Hartlepool
Borough Council

Adult Services and Public Health Committee

Agenda

5 March 2026

Time: 5pm

Location: Council Chamber

Members: Adult Services and Public Health Committee

Councillors Allen (C), Boddy, Cook, Doyle, Hall, Little, Roy (VCh)

Parish Councillor Representative (s):

S Gaiety (Headland Parish Council)

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1. Apologies for absence

2. To receive any declarations of interest by members

3. Minutes

3.1 To receive the Minutes and Decision Record in respect of the meeting held on 22 January 2026 (previously published and circulated).

4. Budget And Policy Framework Items

4.1 None.

CIVIC CENTRE EVACUATION AND ASSEMBLY PROCEDURE
In the event of a fire alarm or a bomb alarm, please leave by the nearest emergency exit as directed by Council Officers. A Fire Alarm is a continuous ringing. A Bomb Alarm is a continuous tone. The Assembly Point for everyone is Victory Square by the Cenotaph. If the meeting has to be evacuated, please proceed to the Assembly Point so that you can be safely accounted for.jo

5. Key Decisions

5.1 Adult Social Care Charging Policy – *Executive Director of Adult Services and Public Health*

5.2 Domestic Abuse Strategy 2026-2029 – *Director of Public Health*

6. Other Items Requiring Decision

6.1 Patient Group Directions Policy – *Director of Public Health*

7. Items for information

7.1 Suicide Prevention and Mental Health Update – *Director of Public Health*

8. Any other business which the chair considers urgent

For Information

Date of next meeting –to be confirmed

Hartlepool Borough Council

Adult Services and Public Health Committee

5 March 2026

Report of: Executive Director of Adult Services and Public Health

Subject: ADULT SOCIAL CARE CHARGING POLICY

Decision Type: Key Decision - ACBS 115/26

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1. Council Plan Priority

Hartlepool will be a place:
where people live healthier, safe and independent lives. (People)

2. Purpose of Report

2.1. The purpose of this report is to seek approval from the Adult Services and Public Health Committee for a new Adult Social Care Charging Policy, following public consultation.

3. Background

3.1. A Council's Adult Social Care Charging Policy outlines how they will charge for care and support, ensuring that charges are fair and based on a financial assessment

3.2. The aims of a Charging Policy that is applied consistently to everyone with eligible adult social care needs are to ensure that people are not charged more than they can afford, and to ensure that the process is transparent and equitable.

4. Proposals

4.1. As reported to Adult Services and Public Health Committee in December 2025, an externally commissioned review, utilising national and regional benchmarking information proposed three proposed amendments to adult social care charging arrangements which would make charging more equitable while also generating additional income.

4.2. The proposed changes that were supported in December 2025 were:

- Implementing an automatic inflationary uplift in line with published pension and benefit rises and CPI for private income. This means that all contributions will be increased automatically from April each year rather than the current approach which applies an increase at the point of a person's annual review. This is a more equitable approach and will reduce transactions once implemented.

- Removing the disregard for the overnight element of higher rate Attendance Allowance / Personal Independence Payment. This element of benefit is currently disregarded in the financial assessment process in Hartlepool, but other Councils have implemented a different approach which increases income. The fees and charges work estimated that 559 Hartlepool residents would be affected and that their contribution would increase by up to £36.50 per week.

- Introducing fees for people for whom the Council acts as appointee to offset the costs of providing this service, which is very labour intensive. It is proposed that there will be two levels of fee based on light touch assessment (£55 per month) and comprehensive assessment (£85 per month). These fees are in line with the major national provider of appointeeship support Money Care, a social enterprise working with over 100 Local Authorities and a national partner of the Department of Work and Pensions. Aligning fees in this way ensures a fair and equitable approach and avoids a two-tier fee structure. The proposed future model is that Money Care will support the majority of Hartlepool residents who require an appointee, with the Council maintaining an offer for some existing people and those who have particularly complex needs. A pilot directing new referrals to Money Care will commence in January 2026 prior to the changes being implemented from April 2026 to test the approach and ensure a smooth transition.

4.3. A new Adult Social Care Charging Policy incorporating these changes is attached as **Appendix 1**.

5. Other Considerations/Implications

Risk Implications	There is a risk of increased appeals regarding the outcomes of financial assessments. A Financial Risk Panel has been established within Adult Social Care which will consider and respond to appeals.
Financial Considerations	The changes that are incorporated within the new Adult Social Care Charging Policy are expected to generate additional income of £164k in 2026/27 and a further £64k in 2027/28 which will contribute to delivery of the Council's Medium Term Financial Strategy. The proposed charges for 2026/27 are attached as **Appendix 2**. The schedule of charges will be updated on an annual basis.
Subsidy Control	Not applicable.
Legal Considerations	Sections 14 and 17 of the Care Act 2014 provide the legal framework for charging for adult social care and support. Section 14 of the Act provides a local authority with the power to charge for meeting needs under sections 18 to 20 of the Act. Section 17 of the Act creates a duty for a local authority to carry out a financial assessment which would arise where the local authority thinks that if it were to meet an adult's needs for care and support, or a carer's needs for support, it would charge the adult or carer under section 14(1) of the Act. The Care and Support Charging and Assessment of Resources Regulations 2014 describe the limitations on local authority powers to make a charge for meeting needs under section 14 of the Act; and provide details about the requirements for carrying out financial assessments for the purposes of section 17 of the Act. Section 2(1) of the Act requires a local authority to provide or arrange for the provision of services, facilities or resources (or take other steps) which it considers will contribute towards preventing, delaying or reducing the needs for care and support of adults or for support in relation to carers. The Care and Support Preventing Needs for Care and Support Regulations 2014 describe the rules permitting and prohibiting a local authority from

	making a charge for the provision of services, facilities and resources under section 2 of the Act. The Care and Support Statutory Guidance, issued by the Department of Health in October 2014 and updated in June 2020 sets out how a local authority should perform its care and support responsibilities. This includes details about interpreting and applying the rules relating to charging and financial assessments as defined in both the Act and regulations. The Adult Social Care Charging Policy has been written in accordance with the Care and Support Statutory Guidance and related primary and secondary legislation. The policy will need to be revised from time to time to take into account any provisions of the Care Act 2014 that are brought into force; any new statutory instruments and any amending or repealing legislation.
Single Impact Assessment	A Single Impact Assessment has been completed and is attached as **Appendix 3**.
Staff Considerations	None
Asset Management Considerations	None
Environment, Sustainability and Climate Change Considerations	None
Consultation	A public consultation has been undertaken through the Your Say platform, with paper copies available in public buildings. The consultation was open for eight weeks from 15 December 2025 to 9 February 2026. The consultation document and consultation questions are attached as **Appendix 4**. The online consultation page was viewed by 145 unique visitors and the supporting document was downloaded 34 times. 44 people went on to complete the survey. Of those who completed the survey 3 people had social care needs and currently contributed towards their care costs, while 22 respondents identified themselves as a carer or family member.

	87% of respondent felt that the proposed changes were easy to understand and 42% felt that they were fair. The proposal to increase charges annually linked to inflation and benefits rises was supported by most of those who responded, with less support shown for the proposal to introduce charges for people receiving support through appointeeship. Comments from people who did not feel that changes were fair related primarily to the fact that working people may be required to pay more with a number of people expressing a view that there should be no charges for social care services. A number of comments related to the benefits system as a whole and potential increases in Council Tax rather than focusing on the impact of changes to the Charging Policy. Some people were concerned that people would have less disposable income as a result of the changes, while others felt that it was fair for those who could afford to contribute to pay more.

6. Recommendations

6.1. It is recommended that the Adult Services and Public Health Committee approve the Adult Social Care Charging Policy.

7. Reasons for Recommendations

7.1. The new Adult Social Care Charging Policy provides a fair and equitable approach to charging for adult social care, within the relevant legal frameworks.

8. Background Papers

8.1. MEDIUM TERM FINANCIAL PLAN (MTFP) 2026/27 TO 2029/30 Report to Adult Services and Public Health Committee: 4 December 2025

9. Contact Officers

Jill Harrison
Executive Director of Adult Services and Public Health
jill.harrison@hartlepool.gov.uk

Sign Off:-

Chief Executive	Date: 09.02.2026
Director of Finance, IT and Digital	Date: 06.02.2026
Director of Legal, Governance and HR	Date: 09.02.2026

Hartlepool Borough Council
Adult Social Care Charging Policy

Contents

1. Introduction

1.1 Adult social care (unlike some health care) is not free. You are liable to pay all of your care costs unless you qualify for financial assistance. A financial assessment is completed to calculate how much you will need to contribute towards the cost of your care and support. If you choose not to have a financial assessment, you will pay the full cost of your care.

1.2 This policy explains how the Council will charge for care and support. If you are eligible for some support from the Council to meet your social care needs, you will be given a Personal Budget to arrange your support. You can take your Personal Budget in the following ways:

- as a Direct Payment (money paid to you or someone on your behalf for you to arrange care and support services that meet your needs)
- support arranged on your behalf by the Council; or
- as a mix of both (Direct Payment and arranged support).

1.3 This policy covers care and support in community settings and residential settings which includes nursing.

2. Policy Statement

2.1 The Care Act 2014 and all regulations issued under the Care Act 2014 provide a single legal framework for charging for care and support. This charging policy applies to all adult social care services and support provided by the Council.

2.2 The policy applies from 1 April 2026 and supersedes all previous adult social care charging policies and practice before this date and for the purpose of this policy; an adult is a person aged 18 and above who is eligible for a Personal Budget from the Council. In determining a charging policy that complies with the Care Act 2014 the Council must also have due regard to the Care and Support Statutory Guidance and Annexes issued under the Care Act 2014.

2.3 The policy covers:

- The legal and regulatory context for charging.
- How the Council will be as transparent and comprehensive as possible so people know what they need to pay towards their care and support and understand any contributions they are required to make.
- The different types of services and support that are charged for
- Promoting cost effective collection methods i.e. Direct Debit
- The financial assessment process, including the appeal process

- Applying charging rules so those with similar needs or services are treated the same way.

2.4 The key aims of the policy are:

- To ensure that where an adult is charged for care and support, that they are not charged more than is reasonably practicable for them to afford and pay.
- For the administration of the charging policy to be cost effective and sustainable for the
- Council so that it can continue to provide services for those needing care and support in the future.
- To promote wellbeing, social inclusion, and support the vision for personalisation, independence, choice and control.
- To encourage and enable those who wish to stay in or take up paid employment to do so.
- To support carers to look after their own health and wellbeing effectively and safely and recognising their valuable contribution to society.
- To be person- focused, reflecting the variety of care journeys and the variety of options available to meet people's needs.

3. The Legal and Regulatory Context for Charging

3.1 Sections 14 and 17 of the Care Act 2014 (as amended) provide the legal framework for charging for adult social care and support. Section 14 of the Act provides a local authority with the power to charge for meeting needs under sections 18 to 20 of the Act. Section 17 of the Act creates a duty for a local authority to carry out a financial assessment which would arise where the local authority thinks that if it were to meet an adult's needs for care and support, or a carer's needs for support, it would charge the adult or carer under section 14(1) of the Act.

3.2 The Care and Support Charging and Assessment of Resources Regulations 2014 describe the limitations on local authority powers to make a charge for meeting needs under section 14 of the Act; and provide details about the requirements for carrying out financial assessments for the purposes of section 17 of the Act. Section 2(1) of the Act requires a local authority to provide or arrange for the provision of services, facilities or resources (or take other steps) which it considers will contribute towards preventing, delaying or reducing the needs for care and support of adults or for support in relation to carers.

3.3 The Care and Support Preventing Needs for Care and Support Regulations 2014 describe the rules permitting and prohibiting a local authority from making a charge for the provision of services, facilities and

resources under section 2 of the Act. The 'Care and Support Statutory Guidance (CSSG), issued by the Department of Health in October 2014 and updated in June 2020 sets out how a local authority should perform its care and support responsibilities. This includes details about interpreting and applying the rules relating to charging and financial assessments as defined in both the Act and regulations.

3.4 This policy has been written in accordance with the CSSG and related primary and secondary legislation. The policy will need to be revised from time to time to take into account any provisions of the Care Act 2014 that are brought into force; any new statutory instruments and any amending or repealing legislation.

4. Chargeable and Non-Chargeable Services

4.1 The Council operates four categories:

1. Exempt services or care and support provided free of charge.
2. Mean tested charging and full cost service following a financial assessment.
3. Flat rate charges for services such as assistive technology.
4. Full cost charges for customers who do not wish to disclose their finances.

4.2 The Council is not allowed to charge for some types of care and support, and the following services are currently exempt from charging:

- Community equipment (aids and minor adaptations): where a person is supplied with equipment or a minor adaptation to their property to support daily living so they can stay in their home. An adaptation is minor if the cost is £1,000 or less.
- Reablement services can be provided to support people to become as independent as possible in their homes; this can be for one day up to a maximum period of six weeks. This could be after a stay in hospital, an illness or to prevent a hospital admission.
- Services provided to people suffering from Creutzfeldt Jakob Disease
- Any service or part of service which the NHS is under duty to provide. This includes Intermediate Care, Continuing Healthcare and the NHS contribution to Registered Nursing Care.
- Services which local authorities have a duty to provide through other legislation, including any specific services provided as After Care Services under Section 117 of the Mental Health Act 1983. There will be occasions when chargeable services are also provided to people who are subject to Section 117 of the Mental Health Act 1983. This is usually when a service is in place that is not specifically related to their Section 117 status. If this is the case the person will be advised of this

in writing, and a financial assessment will need to be undertaken in relation to such services.

5. Means Tested Financial Assessment

5.1 A financial assessment will be carried out for all care and support provided or arranged by the Council. The purpose of the financial assessment is to assess if a person can afford to pay towards the cost of their care or support; it is means tested.

5.2 The financial assessment looks at a person's financial situation to work out how much they will need to pay for their support. It takes into consideration income, benefits, property, savings, pensions and funeral plans, stocks, shares, bonds and any other income.

5.3 The financial assessment calculates how much, if anything, a person can afford to pay towards the cost of their care on a weekly basis. This amount is referred to as the maximum weekly assessed charge. Charges for support are payable from the date services start; not the date the financial assessment is completed. The Council will not charge more than the cost incurred in providing or arranging any care and support which is subject to means tested charging.

5.4 The technical rules for the financial assessment differ between care and support provided in a residential care setting (care home) and care and support provided in all other settings (non-residential). Assessments will be carried out in accordance with the Care and Support Statutory Guidance Chapter 8.

5.5 All documentary evidence requested by the Council to complete the financial assessment must be provided within 30 days of the request. The Council will only ask for documentary evidence that is necessary to complete the financial assessment accurately and comprehensively. Where evidence is requested but not provided the Council will pass on the full cost of the service. An assessment may also be based on notional income. This might include, for example, benefits that would be available on application which have not been applied for, income that is due but has not been received, or income that the person has deliberately deprived themselves of for the purpose of reducing the amount they are liable to pay for their care. People will be encouraged to use the Online Financial Assessment tool which will provide an indication of the amount they will contribute towards the cost of their care.

5.6 Financial assessments will be completed for people and as couples. Where capital is held and income is received on a joint basis, then it will

be assumed that each party is entitled to 50% of that capital / income. The same is assumed for assets such as second properties. The Council will review on a case-by-case basis where an individual states they can demonstrate their share is more or less of the asset and amend the assessment appropriately. The financial assessment will make sure a person (or both people, in the case of a couple) has money left after charges are applied for themselves in line with statutory amounts, this is known as Personal Expenditure Allowance (PEA) for care in a care home and Minimum Income Guarantee (MIG) for care at home. These amounts are set and reviewed annually by the Department of Health.

5.7 The financial assessment process will normally include a welfare benefits check to ensure the person is claiming all the benefits they are entitled to claim and the person (or their financial representatives) may be signposted to the Department for Work & Pensions (DWP).

5.8 Once the assessment has been completed, a written record will be provided to the person explaining how the assessment has been carried out, what the charge will be and how often it will be made. The Council will ensure that this is provided in a manner that the person can easily understand, in line with its duties on providing information and advice.

5.9 A review, or financial assessment may be requested by the person or their financial representative at any time. This may be where their circumstances have changed, or for people who are self-funding, if their total savings/capital has fallen to, or below the upper capital threshold, or where they have not previously had an assessment. The Council will also endeavour to carry out a full annual financial assessment review to help ensure that a person continues to be charged the correct amount for the services they receive.

5.10 At the start of each financial year, the assessment will automatically be updated for known changes in income, expenditure and allowances set annually by the Government This will include:

- Benefits
- State Pension
- Council Tax
- Disability-related expenses
- Changes in Minimum Income Guarantee or Personal Expense Allowances set by the Department of Health and Social Care.

The impact of these changes on assessed contributions will be clearly notified to customers in advance of new bills being issued.

6. Changes in Circumstances

6.1 It is the responsibility of the person receiving care and support or their representative to inform the Council of changes in their financial circumstances which might affect their contribution and to do so within 30 days of the change occurring.

6.2 Where a person fails to inform the local authority of changes, the Council reserves the right to apply any changes from the date of the change in circumstances rather than the date of reassessment.

7. Disability Related Expenses (DREs)

7.1 Disability related expenditure refers to the additional costs a person incurs due to their disability or illness; these expenses must be directly and solely attributable to the person's disability and may be offset against a person's charge.

7.2 The Care Act 2014 statutory guidance states that 'where a person receives benefits to meet their disability needs that do not meet the eligibility criteria for local authority care and support, the charging arrangements should ensure that they keep enough money to cover the cost of meeting these disability related costs'.

7.3 The Council recognises that people with a disability will have additional costs associated with their disability and in order to ensure that these costs can be met, we ask about the disability related expenses a person has when we carry out a financial assessment.

7.4 Where a person requests an allowance to be made for disability related expenditure, evidence must be provided in the form of receipts or bills. Where costs are on-going, the receipts or bills should be sufficient to show a pattern of spending.

7.5 The Council can include the following, but this list is not intended to be exhaustive, and any reasonable additional costs directly related to a person's disability may be considered:

- Payment for any community alarm system or telecare equipment
- Costs of any privately arranged care services required, including respite care
- Costs of any specialist items needed to meet the person's disability needs
- Day or night care which is not being arranged by the council or NHS
- Specialist washing powders and laundry
- Additional costs of special dietary needs due to illness or disability (the person may be asked for permission to approach their GP in cases of doubt)

- Special clothing or footwear, for example, where this needs to be specially made; or additional wear and tear to clothing and footwear caused by disability
- Additional costs of bedding, for example, because of incontinence
- Any heating costs, or metered costs of water, above the average levels for the area and housing type effected by age, medical condition or disability
- Reasonable costs of basic garden maintenance, cleaning, or domestic help, if necessitated by the individual's disability and not met by social care
- Purchase, maintenance, and repair of disability-related equipment, including equipment or transport needed to enter or remain in work; this may include IT where necessitated by the disability; reasonable hire costs of equipment may be included, if due to waiting for supply of equipment from the council
- Personal assistance costs, including any household or other necessary costs arising for the person if not met by social care
- Transport costs necessitated by illness or disability, if not being met by social care or NHS that are above the mobility component of Disability Living Allowance or Personal Independence Payment, if in payment and available for these costs. In some cases, it may be reasonable not to take account of claimed transport costs – if, for example the council provides transport to a day centre but this has not been used.

The care assessment and support plan provide a good starting point for considering necessary disability-related expenditure.

7.6 DRE is considered when the person is in receipt of the care component of Disability Living Allowance, Personal Independence Payment (Care) or Attendance Allowance. Disability benefits are designed to cover daily living expenditure so deductions for DRE will only be confirmed where costs are met entirely by the adult, exceed 'normal' cost of living expenses and specifically result from the person's disability.

7.7 Disability Related Expenditure is calculated based on evidence of relevant spending, and local information, for example typical heating costs for different types of housing or regional area costs, and local costs for domestic help.

The following items may be considered everyday living expenses or lifestyle choices (this list is not exhaustive):

- Food and beverages
- Clothing/shoes
- Accommodation costs such as rent, mortgage and maintenance
- Accommodation related costs such as buildings / contents insurance
- Fuel type / provider and water provider
- Furniture and flooring (including carpets)

- Household appliances
- Household textiles, cutlery, crockery and cooking utensils
- Personal transportation costs (fuel / tax / insurance / servicing)
- Entertainment and media (e.g. TV, phone, internet and streaming services, computer or gaming hardware and software).
- Domestic pet expenses
- Short breaks and holidays.

7.8 DRE exceptions may be made to avoid severe financial hardship or to prevent (or minimise the risk of) harm to the adult or their carer.

7.9 If an individual does not agree with the DRE amount calculated, an appeal can be made in writing to their Finance Officer, requesting a review and explaining why the amount is incorrect (providing evidence if appropriate).

8. Light Touch Financial Assessment

8.1 In some circumstances, the Council may decide that a full financial assessment is not necessary or appropriate and will undertake a light touch financial assessment. This will apply:

1. If a person does not wish, or refuses, to disclose financial information.
2. If a person says they have significant financial resources and / or savings above the limit of £23,250 and do not wish to go through a full financial assessment for personal reasons.

8.2 In circumstances where the person has refused a financial assessment but is eligible for care services the Council will assume the person can meet the full cost of the support needed and will pass on the full charge accordingly. The Council will inform the person that they will have to pay the full cost of any support service and confirm what that cost will be.

8.3 In circumstances where the person states they have sufficient financial resources to meet the cost of their support the Council will advise the person to take independent financial advice regarding their options for meeting the cost of their care and support.

8.4 The Council will inform a person when a light-touch assessment has taken place and will make clear that the person has the right to request a full financial assessment.

9. Self-Funders

9.1 A person who has sufficient income and/or savings and assets to meet the full cost of their care and support is required to do so is designated as a

self-funder. The Council will also treat a person as a self-funder if they choose not to disclose their financial information to enable a full financial assessment to take place.

9.2 Self-funders will be advised to seek care and support themselves and negotiate directly with their chosen care provider. Information is available at www.HartlepoolNow.co.uk regarding the support options available.

9.3 Self-funders who require residential or nursing care and own their own home may be eligible for assistance through a Deferred Payment Agreement. Further information can be found in Section 15.

10. Support Services in the Community

10.1 The Council will charge for care and support delivered in community settings up to an agreed maximum weekly amount set by the Council and uplifted in April each year.

10.2 Community settings include a person's home or a community facility such as a day centre. The person's home includes tenancies within Extra Care, Supported Living and Shared Lives accommodation. All non- residential community-based support services and transport fall within the scope of this policy including:

- Personal care support delivered to the person in their home.
- Sitting Services
- Day services and activities, both building based and in the community.
- Transport, including, but not exclusively, to day services and activities.
- Respite breaks that are not in a residential care home setting
- Daily living support such as shopping, laundry and cleaning delivered to the person living at home.
- Joint funded services – people in receipt of services will be required to contribute towards the cost of the services provided by the Council but not those provided by the NHS as part of a joint package of support.
- Other - Meals in day centres are not included within charging for care services in the community. A charge will be made by the day centre for meals on a 'Pay as you use' basis as meals are not included in the unit cost of a day centre session unless otherwise stated. This ensures people only pay for the activity and support provided at the centre.

10.2 Should the person receive more than one service, charges will be calculated up to the maximum assessed charge and listed on the same statement for ease and efficiency.

10.3 Assistive Technology: The Council offers an assistive technology service to help people to live independently in their own home. The service can

provide access to a 24-hour monitoring service offering a timely response at the touch of a button from anywhere in your home.

For people who receive the assistive technology service following an assessment and as part of their support plan, this will be covered in the contribution that's confirmed following their financial assessment. If a person uses the telecare service as a standalone service there is a fixed fee depending on the package taken.

10.4 Shared Lives: This is a scheme (similar to fostering) where adults with support needs can live with a family who provide board, lodgings and support. The Shared Lives recipient is responsible for making payments in respect of board and lodgings directly to the accommodation provider, they may be able to get help with the lodgings element through the Housing Benefit system. The Shared Lives recipient will be financially assessed for the cost of the placement (care and support element).

11. Residential / Nursing Care

11.1 As with support delivered within t he community the Council will charge for support provided in a residential /nursing home. Where the Council carries out a financial assessment for care and support provided in a residential setting, information and advice will be provided to enable the person to identify how best to pay their charge. This may include offering the person a Deferred Payment Agreement. The financial assessment will take account of the person's property, income and savings.

11.2 The Council can only pay towards the cost of residential / nursing care once a person has been assessed as having eligible needs that mean moving into residential / nursing care is the best option for them. If the person needs nursing care as part of their support within a residential home, the nursing element of care will be paid for by the NHS and is excluded from the Council's charges.

11.3 If a person arranges to move into a residential home without having an assessment by the Council, and later asks for financial help with charges, the Council will determine whether the person meets the national eligibility criteria for social care support. If the person does meet the criteria, the Council will carry out a social care assessment and a financial assessment to establish whether financial support can be provided. If the outcome is that the person is eligible for financial support in residential care, the Council will contribute towards the cost of care from the date the financial assessment is completed and not from the date the person chose to move into the residential home.

11.4 For people who have funded their own care and support within a residential home whose financial resources have reached the threshold for support, the Council will consider contracting from the date a referral is made, subject to a completed financial assessment being received within the relevant timescales including any evidence required. The Council will not backdate contributions to a person's care costs to the date they entered the residential home or the date their capital dropped below the capital threshold if a referral is not made to the Council before this date.

11.5 If a person cannot afford their chosen residential home and does not qualify for help from the Council, or for a Deferred Payment Agreement, the person will need to seek alternative arrangements such as moving to a residential home that is affordable. If customers are paying for their own care, the Council strongly advises seeking independent financial advice to ensure that customers will be able to afford the care they choose for the foreseeable future.

12. Choice of Accommodation

12.1 Where the care planning process has determined that a person's needs are best met in a care home, Hartlepool Borough Council will provide for the person's preferred choice of accommodation, subject to certain conditions. This also extends to shared lives, supported living and extra care housing settings.

12.2 The Council will ensure that at least one option is available and affordable within a person's personal budget whenever possible. A person may be able to choose a more expensive setting, in which case a third party top-up will apply.

13. Invoicing and Payments

13.1 The Council's preferred method of payment is Direct Debit. Alternatively, people will receive a bill every four weeks with details of how to pay.

13.2 Where the person requires an Appointeeship or Court of Protection Deputyship and it is not in place at the time they enter the residential care home the Council will pay the care home on a temporary basis to allow the Appointeeship or Deputyship to be granted. The payments will be accrued for the appointee or deputy to repay back to the Council in full within 28 days of them being granted.

13.3 The Council reserves the right to take legal action where the Court of Protection Deputyship or Appointeeship has not been granted in a

reasonable period of time and it appears unreasonable delay is the cause. (e.g. a Deputyship not being granted due to non-compliance by the person/representative not applying for the order). In these circumstances the Council will refer to the relevant body to appoint an alternative person to manage the customer's property and financial affairs. The Council requires documentary evidence of these Appointeeship and Court of Protection applications within the timescale outlined below to set up and maintain arrangements for payment of care fees:

- For Court of Protection: evidence must be provided within 3 months of the financial assessment being completed .
- For Appointeeships evidence must be provided within 6 weeks of the financial assessment being completed.
- Or within 30 days following any written request by the Council.

Failure to comply with the requirements of the Charging Policy will result in the Council withdrawing funding and seeking to recover the full outstanding amount through its debt recovery policy.

13.4 Where the Council is satisfied that an Appointeeship or Court of Protection application is in progress, the Council will, on a temporary basis, start paying the care fees to the care provider and will accrue these charges (for the person/representative to pay at a later point) whilst the application is being progressed. Once legal authority has been granted, the appointed person(s) will be responsible for repaying (in full) the accrued care fees, within the first 28 days following the date of appointment,

14. Administration Fees

14.1 The Council will charge an administration fee for work undertaken on behalf of people in certain circumstances for example managing Appointeeship, Direct Payments and in some cases supporting self-funders. An annual Schedule of Charges will be published to accompany the Council's Charging Policy.

15. Property and Deferred Payment Agreements (DPA)

15.1 Under the Care Act 2014 the Council can offer people a Deferred Payment Agreement (DPA) which enables a person people to pay their residential care charges and get the support they need without having to sell their home within their lifetime.

15.2 A Deferred Payment Agreement (DPA) is an interest-bearing secured loan that eligible self-funding people can apply for from the Council for the purpose of paying residential care costs. The loan is secured on the self-funder's house and the Council releases the loan by instalments on a

periodic basis, each instalment being the same sum as the residential care fees that are payable by the person (less any personal contribution that the council shall require to be made by the person).

15.3 The Council will charge the person for the costs of establishing and managing the DPA. The person can either pay for the administration costs when the costs are incurred or can ask for the costs to be added to the loan, meaning that the Council's costs along with the loan are recovered upon completion of the sale of the home. Interest will be charged on the costs during the term of the DPA if the costs are added to the loan.

15.4 Property owned by a person is included in the financial assessment. It will not be taken into account (disregarded) when a spouse or partner continues to live there after a person moves permanently into residential care. Where the property is included in the financial assessment, the Council will disregard its value for the first twelve weeks of a person's stay. This period is called the twelve- week property disregard period and gives people time to seek independent financial advice and consider the options available to them to fund their care and support costs. Providing a person and their property meets eligibility criteria, the person may be entitled to enter a DPA with the Council.

15.5 Where a person or their representative chooses not to enter a DPA, then after the 12-week disregard period, the full cost of care is charged, and invoices will be sent for payment every four weeks in arrears. Where full payment is not made and a debt accrues, the Council will pursue the debt under the Debt Recovery Policy.

15.6 Further information on how a Deferred Payment Agreement works and other options can be found at Deferred payments scheme | Hartlepool Borough Council.

16. Third Party 'Top ups'

16.1 In some cases, a person may choose a setting that is more expensive than the fees the Council has set for the care placement arranged on behalf of the person who is eligible for support from the Council. Where they have chosen a setting that costs more than this, an arrangement will need to be made as to how the difference will be met. This is known as a 'top-up' payment. If the person is part or fully funded by the Council, the 'top up' must be paid for by a third party i.e. not the person or the Council.

16.2 There are some circumstances where the resident may pay the top-up:

- where they benefit from a 12-week property disregard
- where they have a DPA.

- where a person is paying the full cost of their care.
- where they are receiving after care under section 117.

16.3 Where no choice of alternative accommodation exists for the customer at the time of the needs assessment the Council may be required (short term) to pay the top up costs. Where a choice does exist the 3rd party will be responsible for "top up" payments and must sign a top up agreement. (I.e. in the placement agreement). In absence of a 'top up agreement' the Council is not obliged to arrange care at a placement costing more than the personal budget. It may choose to do so for a limited period where additional time is required to make financial arrangements, but if such arrangements are not made within a reasonable period of time, the Council may make arrangements for alternative accommodation for the person that is affordable within the personal budget.

16.4 The Council must ensure that the third party is willing and able to meet the cost for the person's care and support. This includes ensuring the person has sufficient information and advice to understand the terms and conditions of the 'top up' agreement as the top up amount may change in the future. The Council should encourage the third-party payee to get independent financial advice before agreeing and entering a Third Party Top up Agreement.

16.5 In the event the 'top up' arrangements fail the Council must either pay the top up, re-negotiate the fees with the home or make alternative arrangements for the person's care and support needs. This may include moving the person to an alternative home that can meet the person's needs and is within the fees the Council has set. All parties including the provider will need to agree on the "top- up" prior to the person moving into the care home and sign the agreement.

17. Deprivation of Assets / Income

17.1 Deprivation of assets or income refers to a person reducing or trying to hide or deprive themselves of capital to avoid paying towards the cost of their care. Examples of this are signing property, investments, or assets over to relatives or giving large monetary gifts.

17.2 This can include placing a property in Trust; a legal device designed to hold assets on behalf of named beneficiaries. The law states that you must not place a property in trust to secure more financial assistance for adult social care. If the Council establishes that this is the case, the person will not qualify for financial assistance and will have to pay all the care home fees. If the person or their representative has been advised to place their savings or property in trust to protect their investments from

being used to pay care home fees, they may have been given incomplete advice.

17.3 The Council will decide whether to investigate to ascertain if deprivation of income or assets has occurred where there are indicators as noted above. Where the Council determines that someone has deliberately deprived themselves of an asset or income to reduce or avoid a charge for care and support, the Council will charge for services as though the person still owns the asset or income.

17.4 The Council will take legal action against the person, their representative or the third party where appropriate to recover money owed for charges. This is in line with national guidance. Financial assistance is strictly means -tested and therefore if the Council considers that you have placed your house (or any of your assets) in trust to avoid paying care fees, it will be decided that you have deprived yourself of your assets to take advantage of state financial assistance and you will not qualify for financial support.

18. Charging for Short Term / Respite Care

18.1 Short term / respite care will be charged using the non-residential standard care rate as per guidance for up to 8 weeks of care per annum. During periods of respite, the financial assessment will consider costs from the person's home, such as household bills. As with all social care costs, the charges will be based on the amount a person has been assessed as being able to pay. If a person has refused or opted out of a financial assessment, they will need to pay the full cost of their stay. Charges for respite will be based on a residential financial assessment.

19. Charging for Support to Carers

19.1 Where a carer has eligible support needs of their own that are not met through support arrangements for the cared-for person, the Council is required to undertake an assessment and to provide a Personal Budget for the carer. Under the Care Act the Council has the power to charge carers for support provided via a Personal Budget direct to the carer.

19.2 The Council recognises that informal or family carers are an invaluable source of support for many people. Through their support, carers indirectly save the Council significant money as without their care and support the Council would need to provide the support at a cost. The Council values the role of carers and for this reason does not financially assess or charge carers. Any change to this approach would require a policy update.

20. Charges for Services Not Received and Refunds

20.1 A key principle of the Council's Charging Policy is that, having carried out its duties to ensure charges for support are affordable and fair, payment should be made accordingly. Where planned care services are not used, or, in the case of home care, not cancelled in advance, the services will be deemed to be delivered in accordance with the person's support plan, and therefore subject to normal charging rules. What this means is that when services are cancelled with appropriate warning and the provider is given sufficient notice, the person won't be charged for the care service. As a Council, we only charge the cost we incur for services commissioned on behalf of a person, so if the cancellation is made at short notice, then the Council is still liable to pay the provider and therefore the customer will also be charged accordingly.

21. Debt Recovery

21.1 The Council is committed to providing value for money and ensuring services continue to be available for people who need them. To enable us to meet our legal and financial obligations, we maintain a robust debt recovery process. This means that, if necessary, we will use all measures available to recover charges as explained in this document.

21.2 The Council will work with all customers to help them to understand the charges and to make regular payments in line with their own financial assessment outcome. However, if payments for care are not forthcoming, legal proceedings will be instigated and all legal costs incurred by the Council will also be claimed from the person or their representative.

21.3 There are circumstances where the Council incurs costs that may be recovered from a person's estate if sufficient assets are available. This can include the cost of a Public Health Funeral (which the Council has a duty to provide if no suitable arrangements are being made by others), the cost of boarding pets (which the Council has a duty to arrange if a person is in hospital or residential care with no alternative arrangements in place) or the cost of managing a property until it's sold.

22. Direct Payments

22.1 When an individual chooses to take a direct payment, the person is paid the gross amount and invoiced for their maximum weekly assessed charge on a four-weekly basis in the same way as for managed services.

There are regular reviews of direct payments to ensure money is spent appropriately.

22.2 Where direct payments are being made and the person is not spending the direct payment for the appropriate purpose, the Council will take steps to recover any payments that have been inappropriately used. In these cases, a review of the care assessment and the financial assessment will also be undertaken. Where there is a build-up of money, over the maximum agreed amount, then steps will be taken to recover the excess funds, and a review will be requested to ensure that the same level of care continues to be required.

22.3 It may also be the case that an individual chooses to use a provider whose costs are more than the personal budget allows, whilst achieving the same results. Where this is the case, in order to enable the person to exercise choice and control, the Council would agree a reasonable amount from the personal budget toward the service with the individual able to contract with the provider of their choice and make up the difference from their own finances. In these circumstances the additional payments made by the individual would fall outside of this charging process.

23. Appeals Process

23.1 If an individual is unhappy with the outcome of their financial assessment, they must start the review and appeals process within 28 days of the notification letter. All appeals must be received in writing and must contain details of the grounds for the appeal, along with any relevant additional supporting evidence. Following receipt of an appeal request the Council will write and confirm next steps and whether any further information is required. All requests for further information from the customer will be required within 14 days of the request letter. The appeals process is described below:

Stage 1 – Review

At the review stage a Senior Finance Officer will review the issues raised and consider any new financial information provided. The Officer will also check to ensure the Charging Policy has been applied correctly. The outcome of the review should be confirmed to the person within 14 days or as soon as is reasonably practicable.

Stage 2 – Appeal

If the individual is still unhappy with their reviewed charge or personal contribution following Stage 1, an appeal can be requested within 28 days of the decision letter. At the appeal stage the case will be reviewed by a Team Manager within the service. The appeal process can take up to 28

days from the time the completed appeals form is received to the time the individual is informed of the outcome.

23.2 The outcome at each stage of the process is communicated to the individual who will continue to be charged the original assessed contribution during the review and appeal process. If, after the review and appeal, the Council asks the person to pay a different weekly contribution, the difference will be backdated and any overpaid contributions will be refunded. If an independent adjudicator makes a recommendation to waive the assessed charge, this will be ratified by a Senior Manager.

23.3 If, following the appeal process, the individual would like to make a formal complaint, information is available regarding the Council's Complaints Process and how to make a complaint to the Local Government and Social Care Ombudsman: Adult social care concerns and complaints - Public information - adult social care | Hartlepool Borough Council.

ADULT SOCIAL CARE CHARGING POLICY:

SCHEDULE OF CHARGES 2026/27

The table below sets out charges that will apply from April 2026 for people who are supported by the Council with a Deferred Payment Agreement, Appointeeship and Deputyship.

Further detail regarding when these charges apply, any exemptions and the services provided is available in the Adult Social Care Charging Policy.

Deferred Payment Agreement	Set Up Fee:	£250
	Annual Review:	£50
	Termination Fee:	£50
	Abortive Cost:	£50
	Interest charge:	4.25%
Appointeeship	Setup fee:	£150
	Community-based standard support:	£62.50/month
	Community-based comprehensive support:	£92.50/month
	Residential / Nursing care:	£55/month
	Additional banking costs:	£55/year
Deputyship	Practice Direction 19B- Fixed Costs and Deputy Remuneration in the Court of Protection (Correct as of 05/02/2026)	
	Setup fee:	£944
	Annual Management Fee (Year 1)	£982
	Annual Management Fee (Subsequent years):	£824
	Property Management:	£380
	Annual Report:	£274

All charges are reviewed on an annual basis and an updated Schedule of Charges will be published each year, and changes communicated to those affected.

Hartlepool Borough Council – Single Impact Assessment Form

5.1

Appendix 3

Guidance for completing this form is available in the "Single Impact Assessment: Toolkit for Officers", available from the Single Impact Assessment page on the intranet at https://hbcintranet/Pages/Single-Impact-Assessments.aspx.

Section 1 – Details of the proposed action being considered

1.1 Lead Department:	Adult Services and Public Health
1.2 Lead Division:	Adult Social Care

1.3 Revised Contribution Policy for Adult Social Care Services
Charging for adult social care services in England is primarily governed by the Care Act 2014 which sets out the legal basis for charging and financial assessments and Charging Regulations that define how local authorities assess what individuals should contribute toward their care. Guidance determines: **Capital Limits** that determine eligibility for financial support: • **Upper Capital Limit**: £23,250 — individuals above this must fully fund their care. • **Lower Capital Limit**: £14,250 — individuals below this pay only what they can afford from income. • **Between Limits**: A means-tested contribution, calculated as **£1 per week for every £250** of capital between the limits. **Personal Expenses Allowance (PEA)** • Applies to care home residents supported by local authorities. • Increased in line with inflation and ensures individuals retain a minimum amount for personal use. **Minimum Income Guarantee (MIG)** • Applies to those receiving care outside of care homes.

- Also increased in line with inflation and ensures individuals are left with a minimum income after charges.

Charging Principles

- Fairness, transparency, and accessibility are key.
- Local authorities must provide a written record of charging decisions.
- Only the person receiving care should be charged.
- Disability-related expenses and certain types of income/capital may be disregarded in assessments.

Local Discretion

- Local authorities can set higher capital limits or choose not to charge for certain services.
- Policies may vary by region and are set often following public consultation or local determination.

Disability-Related Expenses (DRE) are costs that arise specifically because of a person's disability. When a local authority conducts a financial assessment to determine how much someone should contribute toward their care, these expenses must be disregarded—meaning they are deducted from the person's income before calculating care charges.

Examples of Disability-Related Expenses: these can vary but commonly include:

- Extra heating or electricity costs due to medical needs
- Special dietary requirements
- Medical equipment or aids not provided by the NHS
- Transport costs related to disability (e.g., taxis to appointments)
- Additional laundry or cleaning costs
- Incontinence products
- Chiropody or podiatry services
- Special clothing or footwear
- Internet or phone costs if needed for safety or communication
- Care-related costs not covered by the care package (e.g., private carers)

Local authorities should consider all reasonable DREs that are necessary and not met by other services. Councils must leave individuals with enough income to meet their disability-related needs and cannot apply arbitrary limits to DREs.

1.4 Brief description of the proposed action:

Hartlepool Borough Council – Single Impact Assessment Form

Appendix 3

Hartlepool Borough Council is proposing to make changes to the Contribution Policy in three areas:

1. Implementing an automatic inflationary uplift in line with published pension and benefit rises and CPI for private income.
2. Removing the disregard for the overnight element of higher rate Attendance Allowance / Personal Independence Payment.
3. Introducing a fee for people that access the Council's appointeeship service.

These changes were recommended by an independent consultant engaged to review Fees and Charges across the Council, taking into account practices commonly used in other Local Authorities.

In relation to the first proposed change, there is no specific guidance on when inflationary uplifts are applied. Current practice in Hartlepool is to apply the uplift when the individual contribution is reviewed. It is more equitable to apply the uplift in April each year and this will also reduce transactions throughout the year by introducing an annual automated uplift.

In relation the second proposed change, there is no definitive guidance on disregards – this is for local determination as long as the approach taken is within the charging principles and ensures individuals are left with a minimum income after charges.

There is guidance on the administration and management of appointeeships, linked to the third proposed change, with the Department for Work and Pensions allowing councils to apply an administrative fee for managing the appointeeships, especially if it involves regular budgeting and bill payments, liaising with care providers and ensuring welfare needs are met.

Alongside introducing this administrative fee, it is also proposed that an element of work associated with appointeeships is outsourced to Money Care, a Crown Commercial Services approved supplier working with over 100 Local Authorities to provide this service. It is proposed that the Council's administrative fees are aligned with the fees of the private provider to ensure that there is equity for everyone who requires this service, regardless of who is providing it. This approach will also enable capacity within the User Property & Finance Team to focus on financial assessment, implementing a revised streamlined financial assessment service and transferring appointeeships to deputyships where required in line with DWP and OPG guidance.

A new Contribution Policy is being developed to reflect these changes and it is proposed that a 6-8 week consultation is undertaken on the Your Say, Our Future platform during December 2025 – February 2026 (dates to be confirmed). The revised Contribution Policy will then be presented to Adult Services & Public Health Committee in March 2026 for approval.

1.5 Who else is involved:

Member decision following public consultation via the Your Say Our Future platform.

1.6 Who will make the final decision about the proposed action:
Adult Services & Public Health Committee – March 2026

1.7 Which wards will be affected by the proposed action? Tick all that apply					
All wards	X	Hart	☐	Seaton	☐
Burn Valley	☐	Headland & Harbour	☐	Throston	☐
De Bruce	☐	Manor House	☐	Victoria	☐
Fens & Greatham	☐	Rossmere	☐	N/A - Internal council activities	☐
Foggy Furze	☐	Rural West	☐		

1.8 Completed By:		
Name	**Job Title**	**Date Completed**
Neil Harrison	Head of Safeguarding & Specialist Services	09/11/2025

Hartlepool Borough Council – Single Impact Assessment Form

1.9 Version	Author	Summary of Changes	Date
1.0	Neil Harrison	First Draft	09/11/2025

Section 2 – Explaining the impact of the proposed action

2.1 What data and evidence has informed this impact assessment?
The independent review of fees and charges commissioned by the Council identified that it is standard practice for most Councils to apply an annual inflationary uplift in April each year which ensures that the additional income is received for the full financial year. This annual uplift will reflect annual increases in benefits and benefits. As an example, the state pension has increased by an average of 4.05% per year over the last 10 years. The review also highlighted that 80% of the Councils they have worked with do not disregard the overnight element of higher rate Attendance Allowance / Personal Independence Payment. The review identified that there are currently 559 people in receipt of this benefit who receive adult social care support, with approximately 50% of those expected to pay a higher charge as a result of the proposed change. The increase would be subject to individual circumstances but could be up to £36.50 per week. Most Councils that provide an appointeeship service have an administrative charge in place to fully or partly recover the associated costs. Whilst there is guidance on some aspects of fees and administrative charges, administrative charges for appointeeship are locally determined and there is significant variation between charges between Local Authorities. Approximately 350 people currently receive an appointeeship service from adult social care.

2.2 If there are gaps in evidence or not enough information to assess the impact, how have you addressed this or how will you address it?	
Gap(s) Identified	**How it / they have or will be addressed**

No gaps identified.	N/A

2.3 Risk Score

Impact	Negative Impact Score	Explanation – what is the impact?
Age		
Negative Impact	Likelihood score: 2 Impact score: 2 Overall score:4	For older people on fixed incomes or benefits, the proposed changes may reduce disposable income, potentially affecting their ability to pay for essentials like food and utilities. Older people with cognitive impairments such as dementia are more likely to require support with their finances via appointeeship.
Disability		
Negative Impact	Likelihood score: 2 Impact score: 2 Overall score: 4	For people with disabilities on fixed incomes or benefits, the proposed changes may reduce disposable income, potentially affecting their ability to pay for essentials like food and utilities. People with cognitive disabilities are more likely to require support with their finances via appointeeship.
Gender Reassignment		
No Impact		No impact
Marriage and Civil Partnership		
No Impact		No impact. Marital status should not affect eligibility or the impact of proposed changes. Where one partner requires an appointee, there is an expectation that the other partner would

Impact	Negative Impact Score	Explanation – what is the impact?
		act in this capacity; the Local Authority should only be considered where there is no other suitable person able to take on the role.
Pregnancy and Maternity		
No Impact		No impact. The Contribution Policy will be applied consistently, regardless of pregnancy / maternity status.
Race (Ethnicity)		
No Impact		No impact. The Contribution Policy will be applied consistently, regardless of race / ethnicity.
Religion or Belief		
No Impact		No impact. The Contribution Policy will be applied consistently, regardless of religion / belief.
Sex		
No Impact		No impact. The Contribution Policy will be applied fairly and consistently, regardless of sex.
Sexual Orientation		
No Impact		No impact. The Contribution Policy avoids assumptions based on sexual orientation.
Care Leavers (Local)		
No Impact		No impact – The Contribution Policy does not discriminate based on care experience.
Armed Forces (Local)		
No Impact		No conflict with the Armed Forces Covenant. HBC may consider local exemptions or subsidies for veterans, especially those on benefits or with disabilities.
Poverty and Disadvantage (Local)		

Impact	Negative Impact Score	Explanation – what is the impact?
Negative Impact	Likelihood score:1 Impact score:2 Overall score:2	For people on fixed incomes or benefits, the proposed changes may reduce disposable income, potentially affecting their ability to pay for essentials like food and utilities.

Section 3 - Mitigation Action Plan or Justification

Group(s) impacted	Proposed mitigation	How this mitigation will make a difference	By when	Responsible Officer
Age / Disability	Minimum Income Guarantee	This ensures individuals retain enough money to cover basic living costs	Ongoing	Neil Harrison
Disability	Disability Related Expenditure	Local authorities can deduct Disability Related Expenditure (DRE) from income, ensuring that these essential costs aren't counted as disposable income. This helps make charges more equitable	April 2026	Neil Harrison
Poverty and Disadvantage	Minimum Income Guarantee	The Minimum Income Guarantee (MIG) is set nationally and aims to prevent financial hardship.	Ongoing	Neil Harrison
Poverty and Disadvantage	Benefits Maximisation	Anyone undergoing a financial assessment can be supported or signposted to advice regarding benefits to maximise their income. This can be supported by UPFT and the service that is commissioned from West View Advice & Resource Centre. Other organisations within the borough provide similar support – Advice@Hart and Citizens	Ongoing	Neil Harrison

		Advice Bureau provide a universal offer and Hartlepool Carers provides support to carers regarding benefits and entitlements. The Entitled To tool is available on Hartlepool Now and allows people to find out what they may be entitled to claim.		
Age/Disability/ Poverty and Disadvantage	Annual Benefit Increase	In general, benefits increase every year and whilst increases do vary, for 2026 the majority of benefits including Personal Independence Payments (PIP) and Disability Living Allowance (DLA) are expected to increase by 3.8% in line with inflation. The State Pension and Guaranteed Credit Portion of Pension Credit are expected to rise by 4.8%.	Ongoing	Neil Harrison

Justification If you need to justify your proposed action explain this here
The proposed changes ensure that everyone undergoing financial assessment within Hartlepool will experience a consistent and equitable approach, with their annual uplift applied at the same time, the appropriate benefits disregarded and an equitable fee changed for appointeeship. The proposed changes have already been implemented in a significant number of Councils across England. The eight week public consultation will allow for any issues raised by members of the public to be considered before the Charging Policy is finalised.

Section 4 - Sign Off

Hartlepool Borough Council – Single Impact Assessment Form

Responsible Officer sign off:	
Name	Neil Harrison
Job title	Head of Safeguarding & Specialist Services.
Assistant Director / Director sign off:	
Name	John Lovatt
Job title	Assistant Director Adult Social Care

Once the Single Impact Assessment is completed please send to impactassessments@hartlepool.gov.uk.

Section 5 - Review (To be completed after implementation)

5.1 Review completed by:		
Name	**Job Title**	**Date review completed**
Neil Harrison	Head of Safeguarding & Specialist services	Nov 2026

5.2 Did the impact turned out as expected?

5.3 Were the proposed mitigations the correct ones and were they successful in reducing any negative impacts?

5.4 Were there any unexpected outcomes?

5.5 Following the review please identify next steps here (Select one)
☐ Additional mitigation required (give details below - 5.6)
☐ Original proposed course of action needs to be revisited
☐ No further action required

5.6 Additional mitigation(s) or justification

Group(s) impacted	Proposed mitigation	How this mitigation will make a difference	By when	Responsible Officer

Justification If you need to justify your proposed action explain this here

Submit form with completed review to impactassessments@hartlepool.gov.uk

Adult Social Care Charging Policy Consultation

Purpose of this consultation

This document outlines the proposed changes to Hartlepool Borough Council's Charging Policy for Adult Social Care and seeks your views on their potential impact. Your feedback will be presented to the Adult Services and Public Health Committee when they consider the revised Charging Policy in March 2026.

Summary of Proposals

There are three changes proposed to the Charging Policy, which together will generate increased income for the Council.

1. Automatic Annual Inflationary Uplift

Currently the amount people contribute towards their care costs stays the same each year unless they have their contribution reviewed. However the cost of providing care increases each year due to inflation and increases in the National Living Wage.

Proposed Change

We will apply a small annual increase to contributions in April each year in line with inflation and the increases applied to benefits where applicable. This helps to ensure that services are sustainable without large sudden increases.

What does this mean for you?

The amount you are charged will automatically increase in April each year in the same way that other bills and charges go up. You will be notified of the amount before the increase is applied.

2. Removal of Disregard for Overnight Support

Some people receive higher-rate Attendance Allowance or Personal Independence Payment (PIP), which includes an amount for overnight care. At the moment, we disregard (ignore) this when calculating what you pay.

Proposed Change

If you receive the higher rate but do **not** need overnight care, we will include this amount as income in your financial assessment. This ensures that the way we charge people for services is fair and consistent – people who don't need overnight care shouldn't have extra income disregarded, which would reduce their contribution.

What does this mean for you?

If you receive higher-rate Attendance Allowance or Personal Independence Payment (PIP) and don't need overnight care, your assessed contribution may increase.

3. Appointeeship Administrative Fees

When people cannot manage their own benefits due to illness or disability and they don't have a family member who is willing or able to do this on their behalf, the Council can do this on their behalf and this is known as appointeeship (the Council is the appointed body acting on behalf of the person).

Managing benefits for someone involves receiving and paying bills using the income from benefits, keeping accurate records, regular audits and reporting and making sure that the process is legal and protects the best interests of the person. This takes a lot of time and staff resources.

Proposed Change

At the moment, this service is provided at no charge to the person and this is not something the Council can afford to do, particularly as the number of people who need this type of support is growing. We plan to introduce a set up cost and a monthly administrative fee for the service from April 2026.

Our fees will be the same as the fees charged by Money Carers, an independent organisation that provides the same service. This means that everyone in Hartlepool who needs an appointeeship service will pay the same amount based on the level of support they need. There will be a setup fee of £150 from April 2026 and monthly fees of £55 per month for a standard level of service and £85 per month for an enhanced service where this is needed.

What does this mean for you?

If the Council acts as your appointee, a monthly fee will apply from April 2026. There will be two levels of fee depending whether you require a small amount of support or more complex support. The monthly fee will be explained clearly before it is introduced and will be reviewed each year.

Hartlepool Borough Council

Adult Services and Public Health Committee

5 March 2026

Report of: Director of Public Health

Subject: DOMESTIC ABUSE STRATEGY 2026-2029

Decision Type: Key Decision - ACBS 110/26

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1. Council Plan Priority

Hartlepool will be a place:
where people live healthier, safe and independent lives. (People)

2. Purpose of Report

2.1. To present the final Domestic Abuse Strategy 2026-2029 and to seek approval from the Committee to support implementation.

3. Background

3.1. It is estimated that approximately 3.8 million people aged 16 years and over in England and Wales experienced domestic abuse in the year ending March 2025, 2.2 million females and 1.5 males.

3.2. Part 4 of the Domestic Abuse Act 2021 requires each local to

- Assess, or make arrangements for the assessment of the need for accommodation-based support in its area
- Prepare and publish a strategy for the provision of such support in its area
- Monitor and evaluate the effectiveness of the strategy.

3.3. The current strategy for Hartlepool 'Domestic Abuse Strategy: Building a System on Lived Experience 2022-2025' came to an end last year and a needs assessment for 2024-2025 has been carried out to inform the development for the new Domestic Abuse Strategy 2026-2029.

4. Proposals

4.1. The Domestic Abuse Strategy 2026-2029 is attached as **Appendix 1** and has been developed in collaboration with services, people with lived experience and wider partners and as part of a wider public consultation.

4.2. The Domestic Abuse Strategy has three priority areas:

- Supporting Victims
- Recognising Children as Victims
- Pursuing Perpetrators

4.3. An action plan will be developed in partnership and governance will be provided by the Domestic Abuse Partnership Board.

5. Other Considerations/Implications

Risk Implications	There are no risks associated with this report.
Financial Considerations	The local authority receives grant funding from the Ministry of Housing, Communities and Local Government to carry out its statutory duties in relation to the Domestic Abuse Act.
Subsidy Control	There are no subsidy control implications.
Legal Considerations	The Domestic Abuse Act places a statutory duty on local authorities to have a strategy.
Single Impact Assessment	A Single Impact Assessment has been previously completed and presented at Committee. The assessment identified a positive impact for people with protected characteristics, recognising that domestic abuse can affect anyone, and the Domestic Abuse Strategy will ensure that services are accessible to all.
Staff Considerations	There are no staffing considerations.

Asset Management Considerations	There are no asset management considerations.
Environment, Sustainability and Climate Change Considerations	There are no environment, sustainability and climate change considerations.
Consultation	Consultation ended on January 30th, 2026and included: Internal consultation with all stakeholders, including members and the Domestic Abuse Local Strategic Partnership Board. Public consultation has been undertaken through an online survey which included victims of domestic abuse via commissioned support services. Comments have been invited from the following statutory consultees (Safer Hartlepool Partnership) All consultation feedback was considered for the final version of the strategy.

6. Recommendations

6.1. It is recommended that the Committee notes and endorses the Domestic Abuse Strategy 2026-2029.

7. Reasons for Recommendations

7.1. The council has a statutory duty under the Domestic Abuse Act 2021 to have a strategy and provide domestic abuse support services.

8. Contact Officers

Chris Woodcock
Director of Public Health
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Sign Off:-

Chief Executive	Date: 09.02.2026
Director of Finance, IT and Digital	Date: 06.02.2026
Director of Legal, Governance and HR	Date: 09.02.2026

Hartlepool Domestic Abuse Local Strategic Partnership
Domestic Abuse Strategy 2026 – 2029

Contents

Foreword

To be completed by the Leader of the Council.

Introduction

The most recent needs assessment in Hartlepool was published in 2021, followed by Hartlepool's Domestic Abuse Strategy: Building a System Based on Lived Experience 2022-2025. In line with the Council's duty to review and refresh its domestic abuse needs assessment and associated strategy, a new strategic needs assessment has been carried out during 2025. The data and intelligence gathered as part of the needs assessment has informed this strategy for 2026 - 2029.

We would like to thank the Council departments and Partner Agencies that contributed data and information to help in the assessment of the level of need for domestic abuse services in Hartlepool and the development of this strategy. We would also like to thank the service users and survivors who contributed their lived experience, and feedback, which allows us to continue in our victim and survivor-led approach.

Duties and responsibilities

Under the **Domestic Abuse Act 2021**, several key duties have been placed on councils in England to improve support for victims of domestic abuse. These are primarily outlined in **Part 4 of the Act**, and include the following responsibilities:

Statutory Duties on Councils

1. **Provision of Support in Safe Accommodation**
   Councils must ensure that victims of domestic abuse and their children have access to **safe accommodation** and **specialist support services**. This includes:
   - Refuges and other forms of safe accommodation including sanctuary
   - Support services such as counselling, advocacy, and advice on staying safe

2. **Development of Local Strategies**
   Councils are required to:
   - Conduct a **needs assessment** for victims in their area
   - Develop and publish a **local domestic abuse strategy**
   - Review and update this strategy regularly

3. **Multi-Agency Collaboration**
   Councils must work closely and form a Domestic Abuse Partnership Board to ensure appropriate governance with:
   - Police
   - Health services
   - Domestic abuse charities
   - Other relevant partners to ensure a coordinated response

4. **Monitoring and Reporting**
   Councils must report annually on:
   - How they are meeting their duties
   - The effectiveness of their strategies
   - The outcomes for victims and children

5. **Guidance Compliance**
   Councils must have **regard to statutory guidance** issued under the Act when exercising their functions. This includes ensuring that support is trauma-informed and accessible to all victims, including those with complex needs

How this strategy links to other local strategies

The needs assessment which has informed this strategy, also forms part of Hartlepool Council's wider Joint Strategic Needs Assessment (JSNA). The Domestic Abuse Strategy is closely linked to the following JSNA topics:

- Housing
- Violent Crime
- Mental Health
- Safeguarding Children and Vulnerable Adults
- Sexual Health
- Substance Misuse
- Youth Offending

The Domestic Abuse Strategy is also closely linked to the following local strategies:

- Housing Strategy
- Health and Wellbeing Strategy
- Drug and Alcohol Strategy
- Community Safety Plan

Intersecting local initiatives:

- Making Every Contact Count (MECC)
- Whole Systems Approach
- Coordinated Community Response (CCR)
- Safe and Together
- High Risk Adults Panel (HRAP)

The Office for Police and Crime Commissioner for Cleveland has launched a Teeswide Tackling Domestic Abuse Perpetration Strategy for 2025 – 2035 which aligns with the strategic priorities in the Cleveland Police and Crime Plan.

The Tackling Domestic Abuse Perpetration Strategy identifies three key priorities:

- Prevent – by identifying, responding and referring concerns at the earliest opportunity.
- Protect – by identifying perpetrators and holding abuse behaviour to account.
- Pursue – by using protective measures to disrupt and prosecute perpetrators.

Governance

The Domestic Abuse Local Strategic Partnership (DALSP) has oversight and governance of the delivery of the strategy, and is made up of –

- Victims and survivors of domestic abuse
- Hartlepool Borough Council (HBC) including community safety, public health, children's and adults social care and housing
- Integrated Care Board (ICB)
- North Tees and Hartlepool NHS Foundation Trust
- Tees, Esk and Wear Valley (TEWV) NHS Foundation Trust
- Cleveland Police
- Office for the Police and Crime Commissioner for Cleveland (OPCC)
- Probation Service
- Registered Housing Providers
- Voluntary and Community Sector
- Teeswide Safeguarding Adults Board (TSAB)
- Hartlepool and Stockton Safeguarding Children Partnership (HSSCP)

The DALSP reports to the Safer Hartlepool Partnership (SHP).

The picture in Hartlepool

What have we learned?

Whilst the needs assessment shows that domestic abuse continues to be primarily a gender-based crime, perpetrated by men against women, this oversimplifies the situation somewhat. Demographic analysis of the services reviewed in the needs assessment shows that some groups are overrepresented in the client / referral data compared to other groups within that same demographic characteristic (e.g. age bracket) or compared to the local Hartlepool population. Additionally, whilst the numbers for some groups remain low, they are making up an increasingly significant proportion of service users.

Based on the evidence reviewed in this needs assessment, the following groups are overrepresented in the client data:

- Women – make up 79.8% of referrals to Harbour support services, 95% of homeless presentations due to domestic abuse and 71% of adult safeguarding referrals related to domestic abuse yet just 51.6% of the Hartlepool population
- People aged 19-44 – make up 66.9% of Harbour referrals yet just 30.9% of the Hartlepool population
- People living in social housing or private rented accommodation - make up 66.5% of Harbour referrals compared to 41% of the Hartlepool population
- People who are already homeless (particularly women and single households) – make up 42% of referrals to the Council's homelessness team

In terms of groups where total numbers remain low, but they are representing an increasing proportion of the demographic makeup of referrals:

- Ethnic minorities make up a small proportion of referrals to Harbour but this proportion is increasing and is slightly higher than the local population for all minority groups
    - Black, Caribbean or Black British - 1.2% of referrals / 0.5% local population
    - Asian or Asian British – 1.9% of referrals / 1.7% of local population
    - Mixed or multiple ethnicities – 1.1% of referrals / 0.7% of local population
    - Other ethnicity – 0.7% of referrals or 0.6% of local population
- Males make up an increasing proportion of Harbour referrals. They currently make up 20% of referrals (increased from 18.6%) compared to 48.4% of the local population

Particular groups also make up an increasing proportion of the Safe Accommodation referrals:

- People with complex needs who cannot be admitted into refuge accommodation (increased from 4.2% to 9.8%)

- Women who are pregnant at the time of referral (increased from 8% to 12%)
- People with a disability (increased from 4% to 15%))
- People with mental health issues (increased from 33% to 47%)

Future analysis will show if these trends continue over the longer term. However, in the meantime, consideration needs to be given to how the differing (and intersecting) needs of these groups can be accommodated by services.

Strategic Issues Arising from Consultation
People with disabilities are more likely to experience domestic abuse than the general population and Hartlepool has a higher rate of disability and ill health than the England rate. 59% of the survey respondents reported a limiting health condition or disability. Services need to be visible and accessible. There needs to be further education and awareness raising to reduce the stigma of domestic abuse and break down barriers. Some respondents in the survey stated they "were not aware of anything locally" or were "managing the situation themselves".

Services need to be trauma informed and use professional curiosity, including in cases where service users decline to engage. Training should be provided to multi-agency practitioners in recognising and responding to domestic abuse and ensure that practitioners are aware of the many forms of domestic abuse and the definition of 'personally connected' covering intimate partners and family members. One respondent highlighted "staff should have more appropriate training".

What have we already achieved?

The key strategic priorities identified in Hartlepool's Domestic Abuse Strategy: Building a System Based on Lived Experience 2022-2025 were -

- Working with victims/ survivors (adults and children) for them to be true partners in our review and development of services;
- Focus on supporting as early as possible – develop a prevention/ early intervention offer;
- Re-commission support services based on lived experiences;
- Equip the workforce to ask the right questions and to support victims of domestic abuse;
- Develop more choice and options for safe accommodation; and
- Consider the needs of victims/survivors with multiple and complex issues using multi agency support in order to begin to address needs.

Key achievements against these strategic priorities include -

The voices of victims, survivors and children are represented by Harbour as the commissioned service provider but also by other specialist support agencies, including Halo, Hart Gables, A Way Out and ARCH. Services have service user panels and survivor groups that are utilised to influence change and development. Members of the partnership also identify as survivors of domestic abuse both as children and adults and contribute their lived experience. Survivor voice continues to be reflected in the refreshed Needs Assessment and Strategy.

The offer of domestic abuse services within Hartlepool has been updated and is reflected on the Hartlepool Borough Council website. The development of a new website is ongoing.

There have been numerous awareness raising campaigns including –

- Violence Against Women and Girls week of action led by Cleveland Police with support from specialist agencies,
- 'Ask for Angela' was launched by Community Safety in licensed premises across Hartlepool
- 'Ask for Ani' campaign has been reinforced with pharmacies.
- Harbour celebrated their 50th anniversary and hosted a 'Walk a Mile in their Shoes' event, bringing together survivors and the professionals that support them.

A full commissioning process was completed in 2022 for support and safe accommodation and therapeutic support for children Harbour being awarded both contracts commencing on the 1st October 2022 for three years. These are monitored with a robust performance framework with regular outcome monitoring.
Domestic abuse services have been complemented with funding from the Office for Police and Crime Commissioner that is aligned with commissioning arrangements, including hospital, court, mental health and Independent Domestic Violence

Advocate's (IDVA) that operate within Hartlepool and a programme for perpetrators with complex needs. Other organisations have received funding from the OPCC, including ARCH Teesside that provide support to adults and children who are victims of sexual abuse and Halo who received funding from the OPCC to support with black and minority ethnic groups. Unfortunately, this funding is grant funded, time limited and subject to yearly funding allocations.

Reducing parental conflict work is led by Changing Futures North East.

The Safe and Together model continues to be implemented across the workforce which is strengthening our response to domestic abuse by partnering with survivors and intervening with perpetrators and keeping children safe and together with the non-offending parent. Additional training has been provided to Health Advocates within the local authority, including training on responding to disclosures of domestic abuse within the workplace. Training is delivered by Harbour and partners via workforce development and the HSSCP and TSAB.

TSAB updated the Team Around the Individual (TATI) process, now known as High Risk Adult Panel (HRAP) and offers another pathway to strengthen the response to individuals with multiple and complex issues, including victims and perpetrators of domestic abuse. Strategic MARAC (Multi Agency Risk Assessment Conference) continues to oversee the action plan recommended by Safe Lives.

How have we responded to the Safe Accommodation Duty?

Harbour is the commissioned service provider for an integrated response to victims and survivors, including children, and perpetrators of domestic abuse in Hartlepool. This includes the provision of safe accommodation comprising of –

- a 7-unit refuge for women and children, inclusive of one space for disabled people and one space to be used for emergency use for a maximum of 7 days,
- a 6-unit refuge for single women with complex needs
- Dispersed properties for all victims of domestic abuse.

At the time of writing, Harbour have secured additional dispersed properties across the North East, with the total number in Hartlepool being 6.

The provision of safe accommodation for women with complex needs is a unique model of delivery and has received regional and national recognition, with options being explored for co-commissioning and reciprocal arrangements with commissioners across the North East.

The number of units of safe accommodation available in Hartlepool has increased year on year since 2021. However, Hartlepool does not currently have any specialist or second stage (move-on) accommodation.

Hartlepool Home Search was launched as the new Choice Based Lettings System in Hartlepool and victims of domestic abuse are awarded a priority banding in line with the allocations policy, in partnership with the Housing Advice Team and Registered Social Landlords.

The Safe Accommodation Duty also includes the requirement to provide other support services such as counselling, support services and advocacy. Harbour also delivers a Sanctuary scheme to residents of Hartlepool in tandem with Crime Prevention Officers in Cleveland Police.

In addition to safe accommodation, Harbour are commissioned to deliver –

- outreach and assertive outreach in the community,
- empowerment programmes,
- counselling
- a dedicated children and young people therapeutic service
- a preventions service and programme for those who cause harm.
- Three specialist roles for the CHUB, safeguarding and assessment teams and early intervention.

Service users are also encouraged to access the recovery service once formal support has ended and contribute to the Service User Panel to inform strategic decisions.

Harbour offers services to the whole community, including –

- Women, men and trans people
- People from all ethnic groups and backgrounds
- People from the LGBTQ+ community
- Disabled people
- Children

Data returns have been submitted to the Ministry of Housing, Communities and Local Government (MHCLG), formerly Department of Levelling Up, Housing and Communities (DLUHC) for the financial years 2021 – 2022, 2022 – 2023, 2023 – 2024 and 2024 – 2025.

What are the key issues in Hartlepool?

The needs assessment identified the following three key strategic issues:

1. There is an insufficient availability of support services for **victims and survivors** of domestic abuse, particularly for those who are hidden from services or have complex needs. This limits early intervention and identification of domestic abuse, recovery, and long-term safety.

2. **Children** affected by domestic abuse are not consistently recognised as victims in their own right, and current services are not always responsive to their needs—whether in the home, in their own relationships, or in cases of child/adolescent to parent violence and abuse (CAPVA).

3. There is a lack of consistent accountability for **perpetrators** of domestic abuse, and existing intervention services may not be sufficiently effective in changing behaviour or reducing repeat offending.

What are our priorities and what needs to be done to achieve them?

The strategic priorities have been identified from the needs assessment. Additionally, they align closely with the Government's Tackling Domestic Abuse Plan.

Priority 1: Supporting Victims

There is an insufficient availability of support services for victims and survivors of domestic abuse, particularly for those who are hidden from services or have complex needs. This limits early intervention and identification of domestic abuse, recovery, and long-term safety.

Why?

Domestic abuse has a devastating impact on both the victims and the wider community. Providing early intervention and prevention approaches are both lifesaving and will be cost effective in improving the health and wellbeing of the community.
In view of the fact that disabled people are more likely to be victims of domestic abuse and individuals in Hartlepool are more likely to have a disability or report poor health, it is vital that we have accessible services and information.

What needs to be done?

- Early intervention and prevention. Awareness raising and promotion of services, especially with hidden victims (such as those with disabilities, from ethnic minority groups or different cultural backgrounds and male victims) and those with complex needs
- Utilise existing service user forums to ensure that victim and survivor voice informs the commissioning and delivery of services
- Ensure services are accessible, trauma-informed and use professional curiosity when individuals decline their service or do not engage
- Provide training to multi-agency practitioners in recognising and responding to domestic abuse and ensure that practitioners are aware of the many forms of domestic abuse and the definition of 'personally connected' covering intimate partners and family members
- Ensure pathways and information sharing is robust, including MARAC, MATAC and HRAP
- Consider alternative safe accommodation options including specialist, by and for and move-on.
- Review the proportion of out of area referrals both in and out of Hartlepool.
- Consider a multi-agency dashboard to create consistency in the recording and reporting of data relating to domestic abuse
- Understand the effectiveness of the Domestic Violence Disclosure Scheme (Clare's Law).

- Continue to implement the Safe and Together model across multi-agency partners to standardise the response victims receive

Priority 2: Recognising Children as Victims

Children affected by domestic abuse are not consistently recognised as victims in their own right, and current services are not always responsive to their needs—whether in the home, in their own relationships, or in cases of child/adolescent to parent violence and abuse (CAPVA).

Why?

Children experience domestic abuse both in their family homes and in their own interpersonal relationships. This can have a lasting adverse impact through childhood and into adulthood.

What needs to be done?

- Focus on early intervention and prevention to ensure all children understand healthy relationships
- Ensure all services are recognising children as victims in their own right
- Ensure therapeutic support services are available for children
- Review the prevalence of CAPVA, the demand on services and ensure that the offer in place can meet the need of children and their parents.
- Understand the effectiveness of Operation Encompass
- Continue to implement the Safe and Together model across multi-agency partners to standardise the response children as victims receive

Priority 3: Pursuing Perpetrators

There is a lack of consistent accountability for perpetrators of domestic abuse, and existing intervention services may not be sufficiently effective in changing behaviour or reducing repeat offending.

Why?

Without addressing perpetrators behaviour, the cycle of abuse will continue.

What needs to be done?

- Support the OPCC Perpetration Strategy
- Review the criminal justice response to perpetrators within Hartlepool
- Monitor the effectiveness and engagement of perpetrator provision
- Reduce repeat offending and the number of repeat high risk MARAC cases

Continue to implement the Safe and Together model across multi-agency partners to standardise the response perpetrators receive

What are the challenges?

Gaps in the available data continues to be a significant challenge in understanding the level of need in Hartlepool. The needs assessment identified the following gaps:

- Detailed demographic data is patchy, with some services collecting more detailed data than others. Some key gaps in demographic information include:
    - Where survivors have a disability, more detailed information about the types and levels of disability experienced would enable a better understanding of the barriers that exist for people with disabilities.
    - Health data is patchy and, in some cases, unavailable. This is a significant gap in assessing the needs of victims and survivors, perpetrators and their children who access health services. In some cases, data is only available at NHS Trust level and cannot be broken down to find which patients were of Hartlepool residence. Additionally, the Cardiff Model data which was previously provided in 2021 is no longer available.
    - Cleveland Police provide Operation Encompass disclosures to schools but are unable to break this down into district area and were unable to provide any data relating to this. This continues to be a gap as highlighted in 2021.
    - Voluntary and Community Sector organisations, although approached, weren't able to provide data if they are not a commissioned service due to the level of pressure this places on already limited services.

Funding from central government is often allocated on a yearly basis and therefore it is difficult to make commitments when commissioning services. Due to this, teams can be small and staff turnover can also be high and can create instability in services. An example of this, is the hospital based IDVA's that have received grant funding since 2022 from the OPCC will come to an end in March 2026.

Support for victims of crime is precarious due to staffing pressures and funding cuts which has a significant impact on the delivery of crime prevention and target hardening as part of the sanctuary scheme offer.

The demand for services for children is increasing. There needs to be a focus on children being recognised as victims. Additionally, further work needs to be completed to understand the need of Child and Adolescent to Parent Violence and Abuse (CAPVA). A standalone domestic abuse strategy for children should be considered.

Data has shown that perpetrators of domestic abuse are committing multiple crimes and repeating this pattern of behaviour. The current perpetrator provision has seen an increase in repeat referrals therefore the effectiveness of the provision needs to be considered. Additionally, the referrals into the Preventions Service from the Criminal Justice System (CJS) continues to be low. It is increasingly challenging to hold perpetrators accountable for their behaviour, without intervention from the CJS.

What does success look like?

For victims...

Victims and survivors will continue to be partners in the delivery of the strategy and action plan and continue to shape and support services

Victims who have accessed services will report –

- Feeling safer
- A reduction in all types of abuse (physical, sexual, harassment and stalking, jealous and controlling behaviour)
- Improved quality of life
- Improved health and wellbeing
- Improved relationships with their children
- Improved self-esteem and confidence
- Improved support networks

There will be a reduction in repeat victims.

Pathways for victims who do not access services or who have unplanned exits from services will be robust to ensure they receive support that is person-centred and trauma-informed to their individual need.

Services will be flexible and able to accommodate the need of different groups such as:

- Disabled people
- People from an ethnic minority or with cultural needs
- Male victims
- People with complex needs

The community will feel confident in knowing where they can access support and service providers will continue to raise awareness of support to both adults and children.

Practitioners will report that their skills and knowledge regarding domestic abuse have improved. Audits will show that practitioners have a developed understanding of domestic abuse and respond in line with the Safe and Together principles.

There will be an increase in the number of people able to access safe accommodation, including those with complex needs. The number of households who successfully move on from safe accommodation will increase.

There will be consideration of a multi-agency dashboard to create consistency in the recording and reporting of data relating to domestic abuse.

Strategic MARAC will have appropriate oversight and governance of the MARAC process. Information sharing process will be robust, including for MARAC, MATAC and HRAP.

The Domestic Violence Disclosure Scheme (Clare's Law) will be effective in responding to disclosures.

For children...

Children who have accessed services will report –

- Feeling happier
- Feeling safer

There will be an increase in the number of children able to stay with the non-offending parent because of implementing Safe and Together.

Children will be recognised as victims in their own right and offered the appropriate support packages based on their needs, including therapeutic support.

Practitioners will be confident in recognising the difference between reducing parental conflict and domestic abuse. Parents will be able to access the appropriate support accordingly.

Children will receive the appropriate level of Relationships, Health and Sex Education (RHSE) to understand healthy relationships.

There will be a clear link with youth services, including youth offending to strengthen partnership working and ensure as many professionals as possible are trauma informed.

There will be improved professional understanding and a clear offer for families who experience Child to Parent Violence and Abuse (CAPVA).

Operation Encompass will be effective in providing support to children experiencing domestic abuse. There will be a clear understanding of how this operates in Hartlepool, in line with statutory duties.

For perpetrators...

Practitioners will feel confident in intervening with perpetrators and holding them accountable for their behaviour, including within the criminal justice system.

There will be a clear understanding of the role of the criminal justice response to perpetrators of domestic abuse.

There will be a reduction in the number of perpetrators identified as repeating their pattern of behaviour, resulting in a reduction of repeat high risk MARAC cases.

When a perpetrator is identified within the MATAC cohort, their will be a clear reduction in risk that is sustained.

There will be an increase in the number of individuals referred to and accessing preventions interventions. There will be an increase in the number of individuals successfully completing behaviour change programmes.

There will be a robust offer of support for perpetrators, including accommodation in order to safely manage risk to victims and children.

The DALSP will support the priorities outlined in the Tees-wide Tackling Domestic Abuse Perpetration Strategy.

Help and Support

If you or someone else is in immediate danger, call 999 and ask for the police. If you can't speak, you can ring 999 then press 55 when prompted: this is called the Silent Solution System.

For information and support in Hartlepool you can contact –

Harbour Support Services
Harbour works with families and individuals affected by abuse from a partner, former partner or family member and provides an integrated support service to residents of Hartlepool.
T: 03000 20 25 25 (24 hours)
E: info@myharbour.org.uk
W: www.myharbour.org.uk

Adult Safeguarding
If you are worried about an adult being abused or neglected please contact:
The Integrated Single Point of Access (iSPA), *Monday Thursday 8:30am-5pm; Friday 8:30am – 4:30pm*
Tel: 01429 523390
SMS: 078336 72357
Email: ispa@hartlepool.gov.uk
If you need urgent help when our offices are closed, you can contact the Emergency Duty Team on 01642 524552

Children's Safeguarding
The Children's Hub is the first point of contact for anyone who has a concern about the welfare or safety of a child or young person or thinks they may need extra help and support.
Tel - 01429 284284
Email - childrenshub@hartlepool.gov.uk
The service operates Monday to Friday, 8:30am to 5:00pm.
The Emergency Duty Team provides an out-of-hours response to emergency situations involving child protection, child care, mental health and other adult care service matters.
Tel - 01642 524552

Further information and support can be found at
https://www.hartlepool.gov.uk/domesticabuse

Hartlepool Borough Council

Adult Services and Public Health Committee

5 March 2026

Report of: Director of Public Health

Subject: PATIENT GROUP DIRECTIONS POLICY

Decision Type: Non-Key

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1. Council Plan Priority

Hartlepool will be a place:
where people live healthier, safe and independent lives. (People)

2. Purpose of Report

2.1. To agree the adoption of the Patient Group Directions (PGDs) Policy for Hartlepool Borough Council.

3. Background

3.1. PGDs are intended for situations where individual prescribing is not feasible, providing a legal framework for healthcare professionals to administer or supply medicines to predefined patient groups without using a prescription.

3.2. Organisations should have policies and processes in place to consider all aspects of medicines management for patients within a service or pathway. Before a service is designed or commissioned using PGDs and before a PGD is developed, a commissioner must ensure that PGDs are appropriate, legal, and that relevant governance arrangements are in place.

3.3. This policy highlights the role of the Director of Public Health in overseeing the development, authorisation or adoption, and compliance of PGDs, to ensure that the use of PGDs is both safe and beneficial for patient care.

3.4. This policy on PGDs seeks to ensure that Hartlepool Borough Council meets legal and regulatory requirements while improving patient access to necessary medications within commissioned services. The policy is aligned with national legislation and regulatory/professional guidance for the Human Medicines Regulations, the National Institute of for Health and Care Excellence (NICE) and medicines and healthcare products regulatory agency (MHRA) PGD guidance.

4. Proposals

4.1. A Hartlepool Borough Council PGD Policy has been developed and is attached as **Appendix 1**. The policy sets out the requirement to establish a PGD Approval Group to provide evidence to the Director of Public Health (DPH) or nominated deputy, as the Senior Responsible Officer for PGDs, to demonstrate that PGDs are developed in line with legal requirements. Within HBC, the Approval Group will consist of the public health senior management team and a public health pharmacist.

4.2. The Director of Public Health has overall responsibility for:

- Oversight and effective implementation of this policy and acts as the authorised signatory for PGDs where necessary.
- Ensuring that processes are in place so that PGDs are developed, authorised or adopted, and distributed in accordance with current legislation and national guidance/ best practice and also according to local organisational policies and governance arrangements.
- Ensuring they have the necessary knowledge, skills and expertise needed for authorising PGDs and being aware of their responsibilities.
- Ensuring provision of the necessary pharmaceutical, medical and other appropriate clinical expertise for the development, authorisation and implementation of PGDs for use in commissioned public health services requiring PGDs
- Providing assurance of competence of the pharmaceutical, medical and other clinician expertise involved in the development of Hartlepool Borough Council PGDs
- Ensuring the service provider has access to copies of approved PGDs.

5. Other Considerations/Implications

RISK IMPLICATIONS	The policy ensures that Hartlepool Borough Council can meet legal and regulatory requirements while improving patient access to necessary medications within commissioned services.
FINANCIAL CONSIDERATIONS	There are no financial considerations.
SUBSIDY CONTROL	There are no subsidy control implications.
LEGAL CONSIDERATIONS	The policy is required to ensure Hartlepool Borough Council meets legal and regulatory requirements while improving patient access to necessary medications within commissioned services.
SINGLE IMPACT ASSESSMENT	No single impact assessment required.
STAFF CONSIDERATIONS	No staff considerations.
ASSET MANAGEMENT CONSIDERATIONS	No asset management considerations.
ENVIRONMENT, SUSTAINABILITY AND CLIMATE CHANGE CONSIDERATIONS	No environment, sustainability and climate change considerations.
CONSULTATION	No consultation required.

6. Recommendations

6.1. For the Adult Services and Public Health Committee to approve the adoption of the PGD Policy and the establishment of the PGD Approval Group.

7. Reasons for Recommendations

7.1. To ensure Hartlepool Borough Council meets legal and regulatory requirements while improving patient access to necessary medications within commissioned services.

8. Contact Officers

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Sign Off:-

Chief Executive	Date: 19.02.2026
Director of Finance, IT and Digital	Date: 20.02.2026
Director of Legal, Governance and HR	Date: 19.02.2026

DRAFT POLICY FOR

DEVELOPMENT, AUTHORISATION or ADOPTION & USE OF PATIENT GROUP DIRECTIONS (PGDs)

Document Summary	
Department:	Public Health
Document Name:	Policy for the development, authorisation and use of patient group directions (PGDs)
Document short name	Hartlepool Borough Council PGD Policy
Policy Owner:	Hartlepool Borough Council Director of Public Health
Approved by:	Adult Services and Public Health Committee

Date approved:	
Date of review:	2 years from above or when legislation changes

Version	Summary	Owner's Name Date	Status
0.3	Draft New PGD policy shared with Public Health for approval	November 2025	Draft
1.0	Approved PGD Policy	March 2026	Pending

Acknowledgement

With thanks to the support of the Pharmaceutical Advisors of Durham, Stockton and South Tees Public Health who provided example policies.

1. Executive summary

Note this summary is not a substitute for the whole policy document.

1.1 **Summary**

This policy outlines the framework for the development, authorisation or adoption, and use of Patient Group Directions (PGDs) in services commissioned by Public Health for Hartlepool Borough Council hereafter abbreviated to Hartlepool Public Health. PGDs enable healthcare professionals to supply and/or administer specified medicines to predefined patient groups without a prescription. The policy ensures compliance with relevant legislation and guidance described in section 1.5 of this Executive Summary. It details the role and responsibilities of stakeholders, including the Director of Public Health, commissioned service providers and health professional users of PGDs in the development, approval, and use of PGDs. The policy also emphasises the need for pharmaceutical support/advice and robust governance structures to ensure patient safety and effective care delivery with PGDs used appropriately and in compliance with legal standards.

1.2 **Context**

Organisations should have policies and processes in place to consider all aspects of medicines management for patients within the service or pathway. Before a service is designed or commissioned using PGDs and before a PGD is developed, a commissioner must ensure that PGDs are appropriate, legal, and that relevant governance arrangements are in place.

This policy on PGDs seeks to ensure that Hartlepool Public Health meets legal and regulatory requirements while improving patient access to necessary medications within commissioned services. The policy is aligned with national legislation and regulatory/professional guidance for the Human Medicines Regulations including Health Service Circular (HSC) 2000/026, NICE and MHRA PGD guidance and emphasising the safe and effective delivery of patient care. PGDs are intended for situations where individual prescribing is not feasible, providing a legal framework for healthcare professionals to administer or supply medicines to predefined patient groups without using a prescription. This policy highlights the role of Hartlepool Public Health in overseeing the development, authorisation or adoption, and compliance of PGDs, to ensure that the use of PGDs is both safe and beneficial for patient care.

1.3 **Purpose**

This is a new policy designed to establish a clear framework for the development, implementation, and review of PGDs within Hartlepool Public Health commissioned services. The primary drivers of this policy include legal, ethical, and moral obligations to ensure the safe and effective delivery of healthcare. Key sources include the Human Medicines Regulations 2012, the Medicines & Healthcare Regulatory Agency (MHRA) PGD guidance, NICE Medicines Practice Guidance (MPG2) and Health Service Circular (HSC) 2000/026, which together outline the regulatory requirements or associated guidance relating to PGDs. Ethically, the policy supports equitable access to medicines, ensuring timely and appropriate treatment for specific patient groups without compromising patient safety.

The intended outcomes of this policy include:

- Ensuring the safe supply and administration of medicines when using PGDs in line with legal and regulatory standards.
- Improving patient access to essential medications within public health services.
- Strengthening the governance and oversight of PGD usage to ensure compliance with national best practice.

Success will be measured by the consistent implementation and use of PGDs within Hartlepool Public Health commissioned services, as monitored through regular audits and reviews of PGD

implementation. Compliance will be assessed through adherence to PGD approval and review processes, as well as the timely updating of PGDs in accordance with legal and clinical requirements.

Assumptions made in the policy include the availability of appropriate clinical expertise and resources to develop and implement PGDs effectively. Potential risk factors that may impact success include changes in legislation, inadequate training or understanding of PGD processes, and failure to update PGDs in line with emerging clinical evidence or regulations. Additionally, any challenges in stakeholder engagement or co-ordination between Hartlepool Public Health and service providers could affect the successful implementation of the policy.

1.4 **Scope**

This policy applies to all healthcare professionals and service providers involved in the delivery of Hartlepool Public Health commissioned services that use/may use PGDs for the administration and/or supply of medicines. Specifically, it includes any health professionals who are authorised to use PGDs in Hartlepool Public Health commissioned services, ensuring they follow established protocols for patient care within public health services.

The policy applies to the following groups:

- Healthcare professionals (e.g., doctors, nurses, pharmacists, registered pharmacy technicians and any other registered professionals) who are authorised to administer or supply medicines under PGDs in commissioned public health services.
- Hartlepool Public Health and its commissioned service providers, who are responsible for developing, authorising, implementing/distributing and ensuring compliance with PGDs.
- Persons or organisations providing pharmaceutical support or advice and other key clinical governance stakeholders involved in the development, approval or review of PGDs.

Criteria for inclusion are as follows:

- Health professionals must be named, authorised and registered to use PGDs within the services commissioned by Hartlepool Public Health.
- The PGDs should apply to pre-defined groups of people or patients requiring prophylaxis or treatment for clinical conditions or other eligibility outlined within the PGD.

Exclusions or enhancements:

- Exclusions: This policy does not apply to individual person- or patient-specific prescribing, which should always be the preferred method where appropriate. PGDs are only used in specific situations where they offer a clear advantage in patient care, and patient safety is not compromised.
- Enhancements: The policy allows for service enhancement where Hartlepool Public Health identify the need for new PGDs based on emerging public health needs or regulatory changes. Any service provider can propose new PGDs for approval, but these will be subject to review and authorisation by the designated approval group within Hartlepool Public Health.

The aim of the policy is to ensure a consistent approach to PGD development, implementation and use, ensuring that all relevant professionals and services are equipped to safely and efficiently supply and administer medicines to eligible groups of patients.

1.5 **Policy detail**

This policy outlines how PGDs will operate within Hartlepool Public Health commissioned services, ensuring that healthcare professionals can supply and/or administer specified medicines to pre-defined groups of patients in compliance with legal, regulatory, and best practice guidelines. The key regulations that govern the development, implementation, and review of PGDs include Regulations 229-232 of the Human Medicines Regulations 2012, outlining the legal framework for PGDs. Guidance sources include the

- Health Service Circular 2000/026 (9th August 2000), which provides guidance on PGDs.

- MHRA PGD guidance issued by the Medicines & Healthcare Regulatory Agency.
- NICE Medicines Practice Guidance (MPG2; last updated in 2017), ensuring PGDs are developed and implemented according to national standards

and the

- Specialist Pharmacy Services (which brings together all information for consideration which PGDs are identified for development)

The policy will operate within the established framework of Hartlepool Public Health, including the roles of designated professionals and approval bodies, ensuring that all PGDs are created, authorised, and used correctly. Specific modifications or updates will be made in response to changes in legislation, clinical guidelines, or emerging public health priorities.

Roles, responsibilities, and accountability:

Director of Public Health (or nominated deputy):

- Holds overall responsibility for ensuring that PGDs are developed, authorised, and implemented in line with relevant regulations and best practices.
- Acts as the authorised signatory for all PGDs and ensures all legal and professional obligations are met.
- Ensures the necessary expertise and resources are available for developing PGDs and provides assurance on the competence of clinical staff involved.

Person(s) or organisation(s) providing Public Health Pharmacy Support or Advice will, from approval of this policy,

- support the development of PGDs and lead the process towards their approval by the PGD Approval Group.
- seek to ensure PGDs are developed in line with national guidance and clinical governance frameworks.
- seek to ensure that all service providers involved have access to approved PGDs and that appropriate records are maintained.

PGD Approval Group:

- A multidisciplinary group (including clinical governance representatives) that considers and approves new PGDs for use within Hartlepool Public Health.
- Responsible for ensuring all PGDs meet legal, regulatory, and national guidance requirements.

Healthcare Professionals:

- Healthcare professionals involved in administering or supplying medicines under PGDs must ensure they are trained and authorised to use PGDs within the designated scope of their role.
- They must follow the procedures outlined in the PGD, ensuring patient safety and effective use of medicines.

Dissemination (communication):

- Internal Communication: The policy will be disseminated across Hartlepool Public and its commissioned service providers. This will be done through email notifications, intranet postings, and at relevant departmental meetings to ensure all involved staff are aware of their roles and responsibilities.
- External Communication: the policy and any approved or authorised PGDs will be made available to external stakeholders, including healthcare providers, through formal channels such as service-level agreements for the commissioned services and clinical governance meetings regarding the provision of the clinical services. Hartlepool Public Health will ensure that all service providers are informed of any changes to PGDs or policies. This applies too in reverse where any PGDs developed by the commissioned provider are authorised or adopted.

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Training:

- All healthcare professionals involved in the use of PGDs will be trained, and any updated training will be made available to ensure they understand the policy, legal requirements, and their responsibilities.
- Training will include reviewing the contents of any PGD in use, understanding patient safety protocols, and compliance with clinical governance.
- The training will be tailored to the specific needs of different professional groups and will be available in varied formats where possible to ensure wide accessibility.
- Regular updates and refresher courses will be available to keep all stakeholders up to date with any changes in legislation or clinical practices

Monitoring and Evaluation: Compliance with the policy will be monitored through audits, feedback from healthcare professionals, and reviews of PGD usage. Any non-compliance or areas for improvement will be addressed through targeted interventions, retraining, and policy revisions if necessary.

1.6 **Monitoring and review**

The monitoring and review process will ensure that the policy remains effective, complies with relevant legislation, and supports best practices in the use of Patient Group Directions (PGDs) within Hartlepool Public Health commissioned services.

Frequency of review:

- The policy will be formally reviewed every two years to ensure alignment with legislative changes and evolving best practices. However, a review may take place sooner if significant updates to relevant guidelines or legislation are introduced.

Roles and responsibilities:

- Hartlepool Public Health: Responsible for overseeing the policy's implementation and leading the review process. They will ensure that the policy is up-to-date and reflects the current best practices and legal requirements. Audit requirements for the policy will be identified by Hartlepool Public Health and approved by the PGD Approval Group.
- PGD Approval Group: This group will provide feedback on the policy's effectiveness based on audit results and patient safety incident reports. They will help identify areas requiring policy amendments and ensure compliance with national guidance.
- Service Providers: Providers will carry out regular audits of PGD use, ensuring the policy is being followed, and provide feedback to the Public Health team prospectively, including at Commissioning review meetings, regarding any areas for improvement.
- Healthcare Professionals: Responsible for complying with the policy and details of any specific PGD in use, reporting any incidents or challenges encountered in the use of PGDs. Their feedback will be critical in understanding the practical impact of the PGD policy.

Reporting arrangements:

- Audit Results: Audit results will be reviewed by the Public Health team, with key findings shared with the PGD Approval Group. Reports will identify best practice, any areas for improvement, and any gaps in compliance.
- Incident and Complaint Reports: Any incidents or complaints related to PGDs will be reviewed by the service provider and actions taken to address any non-compliance or safety concerns. These reports will be analysed and shared with relevant stakeholders (including Hartlepool Public Health) to ensure corrective actions are implemented.

Compliance and success measurement:

- Compliance will be measured through audits, incident reporting, and feedback from healthcare professionals. Success indicators will include the effective application of PGDs, patient safety improvements, and adherence to the policy's procedures.

Assumptions and risk factors:

- Assumptions:
  - Healthcare professionals are adequately trained to comply with the policy.
  - Service providers will maintain accurate records of PGD use and audits.
  - Hartlepool Public Health will review audit results and incident reporting on a suitable frequency basis, not less than annually.
- Risk factors:
  - Potential delays in policy updates following legislative changes.
  - Inconsistent audit or reporting practices may hinder the monitoring process.
  - Lack of training or awareness may result in non-compliance or patient safety risks.

By establishing a clear monitoring and review process, with any commissioned service provider using PGDs, Hartlepool Public Health will ensure that PGDs are used effectively and safely, supporting high-quality patient care and compliance with regulatory requirements.

7.0 Evaluation

The evaluation of this policy is crucial for determining its effectiveness in achieving the intended outcomes, assuring compliance and quality of care provided under Patient Group Directions (PGDs) within Hartlepool Public Health commissioned services. The evaluation process will help identify strengths, areas for improvement, and any adjustments needed to enhance the policy's impact on patient care and safety.

Evaluation process:

- Audit Results: Regular audits of PGDs, conducted by service providers, will be reviewed to assess the compliance with the policy and the accuracy of PGD implementation. These audits will include an analysis of the outcomes of PGD use, highlighting areas of success and areas requiring improvement.
- Incident and Safety Reporting: Patient safety incidents and medication errors associated with PGDs will be evaluated to identify trends or recurring issues that require attention. The analysis of these incidents will help determine whether adjustments to the policy are needed to mitigate risks and improve safety practices.
- Stakeholder Feedback: Feedback from healthcare professionals, service providers, and patients will be collected to evaluate the policy's effectiveness in practice. This will include surveys or focus groups to gather insights into the practical application of PGDs and any challenges encountered.
- Training and Development: The effectiveness of training programmes provided to healthcare professionals will be evaluated based on their ability to comply with the PGD requirements and their understanding of the policy. Feedback from training will be used to adjust future training updates.

Contents

2. General policy statement

2.1. Patient group directions (PGDs) are defined as "written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment'[1]. These instructions allow certain healthcare professionals to legally supply and /or administer specified medicines to pre-defined groups of patients, without a prescription (see PGDs: who can use them).

2.2. This policy details the legislation and guidance governing the development, implementation, use and review of PGDs within Hartlepool Public Health commissioned services.

2.3. The legislation for PGDs is included in The Human Medicines Regulations 2012 (Reg 229-232), as amended. This includes use by Local Authorities; amendments at 8.9.25 here.

2.4. This policy seeks to ensure Hartlepool Public Health complies with these regulations and key guidance to the legislation or national standards for PGDs including:

- Health Service Circular 2000/026 (9th August 2000) Patient Group Directions (PGDs)[2]
- PGD guidance issued by the Medicines & Healthcare Regulatory Agency (MHRA)[3]
- NICE Medicines Practice Guidance (MPG2) last updated March 2017[4]

2.5. PGDs provide a legal framework that allows the supply and/or administration of a specified medicine(s), by named, authorised, registered health professionals, to a pre-defined group of patients needing prophylaxis or treatment for a condition described in the PGD, without the need for a prescription or an instruction from a prescriber.

2.6. Specific information must be included in a PGD for it to be legally valid, and a PGD must be signed by a doctor (or dentist if relevant), a pharmacist, and on behalf of the authorising body

2.7. A PGD is not a form of prescribing and where possible, medication should be provided on an individual, patient-specific basis, i.e., via prescription. It is recognised that this may not always be possible and the supply and administration of medicines under PGDs should be reserved for those limited situations where this offers an advantage for patient care without compromising patient safety and where it is consistent with appropriate professional relationships and accountability.

2.8. The potential benefits to patient care include:

- Delivering effective patient care that is appropriate in a pre-defined clinical situation, without compromising patient safety
- Offering a significant advantage to patient care by improving access to appropriate medicines
- Providing equity in the availability and quality of services when other options for supplying and/or administering medicines are not available
- Providing a safe legal framework to protect patients
- Reducing delays in treatment
- Maximising the use of the skills of a range of healthcare professionals.

2.9. Hartlepool Public Health commissions a range of public health services for the local community. This policy sets out the arrangements by which Hartlepool Public Health may authorise (or in some cases adopt) the use of patient group directions (PGDs) by providers of these services, to improve patient access to medicines within the identified Public Health services.

2.10. Hartlepool Borough Council directly provides a 0-19 service which employs prescribers. This Policy as written excludes directly delivered services of the council but could be adapted to include such services in the future were this to become necessary.

2.11. The policy describes the role of Hartlepool Public Health in ensuring compliance with current legislation, guidance and best practice, considers the impact on equality and diversity and sets out arrangements for monitoring and evaluating the policy.

2.12. The policy outlines the role of Hartlepool Public Health and others in the development and distribution of PGDs in these circumstances:

- Hartlepool Public Health has developed and authorised the PGD(s)
- The commissioned provider has developed and authorised the PGD(s)
- The provider has developed the PGD(s) and Hartlepool Public Health has authorised the PGD(s)
- A PGD has been developed and authorised by a lead authority, for adoption by Hartlepool Public Health as part of a group of local authorities working together, making arrangements for a commissioned or 3rd party provider to use a PGD as part of a service commissioned by Hartlepool Public Health.

3. Roles and responsibilities

3.1. The SPS website hosts information including a short video explainer and links to a longer e-learning programme accessed via eLfH, for healthcare professionals and others involved with PGDs (including commissioners).

3.2. The designated Senior Responsible Officer for PGDs for Public Health Hartlepool is the **Director of Public Health (DPH)**,or nominated deputy. The DPH has overall responsibility for

- oversight and effective implementation of this policy and acts as the authorised signatory for PGDs where necessary.
- ensuring that processes are in place such that PGDs that support Hartlepool Public Health commissioned services) are developed, authorised or adopted, and distributed in accordance with current legislation and national guidance/ best practice and also according to local organisational policies and governance arrangements; (e.g. in line with SPS guidance How to develop a PGD)
- ensuring they have the necessary knowledge, skills and expertise needed for authorising PGDs and being aware of their responsibilities. (Refer to MPG2 Competency Framework for people authorising PGDs[5]); Competency Framework: For people authorizing PGDs).
- ensuring provision of the necessary pharmaceutical, medical and other appropriate clinical expertise for the development, authorisation and implementation of PGDs for use in commissioned public health services requiring PGDs;
- providing assurance of competence of the pharmaceutical, medical and other clinician expertise involved in the development of Hartlepool Public Health PGDs (see NICE MPG2 competency framework[5]); Competency Framework: For people developing and / or reviewing and updating PGDs)
- ensuring the service provider has access to copies of approved PGDs.

3.3. **Pharmaceutical Advice to Public Health (PhA).** Person(s) or organisation(s) providing Public Health Pharmacy Support or Advice (PhA) will, from approval of this new policy, provide support to the Hartlepool Public Health PGD Approval Group and the Director of Public Health (or nominated deputy) such that the PGDs that support public health commissioned services are developed, implemented and reviewed in line with current

legislation and national guidance, and within robust local clinical governance frameworks. Key roles include:

- supporting documentation submitted seeking approval of the PGD Approval Group for the development of a new PGD within a commissioned public health service;
- leading on the process for the development of a PGD by Hartlepool Public Health directly, for use in a commissioned public health service;
- leading the process by which Hartlepool Public Health authorises the use of PGDs within commissioned public health services where the provider organization is unable by law to authorise PGDs within their own organization (i.e. Independent Healthcare Providers or IHPs who may authorise PGDs for use in their own services, but not for commissioned services).
- ensuring that appropriate organisational records are maintained by Hartlepool Public Health, (see Section 1.8 of NICE MPG2 and section 12 of this policy) e.g.,
    - PGD Approval Group decisions (Appendix 1 and 2 – information also includes members of the PGD Working Groups).
    - A list of all PGDs in use within commissioned public health services, including their review / expiry date.
    - Master authorised copies of all PGDs.
    - Expired versions of all PGDs (see SPS guidance Retaining legal mechanism documentation. Copies of expired PGD master documents will be kept as for all other patient records. For adults all PGD documents must be kept for a minimum of 8 years, and those that apply to children must be kept for 25 years).

- for PGDs written by Hartlepool Public Health, ensuring that all providers can submit copies of the PGD Individual Authorisation Forms on request

  ensuring that that this role is carried out in line with the required competence (see NICE MPG2 competency framework[5]); Competency Framework: For people developing and / or reviewing and updating PGDs).

3.4. The HBC PGD Approval Group

- The role of the PGD Approval Group is to provide evidence to the DPH to demonstrate that PGDs are developed in line with legal requirements in The Human Medicines Regulations 2012, related guidance/ recommendations, in section 1.2 of NICE MPG2 and SPS guidance How to develop a PGD and robust clinical governance procedures
- The PGD Approval Group is a locally determined multidisciplinary group that considers proposals to develop a PGD to deliver a service and is responsible for the process of approval of PGDs.
- In Hartlepool Public Health, the PGD Approval Group will be: The public health senior management team (PHSMT) including specialist pharmacist representation.

Responsibilities of the PGD Approval Group include:

- Considering requests for new PGDs
- Deciding on membership of the PGD Working Group for Hartlepool Public Health developed PGDs and for other PGDs requiring Public Health team input for their development.

- Prioritising proposals to develop a PGD
- Seeking the views of stakeholders on proposals, for example, from clinical groups, patients and the public, and the commissioning or provider organisation(s)
- Gathering intelligence about local service delivery and exploring all the options for prescribing, supplying and/or administering medicines in a specific situation
- Considering the arrangements for the security, storage, packaging and labelling of medicines where applicable
- Considering the resources needed to deliver the service, such as medicines procurement from a licensed manufacturing unit and any diagnostic equipment
- Considering the resources, training and competencies needed for developing, authorising, using, monitoring, reviewing and updating the PGD
- Engaging with finance and commissioning to align decisions within the framework of clinical commissioning
- Ensuring decision-making is robust and transparent with final decisions on proposals formally recorded and communicated to appropriate stakeholders.
- Ensuring all approved PGDs are reviewed in a timely manner.
- Ensuring all PGDs used to support Hartlepool Public Health commissioned services meet all legal, regulatory and national guidance (NICE) requirements and have followed robust governance procedures
- Ensuring a robust and transparent appeals process

4. Identifying the need for a PGD

4.1. Wherever possible medicines are to be administered or supplied on an individual patient basis following the direction of a prescriber for that specifically named patient.

4.2. The majority of clinical care involving supplying and/or administering medicines should be undertaken on an individual, patient-specific basis where this does not compromise patients' timely access to care. PGDs should be reserved for use **only** in cases where they offer an advantage for patient care, without compromising on safety, and where there are clear governance arrangements and accountability.

4.3. The purpose of using a PGD is to:

- deliver effective patient care that is appropriate in a pre-defined clinical situation, without compromising patient safety;
- offer a significant advantage to patient care by improving access to appropriate medicines;
- provide equity in the availability and quality of services when other options for supplying and/or administering medicines are not available;
- provide a safe legal framework to protect patients;
- reduce delays in treatment;
- maximise the use of the skills of a range of health professionals.

4.4. PGDs should not be used to provide long term treatment. PGDs should normally be reserved for meeting immediate or short term conditions or health needs.

4.5. Using a PGD is not a form of prescribing and PGDs do not allow professionals to use prescription forms or other means to order medicines to be supplied by others.

4.6. The use of a PGD does not remove the inherent professional obligation and accountability of a registered healthcare professional as defined by their registration body. It is the responsibility of each professional to ensure that they understand the use, dose, adverse

effects, cautions and contraindications of each medicine they supply or administer. Professionals must continue to use their professional judgement in each individual situation.

4.7. A PGD will only be developed:

- in response to an identified service need or development;
- for situations where the use of PGDs will benefit patient care, without compromising safety, compared to other mechanisms for the supply or administration of medicines;
- where other options for the supply or administration of a medicine have been considered and appraised;
- where exemptions in legislation are not in place to allow supply / administration without the need for a PGD (e.g. a General Sales List product);
- where the national NHS Specialist Pharmacy Service PGD resource[6] has been used to consider whether a PGD is necessary and the most appropriate method to provide the medicine.

4.8. Persons or services identifying a need for a PGD must obtain approval for its development and subsequent use by submitting a PGD development proposal request to the PGD Approval Group using the approved Request for the Development of a PGD Form (Appendix A)

4.9. If the decision that a PGD would be required is made as part of the commissioning/ service development process, a PGD request form can be initiated by either the commissioner or the provider, but must subsequently follow the approval process.

Public health commissioned services that identify a need for a new PGD to be developed (or require a review) by HBC or by IHPs for public health commissioned services, must obtain approval for the PGD by submitting the draft PGD where applicable and the Approval form for a new PGD / existing PGD revision to the PGD Approval Group (see Appendix A).

The information in Appendix A supports Public Health SMT in its role as the PGD Approval Group to meet its responsibilities in line with the recommendations of section 1.2 of NICE MPG2 and SPS guidance How to develop a PGD including the NHS Specialist Pharmacy Service PGD resource[6].

5. Proposal to develop a PGD

5.1. The PGD Approval Group will consider requests for PGD development and approve if appropriate.

5.2. Either HBC or the provider organisation may have responsibility for developing PGDs. This will be determined by the PGD Approval Group.

5.3. Prior to the approval of a request other individuals or groups may be consulted, as appropriate.

5.4. Requests are to be made using the Request for the Development of a PGD Form (Appendix A). This includes the following information:

- the title of the PGD;
- details of the proposer and other individual people who would be involved in developing and authorising the PGD;
- details of the organisation delivering the service (if this organisation is not the authorising body);
- the setting where the PGD would be used;
- the condition to be treated, considering patient inclusion and/or exclusion criteria;

- benefits to patient care;
- potential risks to patient safety;
- details of medicine(s) to be supplied and/or administered, including dosage, quantity, formulation and strength, route and frequency of administration, duration of treatment and whether it is included in the local formulary;
- health professional groups who would work under the PGD, including training and competency needs;
- current and/or future service provisions for supplying and/or administering the medicine(s), including its position within the care pathway;
- evidence to support the proposal;
- resources needed to deliver the service;
- a timescale for developing the PGD;
- indication of how medicines will be purchased and stored, including pre-labelled medicines for supply;

5.5. Approval for development of a PGD would be granted in writing using the PGD Development Approval Form (Appendix B), following consideration of the information provided, benefits and risks and the principles outlined in section 3, and is to include:

- approval of the doctor, pharmacist and other members of the working group proposed or, if not identified in the request, identification and approval of the persons to develop the PGD;
- stipulation of any specific requirements or limitations to the PGD including:
    - minimum qualification/training requirements for those using the PGD;
    - maximum doses or length of treatment;
    - criteria for patients to be excluded from the PGD;
    - criteria for exclusions or restrictions on the use of the PGD regarding service provision.

5.6. The PGD Approval Group will appoint a PGD working group to develop each PGD.

5.7. Section 1.3 of NICE MPG2 recommends that the PGD working group is a multidisciplinary group which will include as a minimum a named lead author, a doctor (or dentist as appropriate), a pharmacist, and a representative of any other professional groups who will practice under the PGD. Other experts may be seconded to the group as needed. Any of these professionals may be the lead author as agreed by the group.

5.8. The senior doctor should be a doctor who has expert knowledge in the therapeutic field the PGD is addressing (refer to MPG2 resources: competency framework[5])

5.9. The senior pharmacist should be a pharmacist who has expert knowledge in the therapeutic field the PGD is addressing together with expert knowledge on the development and use of PGDs.

5.10. The representative of the other professional group(s) (if required) should also be a specialist in the particular clinical field being addressed within the PGD.

5.11. All PGD Working Group members should have the appropriate competence to carry out their expected role as defined in NICE MPG2 Competency Framework: For people developing and / or reviewing and updating PGDs.

5.12. Any one of the involved professionals will be nominated as Lead Author as agreed by the group.

5.13. Draft PGDs should be sent to representatives of the professional groups who will be operating under the PGD for comment and for identification of potential issues that may arise when PGDs are implemented; e.g., for PGDs to be used in community pharmacy, the Local Pharmaceutical Committee.

5.14. A list of members of the PGD Working Group and any minutes and / or version controls of the PGD development must be kept. See SPS guidance Patient Group Directions and electronic record systems for electronic solutions that can be used to write and agree a PGD.

5.15. The PGD Working Group is also responsible for ensuring that the PGD is updated as appropriate.

6. Writing a PGD

6.1. The development of a PGD should not proceed until the PGD Approval Group, with the delegated authority of HBC has formally agreed that a PGD is needed.

6.2. Patient Group Directions must be developed in accordance with legislation, national guidance and include any specific requirements stipulated in the approval of the development of the PGD.

6.3. PGDs must be written using the national Patient Group Direction (PGD) exemplar template[7] produced by NHS Specialist Pharmacy Services that outlines the information legally required and a generic PGD competency framework.

6.4. Every section must be completed in the PGD in order to comply with HSC 2000/026: Patient Group Directions (Department of Health, 2000).[2] If a section is not applicable, it must be made clear why that is the case.

6.5. Use the best available evidence, such as NICE guidance and other sources of high-quality information when developing PGDs.

6.6. References used must be clinically accurate and up-to date and listed in an appendix to the PGD. References must be updated when a PGD is renewed.

6.7. The senior doctor, pharmacist and member(s) of the healthcare professional expecting to use the PGD (if required), must sign the PGD front sheet to indicate satisfactory completion of the PGD. The signature may be added electronically with permission from the signatory.

6.8. All group members should have appropriate training and competence to carry out their expected role as defined in NICE MPG2 competency framework[6].

6.9. All of the group should be involved in the development of the PGD and are responsible for ensuring that supply and administration of medicines by PGD is within the law.

6.10. The PGD working group will involve local drug and therapeutics committees and prescribing committees when relevant.

6.11. The working group will be responsible for the development and review of one or a number of PGDs as agreed with the PGD Approval Group. In addition, the working group is responsible for ensuring all relevant PGDs are updated and maintained appropriately

6.12. All stakeholders in the development of the PGD should be identified by the PGD Development (or Working) Group and consulted on the development of the PGD. Draft PGDs will be sent to representatives of the professional groups who will be operating under the PGD for comment and for identification of potential issues that may arise when PGDs are implemented (‘road-testing’). A list of members of the PGD Development (or Working) Group and any minutes and / or version controls of the PGD Development (or Working) Group meetings must be kept.

6.13. In the case where the provider is an authorising body, Hartlepool Public Health will not be required to develop or authorise PGDs used by the provider to deliver the commissioned service, unless otherwise stated in the service specification. Hartlepool Public Health will be

required to seek assurance from the provider that all relevant PGDs have been developed and used in line with regulatory and best practice requirements (Appendix D).

6.14. In the case where the provider has developed the PGDs to deliver the commissioned service but is not an authorising body or legally able to authorise PGDs, then Hartlepool Public Health will be required to act as the authorising body (signatory) for these PGDs. For this to take place the provider will need to submit their PGDs to Hartlepool Public Health for review and authorisation (section 7)

6.15. Hartlepool Public Health will take the lead on developing PGDs for services directly commissioned by HBC that specifically require and specify the use of Patient Group Directions, unless otherwise stated in the service specification. In these cases, Hartlepool Public Health will:

- wherever possible develop PGDs in collaboration with the service provider(s) or representative body.
- write PGDs using the national Patient Group Direction (PGD) exemplar template[1] produced by NHS Specialist Pharmacy Services and inserting the Hartlepool Public Health logo where directed.
- Submit PGDs for authorisation following process outlined in section 6.

6.16. The development of new PGDs, which are not part of any nationally endorsed programme, should not be commenced until the person(s) that have identified the need for the PGD, have followed the pathway described by NICE MPG2[5] and obtained the appropriate approval for its development and use, by completion of the Request for the Development of a PGD Form (Appendix A).

6.17. The update and renewal of existing Patient Group Directions will follow the same process as for the development of new PGDs, but without the need for the completion of a Request for the Development of a PGD form, as described in Appendix C.

6.18. The PGD Working Group may consult with other relevant stakeholders or persons during the development of the PGD. In submitting the PGD for authorisation to the PGD Approval group, the working group must detail any consultation that has been undertaken.

6.19. The PGD must enable the highest standard of practice for each clinical situation to be achieved.

6.20. Patient Group Directions must be signed by the senior doctor, pharmacist and at least one representative of the professional group(s) involved in the development of the PGD prior to submitting it for approval. Signatures of the doctor(s) and pharmacist(s) are an acceptance of responsibility for the clinical and pharmaceutical accuracy and appropriateness of a PGD in the circumstances in which it will be used. Those signing PGDs need to ensure adequate indemnity arrangements are in place.

6.21. The supply and administration of medicines under Patient Group Direction should be reserved for those limited situations where this offers an advantage to patient care without compromising patient safety and be consistent with appropriate professional relationships and accountability. The majority of clinical care should still be provided on an individual, patient specific basis, as recommended by legislation.

6.22. The legislation specifies that each all PGDs must contain the following information:

- the name of the business to which the direction applies;
- the date the direction comes into force and the date it expires;
- a description of the medicine(s) to which the direction applies;

[1] SPS National Patient Group Direction (PGD) exemplar templates – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice

- class of health professional who may supply or administer the medicine;
- signature of a doctor or dentist, as appropriate, and a pharmacist;
- where not for use by pharmacy professionals, signature of a representative health care professional (HCP) from the profession that will be using the PGD (NB. This is not a legal requirement, but best practice);
- signature by an appropriate authorising body (ICBs, Local Authorities, NHS Trusts or Foundation Trusts, Special health authorities, NHS England);
- the class of health professional who may supply or administer the medicine;
- the clinical condition or situation to which the direction applies (i.e. clinical criteria under which a person is eligible for treatment);
- a description of those patients excluded from treatment under the direction;
- a description of the circumstances in which further advice should be sought from a doctor (or dentist, as appropriate) and arrangements for referral;
- details of appropriate dosage and maximum total dosage, quantity, pharmaceutical form and strength, route and frequency of administration, and minimum or maximum period over which the medicine should be administered;
- relevant warnings, including potential adverse reactions;
- details of any necessary follow-up action and the circumstances;
- a statement of the records to be kept for audit purposes.

6.23. Any adverse clinical incidents that occur in relation to the supply and/or administration of medications within a PGD should be recorded using local reporting mechanisms. Any serious adverse side effects of medications should be reported in the usual way, using the yellow card system.

6.24. There must be comprehensive arrangements for the security, storage and labelling of all medicines.

6.25. Wherever possible, medicines should be supplied in pre-packs made up by a pharmacist. In particular there must be a secure system for recording and monitoring medicines use from which it should be possible to reconcile incoming stock and out-goings on a patient by patient basis. Names of the health professionals providing treatment, patient identifiers and medicine provided should all be recorded. The NHS Executive document "Controls Assurance Standard - Medicines Management (Safe and Secure Handling)" provides guidance on related legislative requirements and best practice.

6.26. The EC Labelling and Leaflet Directive 92/27 applies to all supplies of medicines, including those supplied under PGDs. A patient information leaflet should be made available to patients treated under PGDs.

6.27. It is important that the use of any medicine is consistent with the Summary of Product Characteristics for the relevant product (save in special circumstances) and any relevant authoritative good practice guidance.

7. Authorisation of PGDs

7.1. A final version of the PGD must be submitted, with the PGD Approval Form (Appendix C) completed for authorisation.

7.2. Prior to authorisation the senior doctor, pharmacist and other appropriate members of the PGD working group must have signed the appropriate section of the PGD front sheet to indicate satisfactory completion of that PGD.

7.3. PGDs must be authorised only by an appropriate authorising body in line the Human Medicines Regulations 2012. In England, organisations who can authorise PGDs for publicly funded services are:

- NHS Integrated Care Boards (ICBs)
- Local Authorities (LAs)
- NHS Trusts or NHS Foundation Trusts (FT)
- NHS England (NHSE)
- UK Health Security Agency (UKHSA)

7.4. The commissioning and/or provider organisation can be an authorising body. If the provider is an authorising body, the commissioning organisation is not legally required to authorise the PGD for the provider. Therefore, Hartlepool Public Health will not act as the authorising body in such cases, unless specified in the contract. In this case of the latter, the PGD Approval Form (Appendix C) should be completed and submitted prior to authorisation.

7.5. In the case that the provider is the authorising body, both the commissioner and provider have joint responsibility to ensure that the legal and governance frameworks are in place for each PGD. In these cases Hartlepool Public Health will seek assurance from the provider that that all legal, regulatory and governance requirements are followed and in place (see Appendix D).

7.6. Provider organisations that can legally authorise their own PGDs should assure Hartlepool Public Health that they:

- have a robust governance process in place for the development, authorisation, implementation, and monitoring of PGDs, which meet statutory and regulatory requirements and that these processes are included in a PGD Policy;
- maintain a register of all healthcare professionals competent and registered to deliver the PGD;
- maintain a record of all PGDs and a record of all changes and versions of the PGD;
- ensure all authorised healthcare professionals registered to deliver the PGD services have access to the most up to date versions;
- have a medicines policy for the safe and secure handling of medicines, which includes the supply and storage of medicines.

7.7. In the case that the provider is the authorising body, the Public Health team's appointed medicines adviser will review the content of the PGD to ensure that it contains all legally required information, and check that local protocol and governance arrangements have been followed as per NICE Guidelines. The Public Health team's appointed medicines adviser is not responsible for reviewing the clinical content of the PGD: this is the responsibility of the commissioned provider organisation.

7.8. Hartlepool Public Health will be the appropriate authorising body for:

- PGDs that have been developed by provider organisations for services commissioned by Hartlepool Public Health team, where the provider is not legally able to be an authorising body (such as an Independent Healthcare Provider).
- PGDs that have been developed by Hartlepool Public Health team for use in Public Health commissioned services.

7.9. In cases where the commissioned provider is not an authorising body (i.e. authorised to sign off its own PGDs), the Director of Public Health (or nominated deputy) for Hartlepool Public Health will act as the authorising signatory.

7.10. The designated signatory for Hartlepool Public Health (The Director of Public Health, or nominated deputy) must sign on behalf of the authorising body (Hartlepool Public Health) to establish that all:

- local processes and governance arrangements have been followed, following assurance from the Public Health team's appointed medicines adviser.

- all legal requirements have been met, following assurance from the Public Health team's appointed medicines adviser.

7.11. Electronic signatures may be used in line with the SPS guidance "Questions about electronic systems and PGDs".[9]

7.12. It is good practice for the authorised signatory not to be involved with the development of the PGD.

7.13. The signatory on behalf of the organisation should not be required to check clinical content of the PGD in detail but they should be confident that the doctor and pharmacist signatories (and anyone else involved in the development of the PGD) have adequate competency, skills and experience to carry out the role;

7.14. Evidence of the decision for final approval of a PGD will be documented in the PGD Approval Form (appendix C)

7.15. In the event that a service which requires the implementation of a PGD is commissioned by one or more authorising bodies, an agreed lead commissioner must be identified under a memorandum of understanding which outlines the roles and responsibilities regarding the PGD.

7.16. Before new or reviewed PGDs can be issued for use, the PGD must be authorised by the Hartlepool Public Health designated signatory (see section 2). The designated signatory must sign and date the PGD front signature sheet.

7.17. Any proposed changes or updates to an existing PGD must follow the same authorisation procedure. Once authorised, the amended PGD will immediately supersede the previous PGD for that area of practice.

8. Implementation of PGDs

8.1. When a new or revised PGD is developed and authorised, an electronic copy will be sent to all appropriate providers. A pdf copy of the original document will be available on Hartlepool Public Health website or other appropriate website e.g. PharmOutcomes.

8.2. Authorised PGDs should be made available to health care professionals delivering the service via the provider organisation intranet to ensure they have access to most up to date versions.

8.3. Each individual member of staff working to a PGD must sign the 'Individual Authorisation' page in the document. A senior practitioner in the service or service manager must ensure that only staff that are competent to work under the PGD are signed up to it. They must also sign the 'Individual Authorisation'. A copy of this must be photocopied and returned to the service lead/manager as a record.

8.4. Providers who use PGDs to deliver Public Health commissioned services will be expected to:

- follow robust process in line with regulation and NICE Guidelines MPG2, 2013;
- comply with all statutory and regulatory requirements relating to PGD development, authorisation and use.

9. Review of PGDs

9.1. A PGD is to be reviewed, if necessary revised, and re-authorised every 2 years or sooner if new information becomes available.

9.2. Each PGD must have a review date. This will normally be two years from the development of the PGD or from the last review date. The review date is not an expiry date. PGDs can be

used past their review date, so long as they have been risk assessed for continued use and this information has been shared with Hartlepool Public Health PGD Approval Group.

9.3. The PGD Approval Group is responsible for ensuring that PGDs are reviewed in a timely manner and for identifying appropriate persons to form the working group.

9.4. PGDs must not be used beyond their expiry date as any supply and/or administration of a medicine(s) beyond this would be made without legal authorisation. The expiry date for a PGD should be considered and determined on a case-by-case basis with patient safety paramount. It will normally be two years from the date the PGD was authorised (or re-authorised following review) and NICE recommend a maximum of 3 years.

9.5. In exceptional circumstances PGDs (developed and authorised by Hartlepool Public Health) that have reached their expiry date can have an authorised extension of up to 12 months to allow their continued use. An extension letter must be sent to all providers that are using any PGDs that have been extended in this way.

9.6. The PGD Approval Group is responsible for highlighting new information or circumstances which may require a PGD being reviewed.

9.7. Unless there are major changes to the personnel reviewing or using the PGD or the use of the PGD, the process in section 3 (identifying the need for a PGD) does not need to be followed.

9.8. Revised PGDs are to be developed, authorised and distributed as detailed in sections 5, 6 and 7.

9.9. When a PGD is reviewed all the changes made must be highlighted when submitting to the PGD Approval Group for authorisation. Major changes to an existing PGD will be highlighted within a covering letter when distributed.

9.10. PGDs should be reviewed, prior to the expiry date, with any:

- changes in legislation;
- important new evidence or guidance that changes the PGD, such as new national guidance;
- new information on drug safety;
- changes in the summary of product characteristics;
- changes to the local formulary.

9.11. Any review should follow the same process as for developing a new PGD and should review the clinical and pharmaceutical content following the identification (through a literature search) and evaluation of the latest evidence.

10. Competence to develop and authorise PGDs

10.1. NICE has published good practice guidance on the use of PGDs[5]

10.2. The guidance includes the core competencies needed for the safe use of PGDs in practice. This guidance should be read by all those involved with development, authorisation and users of PGDs.

10.3. Webpages of the SPS are particularly accessible to support all contributors to the process for developing and implementing PGDs, to “Understand what a Patient Group Direction (PGD) is and how it is used in clinical practice”. This is regularly updated (last update June 2025) see https://www.sps.nhs.uk/articles/introduction-to-pgds/

10.4. Hartlepool Public Health will need to understand and meet the requirement of national regulatory guidance “to ensure that only fully competent, qualified & trained professionals operate within directions”

- By ensuring that PGDs developed, include minimum requirements and standards of training, experience and skills.
- By identifying any additional training requirements, standards of training and the necessary experience/skills needed in specific circumstances, when approving PGDs.
- Where required, through service specifications and monitoring of services in which a PGD is used.
- By obtaining assurance from providers that only fully competent, qualified & trained professionals will be using the PGD.

11. Other legislation

11.1. Legislation for the labelling of medicines applies to all supplies of medicines, including those supplied under PGDs. Separate requirements exist for prescription-only medicine (POM) and for Pharmacy (P) and General Sales List (GSL) medicines.

11.2. A manufacturer's patient information leaflet (PIL) must be provided to patients who have a medicine supplied under a PGD. This is not required by legislation when a medicine is administered.

11.3. Providers should have a clear policy for the security, storage and labelling of all medicines. Medicines should be supplied in pre-packs made up by a pharmacist. There must be a secure system for recording and monitoring how medicines are used including stock control. See SPS for guidance.

12. Records and retention

12.1. Records will be kept of any applications to develop a PGD and notifications of decision made.

12.2. Where PGDs have been developed, a list of the names of members of the PGD Working Group(s) will also be kept.

12.3. Where Hartlepool Public Health is the authorising body, minutes and/or controlled documentation of the meetings will be kept.

12.4. The signatures of people signing a PGD will be kept securely.

12.5. A master copy (word or PDF) of current approved PGDs in use within Public Health commissioned services will be maintained.

12.6. Copies of expired PGD master documents will be kept as for all other patient records. For adults all PGD documents must be kept for a minimum of 8 years, and those that apply to children must be kept for 25 years.

12.7. Protected copies of PGDs (as PDFs) developed and authorised by Hartlepool Public Health will be disseminated to the relevant provider organisations. For each PGD, the provider organisations should:

- identify a senior, responsible person from within the service to authorise named, registered health professionals to practice under the PGD;
- ensure that authorised health professionals have signed the appropriate documentation.

12.8. It is good practice for the provider to keep up to date lists of all authorised health care professionals for each PGD and for the commissioner to keep a log of all PGDs used for their commissioned service. The responsibility for authorising healthcare professionals will usually

be the providers but should be an agreement between the commissioner and provider and may be contained in their contract

12.9. Any incidents and outcomes, training records and results of monitoring and evaluation will also be stored securely.

13. PGD audit and monitoring

13.1. As stated in HSC 2000/026, care provided under a patient group direction must be audited.

13.2. Practitioners need to be able to access records of patients who have received medication under a PGD for audit purposes so that the appropriateness of the supply or administration (or of not supplying or administering a medicine) can be reviewed.

13.3. The provider organisation will be responsible for initiating and carrying out audit of their service PGDs with support as necessary from the Hartlepool Public Health and/ or the audit team.

13.4. The results of the audit should be shared within the service and reported to the PGD Approval Group.

13.5. The results must highlight areas of best practice as well as areas of concern and identify any areas of training and development need.

13.6. Action plans to manage improvement in compliance will be developed where necessary.

13.7. PGDs will not normally be accepted for revision unless an audit report has been provided.

13.8. Patient safety incidents relating to PGD use will be reported, collated and reviewed by the provider organisations in a planned programme, in line with national patient safety reporting systems.

13.9. Quarterly medication error/incident reports will be produced by the provider organisation and shared with the PGD Approval Group.

13.10. Compliance with this policy will be monitored using analysis of incidents and complaints where there has been a failure to follow procedure.

14. Policy monitoring and review

14.1. The Hartlepool Public Health team will be responsible for monitoring this policy.

14.2. The policy will be reviewed every two years and amended and updated as necessary.

15. Equality and diversity

15.1. This policy will apply equally and not disadvantage either directly or indirectly any person who lives, works or visits the borough, in respect of the protected characteristics of the Equality Act 2010.

16. Reference Sources or Bibliography

1. Specialist Pharmacy Service. Introduction to PGDs. https://www.sps.nhs.uk/articles/introduction-to-pgds/ (Accessed 16/11/2025)

2. Human Medicines Regulations 2012 (as amended) http://www.legislation.gov.uk/uksi/2012/1916/contents/made (Accessed 16/11/2025)
3. Health Service Circular (HSC) 2000/026. Patient Group Directions (England Only). https://webarchive.nationalarchives.gov.uk/ukgwa/20080117120000uo_/http://www.dh.gov.uk/prod_consum_dh/DH_4012260b9c5.pdf (Accessed 16/11/2025)
4. Medicines and Healthcare Regulatory Agency (MHRA). Patient Group Directions: who can use them (updated 4.12.2017) https://www.gov.uk/government/publications/patient-group-directions-pgds/patient-group-directions-who-can-use-them (Accessed 16/11/2025)
5. NICE. Medicines Practice Guideline MPG2. Updated March 2017. https://www.nice.org.uk/guidance/mpg2 (Accessed 16/11/2025)
6. NICE. Patient Group Directions Tools and Resources. MPG2 competency frameworks. https://www.nice.org.uk/guidance/mpg2/resources Accessed (Accessed 16/11/2025)

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7. Specialist Pharmacy Service. When to use a PGD (last updated 12/02/2024) When PGDs can be used – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice (Accessed 16/11/2025)
8. Specialist Pharmacy Service. National Patient Group Direction (PGD) exemplar templates https://www.sps.nhs.uk/articles/sps-national-patient-group-direction-pgd-exemplar-templates (Accessed 24/07/2024)

   Specialist Pharmacy Service . Questions about electronic systems and PGDs. August 2016. https://www.sps.nhs.uk/articles/questions-electronic-systems-and-pgds/ (Accessed 16/11/2025)

17. Appendices

Appendix A: Request for the Development of a PGD

The following document should be completed prior to the development of a PGD for use in a HBC public health commissioned service.
This form captures the information required by section 1.2 of NICE MPG2 and SPS guidance How to develop a PGD

Title of PGD
Name of service in which the PGD is to be used
Is this organisation also the authorising body? Yes/No – if no, who will be:
Setting and circumstances in which the PGD is to be used
Include role/ position within the care pathway:
Condition or health need to be met & broad benefit to patient care
Include consideration of patient inclusion and/or exclusion criteria:
Benefits and advantages of using a PGD over other methods of supply or administration e.g. prescribing, patient specific direction, training of additional non-medical prescribers:
Potential risks to patient safety
Medicine(s) to be included in PGD
Including dosage, quantity, formulation and strength, route and frequency of administration, duration of treatment and whether it is included in the local formulary:

Please tick below to indicate how the medicine will be provided:

Supply		Administration		Both		

Professional group(s) to be included in PGD

Specific qualifications or training requirements of those HCP

Include how will competency be assessed, who will authorise HCPs to practice under the PGD, and who will keep and maintain the list of authorised users:

Potential risks to patient safety

Is the PGD required to support a new service development?

Yes/No
If yes provide details of funding approval for the service development

Details of how medicine will be funded, purchased and stored

Include if applicable, the arrangements for packaging and labelling, and collection of prescription-equivalent charges:

Other resources needed to deliver the service and funding source

Timescale for developing the PGD

If known please name the healthcare professionals who will form the PGD working group	
Doctor	
Pharmacist	
Clinician representative practising under the PGD	
Other(s)	

If known or applicable please name the healthcare professionals who will authorise the PGD	
Lead Doctor	
Lead Pharmacist	
Lead Clinician practising under the PGD	
Organizational authorization	
Other(s)	

	Name	Title	Signature	Date
Proposer (manager or clinical lead):				
Head of Service				

Proposer

We confirm that:

- An organizational PGD policy is in place.
- The service has considered whether a PGD is appropriate by considering other potential options for supply and the SPS guidance When to use a PGD.
- The PGD content will comply with the specific information which must be included in a PGD for it to be legally valid, and with the NICE MPG2 Commissioning support: PGD template. and the SPS – national PGD template
- The process for developing the PGD will comply with NICE MPG2 and SPS guidance How to develop a PGD
- The professionals that will be involved in developing, authorizing, monitoring, reviewing, and updating the PGD will have the necessary competencies as described in NICE MPG2 Competency Framework: For people authorizing PGDs and Competency Framework: For people developing and / or reviewing and updating PGDs.
- The professionals that will be involved in using the PGD will work according to the guidance in NICE MPG2 section 1.5 and will have the necessary competencies as described in NICE MPG2 Competency Framework: For health professionals using PGDs.
- The organization will maintain a register of all healthcare professionals competent and registered to deliver the PGD.

- The organization has a medicines policy for the safe and secure handling of medicines, which includes the supply and storage of medicines.

Please send to completed form by email to the relevant lead for this service within the public health team (Hartlepool)

This section for completion by the HBC PGD Approval Group

Checklist for the PGD Approval Group to consider for request to develop a new PGD to support a HBC commissioned service
in line with the necessary legal requirements, national guidance recommendations, and robust governance procedures (section 1.2 of NICE MPG2 and SPS guidance How to develop a PGD)

PGD Details:

PGD title	
Service in which the PGD is to be used	
Service lead	

Date of PGD Approval Group meeting:

Consideration	Public Health Pharmacy Adviser comments	Additional comments (PGD Approval Group)
Have all options for other routes of supply / administration been considered? e.g. training of further non-medical prescribers?		
Does use of this PGD align with the public health commissioned service framework?		
Will use of a PGD compromise patient safety?		
Is the medicine appropriate for use under a PGD?		
Are appropriately registered health professionals available to use the PGD, and have training and competency needs been addressed?		
Are there other resources needed to deliver the PGD within an appropriate timeframe e.g. finance and commissioning implications.		
Are there suitable governance and accountability arrangements in place for developing, authorizing, using, monitoring, reviewing, and updating the PGD?		
What are the arrangements for the security, storage, packaging and labelling of medicines		

Consideration	Public Health Pharmacy Adviser comments	Additional comments (PGD Approval Group)
where applicable, and collection of prescription charges where applicable (see SPS guidance NHS prescription charges for medicines supplied under PGDs or HMR 2012 exemptions). Confirm suitability of these arrangements		

Please use Appendix B: PGD Development Approval Form and /or Appendix C for output of the Approval Group:

Appendix B: Output of PGD Approval Group: PGD Development Approval Form

PGD Details:

PGD title	
Service in which the PGD is to be used	
Service lead	

The request to develop a Patient Group Direction for use within Hartlepool Public Health Commissioned services has / has not been (delete as appropriate) approved for development.

Name	Signature	Date
PGD Approval group member		
PGD Approval group member		

Approval has been granted on the condition that the following requirements or restrictions are included in the Patient Group Direction:

Qualifications, training and competency

Other requirements / restrictions (indicate and provide detail)
e.g. Minimum qualification/training requirements for those using the PGD *Maximum doses or length of treatment* *Criteria for patients to be excluded from the PGD* *Criteria for exclusions or restrictions on the use of the PGD regarding service provision*

Other comments:

Appendix C: PGD Approval Form

PGD Details:

PGD title	
Service in which the PGD is to be used	
Service lead	
New PGD / Update or review of existing PGD	

PGD Working Group:

Working Group Members	**Name**	**Job Title**
Date(s) of Meeting(s) (Working Group should meet at least once)		
Staff Groups Consulted		

If the PGD has been revised, please detail the amendments made to the original PGD:

_____

_____

Service Manager/Lead, Clinical Lead or Lead Author

Signature

_____Date_____

……

For office use only

Date of PGD Approval Group Meeting:

Outcome of the Approval Group: Approved ☐ Declined ☐

If declined state reasons why below:

The service manager/lead and the service clinical lead have 14 days to appeal the decision of the PGD Approval Group in writing or to re-submit the amended PGD with the recommended changes.

Appendix D: For an approved PGD
Pre-authorisation or adoption Assurance Check

This PGD review checklist forms part of the governance assurance and approval process required by Hartlepool Public Health, to support their responsibilities in authorising or adopting PGDs for use by their commissioned services.

To be completed by the Public Health Pharmacy Adviser and senior nurse if applicable. This completed form along with the reviewed PGD must be submitted to the PGD Approval Group and the Director of Public Health (or nominated deputy) for final review and governance approval.

Please attach a copy of the draft PGD with this approval form

Title & version of PGD			
New PGD	**Yes/No**		
Revision of existing PGD	**Yes/No**		
Provider name			
PGD written by			
Valid from		**Expiry date**	
Name of ratification group			

This form captures the information required by SPS guidance How to develop a PGD

Title of PGD
Name of service in which the PGD is to be used
Is this organisation also the authorising body? Yes/No – if no, who will be:
Setting and circumstances in which the PGD is to be used
Include role/ position within the care pathway:
Condition or health need to be met & broad benefit to patient care
Include consideration of patient inclusion and/or exclusion criteria:
Benefits and advantages of using a PGD over other methods of supply or administration e.g. prescribing, patient specific direction, training of additional non-medical prescribers:

Potential risks to patient safety

Medicine(s) to be included in PGD
Including dosage, quantity, formulation and strength, route and frequency of administration, duration of treatment and whether it is included in the local formulary: Please tick below to indicate how the medicine will be provided:

Supply		Administration		Both		

Professional group(s) to be included in PGD

Specific qualifications or training requirements of those HCP
Include how will competency be assessed, who will authorise HCPs to practice under the PGD, and who will keep and maintain the list of authorised users:

If PGD has been revised, please describe main amendments made to the original PGD:

Is the PGD required to support a new service development?

Yes/No If yes provide details of funding approval for the service development
Details of how medicine will be funded, purchased and stored
Include if applicable, the arrangements for packaging and labelling, and collection of prescription-equivalent charges:
Other resources needed to deliver the service and funding source
Has final draft of PGD been agreed with the relevant stakeholders / representatives of the professional groups who will be operating under the PGD?

PGD Working Group:

Working Group Members	**Name**	**Job Title**
Date(s) of Meeting(s) (Working Group should meet at least once)		
Staff Groups Consulted		

If the PGD has been revised, please detail the amendments made to the original PGD:

Healthcare professionals who have or will authorise the PGD	
Lead Doctor	
Lead Pharmacist	
Lead Clinician practising under the PGD	
Organizational authorization	
Other(s)	

Checklist continues;

Present & fully documented in the PGD?	Please tick			Comments
	Yes	No	N/A	
Signatures & PGD validity details				
Signatures of all health professionals who formally developed the PGD present?	☐	☐	☐	
Name of PGD and version included?	☐	☐	☐	
Date the direction comes in to force and the date it expires?	☐	☐	☐	
Signature(s) of governance approval of the PGD by the provider organisation?	☐	☐	☐	
Content				
Name of the service(s) to which the direction applies.	☐	☐	☐	
Staff characteristics section	☐	☐	☐	
Link to appropriate Green Book chapter and/or references for immunisation if applicable	☐	☐	☐	
Clinical condition/situation section				
Alternative options considered?	☐	☐	☐	
Clinical condition or situation defined?	☐	☐	☐	
Inclusion / exclusion criteria documented?	☐	☐	☐	
Caution section completed?	☐	☐	☐	
Action to be taken if patient excluded?	☐	☐	☐	
Action to be taken if the patient or carer declines treatment?	☐	☐	☐	
Arrangements for referral for medical advice?	☐	☐	☐	
Description of treatment section				
Name, strength & formulation of drug	☐	☐	☐	
More than one medicinal substance?	☐	☐	☐	
Defines legal classification?	☐	☐	☐	
Black triangle medicine used?	☐	☐	☐	
Off label use defined?	☐	☐	☐	
Route / method of administration?	☐	☐	☐	
Dose and frequency of administration?	☐	☐	☐	
Duration of treatment?	☐	☐	☐	
Quantity to be supplied / administered?	☐	☐	☐	
Storage and disposal?	☐	☐	☐	
Drug interactions?	☐	☐	☐	
Identification & management of adverse reactions?	☐	☐	☐	
Reporting procedure of adverse reactions	☐	☐	☐	
Written information to be given to patient or carer	☐	☐	☐	
Patient advice / follow up treatment	☐	☐	☐	
Special considerations / additional information	☐	☐	☐	
Records section included & fully defined?	☐	☐	☐	

References & PGD management details				
Reference section completed?	☐	☐	☐	
Practitioner authorisation section?	☐	☐	☐	
Authorising manager section?	☐	☐	☐	
PGD governance process				
Does the organisation that has clinically developed the PGD have satisfactory PGD governance processes in place? developing, authorizing, using, monitoring, reviewing, and updating the PGD?	☐	☐	☐	
Does the provider requesting PGD approval as authorising body, have adequate/satisfactory formal governance structures in place?	☐	☐	☐	
Does use of this PGD align with the public health commissioned service framework?	☐	☐	☐	
Will use of the PGD compromise patient safety?	☐	☐	☐	
Is the medicine appropriate for use under a PGD?	☐	☐	☐	
Are appropriately registered health professionals available to use the PGD, and have training and competency needs been addressed?	☐	☐	☐	
Are there other resources needed to deliver the PGD within an appropriate timeframe e.g. finance and commissioning implications	☐	☐	☐	
Suitability of arrangements for security, storage, packaging and labelling of medicines where applicable, and collection of prescription charges where applicable	☐	☐	☐	
Suitability of arrangements for collection of prescription charges where applicable	☐	☐	☐	
Checklist completion details (carried out by Public Health Pharmacy Advise confirmed by PGD Approval Group)				
Completed by:				
Signature				
Title & role:				
Date checklist review completed:				

Confirmation of action by DPH as applicable

PGD Authorisation

Name	Signature	Date
DPH		

or

PGD Adoption

Name	Signature	Date
DPH		

Once the PGD has been approved:

1. Who is responsible for keeping the master copy of the authorised PGD?

2. How will individual authorised practitioners access the most current versions of authorised PGDs?

3. Who is responsible for monitoring and reviewing the use of the PGD e.g. in line with any significant changes to clinical practice?

4. When is the next PGD review date?

Hartlepool Borough Council

Adult Services and Public Health Committee

5 March 2026

Report of: Director of Public Health

Subject: SUICIDE PREVENTION AND MENTAL HEALTH UPDATE

Decision Type: For information

1. Council Plan Priority

Hartlepool will be a place:
where people live healthier, safe and independent lives. (People)

2. Purpose of Report

2.1. The purpose of this report is to provide an update on the efforts to support a reduction in suicides across Hartlepool and improve mental health and wellbeing.

3. Background

3.1. Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

3.2. Mental health data for Hartlepool indicates higher-than-average prevalence rates for depression, anxiety, and related issues compared to both regional (North East) and national (England) averages. It is estimated that nearly one in four adults in Hartlepool have depression or anxiety. Approximately 19.3%

of people aged 16 and over are estimated to have a common mental health disorder, the third-highest level in the North-East. The annual GP Patient Survey (GPPS) has consistently shown that response in Hartlepool demonstrates a higher-than-average level of depression and anxiety in patients. Across the four-year reporting period Hartlepool has maintained a gap of at least 3% above the England average. The GPPS has also shown a spike in those long-term mental health problems in 2017/18.

3.3. Hartlepool and the wider North-East continue to show persistently high suicide rates, often exceeding the national average. During 2019–2021, Hartlepool recorded a rate of 14.7 deaths per 100,000 residents, with men accounting for more than three-quarters of these cases.

3.4. The causes of suicide are often complex with rarely a single cause; therefore, the prevention of suicide must address this complexity. Whilst suicide is often the result of a combination of factors, we know that there are certain risk factors and adverse experiences that can result in the feeling of desperation which include:

- physical illness,
- financial difficulty and economic adversity,
- harmful gambling,
- substance misuse,
- domestic abuse,
- social isolation and loneliness.

3.5. The Tees Suicide Prevention Strategic Plan 2024-2029 developed with partners mirrors the priorities within the national Suicide Prevention Strategy for England and uses local data and intelligence on suicide and self-harm collected through the police and coroner which includes regional and local real-time intelligence which continues to expand in breadth and quality, and there are mechanisms to inform our understanding of trends.

3.6. The views and experiences of people with personal experience are involved routinely in the development of policy and actions.

4. Update

4.1. Hartlepool public health completed mental health, and wellbeing needs assessments for both children and adults. A public mental health plan is being developed with partners using the available data in both needs assessments to identify key priority areas and will link to the recommendations in the recently published Men’s Health Strategy November 2025 recommendations.

4.2. Public health contributes to the mental health community transformation work and working with health and social care colleagues to embed the I-THRIVE model across Tees. The THRIVE Framework is an integrated, person-centered and needs-led approach to delivering mental health services for children, young people and families into five categories: thriving, getting advice and signposting, getting help, getting more help and getting risk support. Emphasis is placed on the promotion of mental health and wellbeing, and for children, young people and their families to be empowered to be actively involved in decisions about their care through shared decision making.

4.3. Hartlepool is jointly commissioning Mental Health First aid (MHFA) Training and Applied Suicide Intervention Skills Training (ASIST) which will be rolled out in April 2026.

4.4. Since 2024 Public Health has funded additional mental health support through TEWV (Tees Esk and Wear Valley) and Alliance which includes embedded roles within drug and alcohol services, providing support for people accessing drug and alcohol treatment services as part of their recovery.

4.5. A needs assessment was conducted across Hartlepool looking at gambling-related harms which can be varied and long-lasting and can include:

- Decline in mental and physical health and wellbeing,
- Financial harm,
- Relationship disruption, conflict or breakdown,
- Criminal activity,
- Reduced performance in education or employment,
- Cultural harms, including stigma and isolation

4.6. Public health jointly funds Togetherall along with adult social care. Togetherall provides a safe accessible intervention that is moderated by licensed mental health professionals who clinically assess risk, and when needed, escalate to appropriate support pathways, such as safeguarding and crisis support. It improves access to mental health support and peer support as there are no waiting lists and support is available 24 hours a day, 365 days.

4.7. Impact to date:

- 607 Hartlepool residents signed up
- 71% of residents state they have not had any formal mental health support
- 22% identify as male
- 8% identify as being from an ethnic minority background

- 5% identify as gender diverse
- 35% are unable to work, unemployed or retired
- 35% identified as having a long-term health concern
- 20% identified as having a disability
- 40% of members had thoughts of hurting themselves and/or suicidal ideation
- 163 individuals received 1-1 support from a licensed clinician
- 16 crisis interventions have taken place
- 70% of access happens outside of traditional hours
- 91% of Hartlepool residents found the community helpful
- Ward data shows people from the following wards are most likely to access Togetherall; Victoria, Headland and Harbour, Burn Valley and Throston.

4.8. Public Health jointly commissions a Suicide Prevention Coordinator across Tees which is jointly funded and provides a coordinated response across Tees. The purpose of this role is to lead the implementation of the Tees Suicide Prevention Strategic Plan 2024-2029. A Tees Suicide Prevention Partnership group has been established which ensures a collaborative approach to implementation of the eight key priority areas to contribute to a year-on-year reduction in suicides across Tees:

- Supporting practice through local data collection, research, and intelligence.
- Provide tailored, targeted support to key priority groups.
- Identifying and addressing common risk factors linked to suicide.
- Promoting online safety and responsible media content
- Identifying and supporting crisis pathways across sectors
- Reducing access to the means and methods of suicide
- Providing effective bereavement support to those affected by suicide
- Making suicide everybody's business, understanding that suicide is not a single issue and requires work across services.

4.9 Impact to date:

- The provision of a regional postvention service 'If you care share' supporting those bereaved/affected by suicide, commissioned through the ICB and partners.
- Use of local data to ensure areas of high frequency used by people in crisis are managed correctly including increasing CCTV, footfall and Samaritan signage to increase the opportunity for intervention.
- The promotion of a local directory of services so people can access crisis support in the most appropriate environment for them, when they need it, whether that is through statutory health, VCSE or social care services.

- Promoting the Making Every Contact Count approach to encourage health and social care staff and health champions to use the opportunities arising during their routine interactions with individuals to have conversations about how they might make positive improvements to their health or wellbeing.

5. Other Considerations/Implications

Risk Implications	There are no risk implications.
Financial Considerations	Services are funded through the public health ring fenced grant.
Subsidy Control	There are no subsidy control implications.
Legal Considerations	There are no legal considerations.
Single Impact Assessment	No single impact assessment required.
Staff Considerations	No staff considerations.
Asset Management Considerations	No asset management considerations.
Environment, Sustainability and Climate Change Considerations	No environment, sustainability and climate change considerations.
Consultation	No consultation required.

6. Recommendations

6.1. It is recommended that the Committee notes the information within this report and the work to reduce suicides and to support the wider mental health and wellbeing of residents.

7. Reasons for Recommendations

7.1. Each suicide has far reaching consequences on local communities and supporting a year-on-year reduction in suicides is a national and local priority.

7.2. Mental health is vital to public health; mental wellbeing is profoundly important to quality of life and the capacity to cope with life's ups and downs. It is protective against physical illness, social inequalities and unhealthy lifestyles.

8. Background Papers

Children's mental health and wellbeing need assessment 2023.
https://www.hartlepool.gov.uk/downloads/file/1031/children-and-young-people-s-mental-health

Adult mental health and wellbeing need assessment 2025.
https://www.hartlepool.gov.uk/downloads/file/1383/mental-health-and-wellbeing-needs-assessment

Tees Suicide Prevention Strategic Plan 2024-2029.
https://www.middlesbrough.gov.uk/media/3k5hhtf4/tees-suicide-prevention-plan-2024.pdf

9. Contact Officers

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Sign Off:-

Chief Executive	Date: 09.02.2026
Director of Finance, IT and Digital	Date: 09.02.2026
Director of Legal, Governance and HR	Date: 09.02.2026