitter etc. ➢ Work with communities to maintain green spaces clear	➢ Insulate your home ➢ Identify cool areas ➢ Get your flu jabs ➢ Check your entitlements to benefits and local grants ➢ Check on vulnerable neighbours

	➢ Working with at risk individuals' families, and communities to support and put in place protective measures.(LA and multi-agency partners) ➢ Supporting people and young children.(LA and multi-agency partners) ➢ Liaise with community and faith groups and voluntary organisations (LA) ➢ Develop and manage cross referral pathways with housing, health, social care, voluntary, benefits and money advice services. (LA/Health/multi-agency) ➢ Develop NEEP/escalation plans (LHRP and UCB) ➢ Pro-active communications education, winter warmth, heatwave advice (All) ➢ Cold weather alerts and health heat watch to be distributed (All) ➢ Working with partners and staff on risk reduction awareness, e.g. flu jabs, information and education (All)	of rubbish and debris	
LEVEL 2- ALERT & READINESS	➢ Pro-active communications ➢ Twice weekly surge conference calls ➢ Distributing of alerts to General Practice, Community and relevant parties ➢ Identification of vulnerable individuals ➢ Liaise with community leaders to assist with supporting vulnerable individuals/families within their communities	➢ Community leaders Identify vulnerable individuals/families ➢ Work with the identified vulnerable individuals/families to identify further needs or requirements ➢ Promote groups that can give advice or support to communities	➢ Stay tuned into the weather forecast and keep yourself stocked with food and medications ➢ Check ambient room temperatures ➢ Make sure that you get any benefits to which

	➢ Work with voluntary organisations to identify at risk ➢ Work with care homes and vulnerable person to maintain room temperatures ➢ Check vulnerable individuals have enough supplies of medication and food ➢ Weekly surge conference calls ➢ Maintain surge/escalation watch ➢ Refer to organisational Business Continuity Plans ➢ Consider the co-ordination of a virtual LRF via email or teleconference (LRF Manager/Coordinator)	➢ Communicate with communities on all issues via newsletter face to face community groups etc. ➢ Test community action plan	you are entitled ➢ If you have any concerns contact relevant agency ➢ Maintain contact with family and friends
LEVEL 3- SEVERE WEATHER ACTION	➢ Twice daily surge conference calls ➢ Refer to NEEP/Surge documentation ➢ Refer to organisational BCP ➢ Support community/primary care staff to maintain home visits ➢ Commission additional care and support ➢ Consideration to be given to phoning/contacting high risk vulnerable individuals/families on a daily basis ➢ Ensure care homes and vulnerable persons maintain room temperatures ➢ Distribution of DH advice/guidance to at risk groups (including nursing/residential homes, General practice and community staff ➢ LRF initiated SCG/TCG activated (LRF Chairs)	➢ Activate community action plan ➢ Work with the identified vulnerable individuals/families to identify further needs or requirements ➢ Communicate with communities on all issues via newsletter face to face community groups' social media etc. ➢ Promote know your neighbour ➢ Clear pathways ➢ Clear urban areas of rubbish ➢ Report any concerns to relevant partner agencies	➢ Clear pavements ➢ Set daytime room temperature to 21°C ➢ Set bedroom night-time temperature to at least 18°C ➢ Stay tuned into the weather forecast and keep yourself stocked with food and medications ➢ Dress warmly, eat well ➢ Check those you know are at risk ➢ If you have any concerns contact relevant agencies ➢ Maintain contact with family and friends during exceptional weather
➢ LEVEL 4- MAJOR	➢ At this point a major Incident will be		

INCIDENT	declared locally, regionally, nationally or internationally. ➢ All existing emergency policies and procedures will apply. ➢ Recovery working group established ➢ Individual organisations operation rooms established 24/7 ➢ LRF initiated SCG/TCG activated (LRF Chairs)		

Key

- LHRP – Local Health Resilience Partnership
- HWB – Health and Wellbeing Boards
- LA – Local Authority
- HA – Highways Agency
- All – all member organisations of the LRF irrespective of category responder status
- UCB – Urgent Care Boards

4. Governance and Monitoring

- The LHRP will provide overall governance for the ownership of this document.
- The LHRP's Health and Social Care Sub Group will have responsibility to obtain assurance from its members that health actions required at Level 1 are being undertaken and there is evidence to support this.
- The relevant LRF manager/coordinators will be responsible for assurance from its members outside of the LHRP that actions are being completed.
- Exception reporting will be made to the LHRP or if urgent outside of the scheduled meeting, to the Co-Chairs.
- It is anticipated that at levels higher than 1, monitoring of the relevant actions will be undertaken through the LRF establishing a coordinating group, therefore no specific owners of actions have been given to levels above 1.

Trigger	Level	Action	Communication	Command and control	Impact	Implications?
• What needs to have happened (actual), or be about to happen (prospective trigger)? • Are these internal organisational triggers, or multi agency	• Description of what is happening in the organisation	• What will be done to mitigate the raised level of pressure as a result of moving to this level? • Who by? When? Where?	• What will be communicated internally and externally? • Who by? When?	• What command and control arrangements will be in place? • Who has the authority and responsibility to trigger? • When and where will it be triggered? • Are these different in hours and out of hours?	• Expected impact of these actions	• Any implications of these actions on other organisations
Level 1 Cold Weather/Heatwave Plan (Green) - Planning	Level 1 Normal Operations	• Normal operations • Develop, exercise and review plans • Identify vulnerable services • Identify vulnerable individuals • Work with LRF partners to produce strategies that will prevent escalation • Work with communities to prepare • Weather warnings to be communicated to	• Cascade and test plans internally and externally • Share plans with LRF partners • Proactive use of websites and media to prepare the public for emergencies	• Normal management arrangements	• Minimal	• Co-ordinate plans with LRF Partners

		relevant partners				
• Increased activity within health & social care in accordance with NEEP plans • Critical care bed level 3 • Increased level of 999 emergency calls • Increase in hill /shrub fires • Loss of staff 10% • Severe weather for less than 7 days • National direction • Level 2 (Yellow) National Heatwave Plan • Level 2 National Cold Weather Plan	Level 2 Concern	• Monitor situation • Consider co-ordinating an LRF virtual group via email or teleconference • Consider co-ordinating an LRF media group • Agree sit rep reporting and updating to LRF • Area Team to monitor health impact • Communicate severe weather warnings to all stakeholders • Organisations monitor escalation plans • Work with community leaders	• Any available intelligence to be shared with multi-agency partners and stakeholders. • Warn & inform the public	• Command and control arrangements as per organisational procedures • Command and control arrangements as per organisation NEEP • Pro-active communication with partners to highlight potential impacts • LRF chair/manager/co-ordinator to consider co-ordinating an LRF virtual group via multi agency command and control in and out of hours • Individual agency Incident Command Centres on standby	• Organisations able to escalate as appropriate	• Multi agency liaison

• Loss of staff 20% • Significant activity within health & social care in accordance with NEEP Plans • ACCEP3 • Significant increase in emergency calls and requests for assistance • Deterioration in weather conditions/severe weather for a 7 day period onward • Road closures, Highways Agency experiencing severe number of call outs to assist stranded motorists • Gritting taking place only on Priority roads • Community/village isolation • Utilities failure for a period>24rs • Closure of schools and education facilities • Level 3 (Amber) National Cold Weather Plan • Level 3 (Amber) National Heatwave Plan	Level 3 Response	• Individual agency Incident Command Centres established • Multi agency Tactical Coordination Group established • Consider the activation of a Strategic Coordinating Group (SCG) • Request for mutual aid assistance • Respond/liaise with vulnerable persons • Respond/liaise with vulnerable sites and communities • Work with and support partner agencies • LRF Media Cell established	• Any escalation to LRF will be confirmed by LRF chair / manager/co-ordinator • Warn & inform the public • Coordinated media messaging	• Individual agency Incident Command Centres to be established 24/7 • Command and control arrangements as per organisational procedures • Command and control arrangements as per NEEP • Pro-active communication with partners to highlight potential impacts • LRF chair/manager/co-ordinator to establish an LRF virtual group via multi agency command and control in and out of hours • Liaison to take place with Government via Resilience and Emergencies Division of DCLG reference expectation/direction	• Command and control arrangements established 24/7	• Multi-agency command & control considered

• Loss of staff up to 35% Main arterial routes severely disrupted • Severe weather for more than 7 days • Critical Care Level 4 • Durham Tees Valley Airport affected for more than 7 days • East coast main line severely affected for more than 7 days • Shortage of salt/grit supplies • Water shortage • National strategy that impacts on animal deaths • Large sporting/music events cancelled due to extreme weather • LRF identifies need for multi-agency local command and control to • Ability to respond to vulnerable person/sites/communities restricted • *Level 3 (Amber)National Cold Weather Plan* • *Declaration of National Emergency*	Level 4 Severe Pressure	• Tactical command and control established/operational • Individual agency Incident Command Centres established • Individual agency Incident Command Centres established • LRF Command and control operational • Consider the activation of a Strategic Coordinating Group (SCG) • Request for mutual aid assistance • Responding to vulnerable persons • Responding to vulnerable sites and communities	• Escalation will be co-ordinated by LRF/SCG chair/Manager/co-ordinator • Warn & inform • Coordinated media messaging	• Individual agency Incident Command Centres to be established 24/7 • LRF consider 24/7 operation of TCG and SCG • Liaison to take place with Government via Resilience and Emergencies Division of DCLG reference expectation/direction	• Command and control arrangements established 24/7	• Multi-agency command & control

• Extreme activity within health & social care having a critical impact on the region/national capacity • Critical Care Level 5 • Staff shortage>50% • Main arterial routes closed as a result of adverse weather • East coast main line closed as a result of adverse weather • No salt/grit • Impact of utility failure >48hrs resulting in potential death or injury • Water shortage resulting in potential death injury or severe health consequence • Mass fatalities • National infrastructure implications • Level4 (Red – Emergency) National Heatwave Plan • Level 4 – (Red) • National Cold Weather	Level 5 Emergency Response	• SCG established • Recovery working group established • Individual organisations operation rooms operating 24/7 • Priorities identified and co-ordinated • SCG to co-ordinate sitreps to regional and national departments	• Escalation will be co-ordinated by LRF/SCG chair/manager/co-ordinator • Warn & inform the public • Coordinated media messaging	• Individual agency Incident Command Centres to be established 24/7 • TCG operational 24/7 • SCG consideration of 24/7 operation • SCC could be operational 24/7	Multi-agency Command and control arrangements established 24/7	• Multi-agency command & control
• National service failure • All service provision disrupted • Actual demand overwhelming available capacity • Catastrophic infrastructure failure	Level 6 Service Failure	• National response • COBR co-ordinating • Regional co-ordination • Local co-ordination	• National communication strategy • Coordinated media messaging	• SCC operational 24/7 • SCG operational 24/7 • TCG operational 24/7	• National Command and control arrangements 24/7	• National Command and control arrangements 24/7 • International Command and Control

HEALTH AND WELLBEING BOARD

28 October 2013

HARTLEPOOL BOROUGH COUNCIL

Report of: Audit and Governance Committee

Subject: REFERRAL TO THE AUDIT AND GOVERNANCE COMMITTEE - AUTISM

1. PURPOSE OF REPORT

1.1 To inform Members of the outcome of the Audit and Governance Committee's discussions and decision in relation to the referral from the Health and Wellbeing Board.

2. BACKGROUND

2.1 The Health and Wellbeing Board, at its meeting on the 5 August 2013, approved the Tees Autism Strategy and during the course of the meeting discussed a variety of issues in relation to the diagnosis and treatment of autism. The Board, as part of its discussions, was of the view that the issue would be appropriate for further consideration through the Scrutiny process and made a formal referral to the Audit and Governance Committee, for inclusion in its work programme.

2.2 A summary of the issues raised for consideration as part of the referral is provided below:-

(i) The focus of the Tees Autism Strategy (i.e. Adults) and how it relates to children, including their transition at the age of 14 – 25;

(ii) The Social implications of autism in terms of impact on families and financial implications;

(iii) The need to address issues associated with autism in childhood; and

(iv) The importance of:

- Raising awareness of the wide ranging nature, and complexity, of autism and the very skilled nature of the management of the condition; and

- The provision of training to the wider community.

2.3 The Audit and Governance Committee at its meeting on the 20 September 2013, considered the content of the referral. In doing so, the Committee noted that the Tees Valley Autism Strategy had been developed in conjunction with those diagnosed as being on the autistic spectrum, their families, service providers (both in the health and voluntary sectors) on a "you said, we did" basis. This had resulted in the development of a strategy that is fully responsive to service users needs.

2.4 In light of the information provided, and the only recent implementation of the Strategy, concern was expressed concern that the referral lacked significant detail to enable an effective scrutiny investigation to be undertaken, and as such an investigation would at this time add little to the excellent piece of work already undertaken in the formulation of the strategy. In addition, the following points were raised;

i) Given the complexity of the issue, other bodies would be much better placed to explore and define gaps in services, and address them.

ii) Time and effort would be more appropriately applied to the implementation, and monitoring, of the recently approved Strategy.

2.5 The Committee discussed the referral in detail, including the constitutional requirement for consideration of such referrals, and after careful consideration, concluded that there was insufficient scope for an investigation at this time (on the grounds outlined at 2.4 above). On this basis, the Health and Wellbeing Board is asked to note that its referral has not been accepted for scrutiny by the Audit and Governance Committee.

2.6 In taking this decision, Members emphasised their full support and appreciation of the extreme complexity of the issue and wished to make clear that this decision does not seek to undermine or devalue the importance of providing effective diagnosis and treatment services for those with autism.

3. RECOMMENDATIONS

3.1 That the Health and Wellbeing Board note the Audit and Governance Committee's decision in respect of this particular referral..

4. REASONS FOR RECOMMENDATIONS

4.1 The Committee concluded that there is insufficient scope for an investigation at this time, on the grounds outlined at 2.4 of the report.

5. BACKGROUND PAPERS

i) Minutes of the Health and Wellbeing Board held on the 5 August 2013; and

ii) Report and minutes of the Audit and Governance Committee held on the 20 September 2013

6. CONTACT OFFICER

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HEALTH AND WELLBEING BOARD

Monday 28th October 2013

Report of: Children's Services Committee

Subject: Referral from Children's Services Committee regarding Speech and Language Therapy.

1. PURPOSE OF REPORT

1.1 The purpose of this report is to inform the Health and Well Being Board of a referral of an issue from the Children's Services Committee regarding Speech and Language Therapy Services.

2. BACKGROUND

2.1 The Children's Services Committee wish to refer an item for consideration to the Health and Well Being Board regarding the implications of the Early Intervention Grant Funding no longer being available for speech and language therapy services.

3. Referral

3.1 Speech and language services are commissioned through the early intervention grant in addition to services currently delivered by North Tees and Hartlepool NHS Foundation Trust. The purpose of this additional service was in recognition of the importance of speech and language to early childhood development and to provide an early intervention service for children with speech and language difficulties who did not yet meet the criteria for health provision. In addition, the intention of commissioning these services was to support the skills development of the family support workers to understand the importance of speech and language, to recognise any problems at the earliest stage and have the skills to promote the speech, language and communication of young children. This workforce development has been implemented over the past 18 months. It is proposed that this contract is not extended beyond March 2014 and that the locality teams work closely with the Foundation Trust to continue to maximise health speech and language services and deliver preventative work through family support workers. Not extending this contract will create a saving of £120,000

4. RECOMMENDATIONS

4.1 The Health and Well Being Board is asked to consider the implications of this speech and language therapy service no longer being commissioned and how this impact can be mitigated.

5. REASONS FOR RECOMMENDATIONS

5.1 Referral request from Children's Services Policy Committee.

6. BACKGROUND PAPERS

6.1 Children's Services Committee 01 October 2013 Savings Proposals for Early Intervention Services

7. CONTACT OFFICER

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