AUDIT AND GOVERNANCE COMMITTEE AGENDA

HARTLEPOOL BOROUGH COUNCIL

Thursday 16 October, 2014

At 10.00 am

In Committee Room B,
Civic Centre, Hartlepool.

MEMBERS: AUDIT AND GOVERNANCE COMMITTEE

Councillors Ainslie, S Akers-Belcher, Cook, Martin-Wells, Thompson, Sirs and Springer.

Standards Co-opted Members; Mr Norman Rollo and Ms Clare Wilson.
Parish Council Representatives: 2 vacancies.

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

   3.1 To confirm the minutes of the meeting held on 25 September, 2014 (to follow)

4. **AUDIT ITEMS**

   No items

5. **STANDARDS ITEMS**

   5.1 Appointment of Parish Council Representatives for Standards Issues – *Chief Solicitor*

6. **STATUTORY SCRUTINY ITEMS**

6.1 Investigation into Cardiovascular Disease – Setting the Scene:-

(a) Covering Report – *Scrutiny Support Officer*
(b) Presentation – *Public Health and the Tees Valley Public Health Shared Service*

6.2 Director of Public Health Annual Report 2013/14 – *Director of Public Health*

6.3 Substance Misuse Strategy Group – Updated Substance Misuse Treatment Plan 2014/15– *Director of Public Health*

6.4 Health and Wellbeing Board's response to the Investigation into Chronic Obstructive Pulmonary Disease – *Health and Wellbeing Board*

7. **MINUTES FROM THE RECENT MEETING OF THE HEALTH AND WELLBEING BOARD**

No items.

8. **MINUTES FROM THE RECENT MEETING OF THE FINANCE AND POLICY COMMITTEE RELATING TO PUBLIC HEALTH**

8.1 Extract from the minutes of the meeting held on 18 August 2014.

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

No items.

10. **MINUTES FROM RECENT MEETING OF SAFER HARTLEPOOL PARTNERSHIP**

10.1 To receive the minutes of the meeting held on 18 July, 2014.

11. **REGIONAL HEALTH SCRUTINY UPDATE**

11.1 Minutes of the meeting held on 17 April, 2014.

11.2 Verbal Update from the meeting held on 29 September, 2014

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

13. **LOCAL GOVERNMENT (ACCESS TO INFORMATION) (VARIATION) ORDER 2006**

EXEMPT ITEMS

Under Section 100(A)(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following items of business on the grounds that it involves the likely disclosure of exempt information as defined in the paragraphs referred to below of Part 1 of Schedule 12A of the Local Government Act 1972, as amended by the Local Government (Access to Information) (Variation) Order 2006

14. **STANDARDS ITEMS**

14.1 Consideration of Investigation Report – SC07/2014 – *Chief Solicitor and Monitoring Officer (para 1)*

FOR INFORMATION: -

Date of next meeting – Thursday 13 November, 2014 at 10.00 am in the Civic Centre, Hartlepool.

AUDIT AND GOVERNANCE COMMITTEE

MINUTES AND DECISION RECORD

25 SEPTEMBER 2014

The meeting commenced at 2.00 pm in the Civic Centre, Hartlepool

Present:

Councillor Ray Martin-Wells (In the Chair)

Councillors: Jim Ainslie, Rob Cook, Kaylee Sirs, George Springer and Paul Thompson.

Also Present: Co-opted Members: Norman Rollo and Clare Wilson.
Mark Kirkham and Diane Harold, Mazars

Officers: Peter Devlin, Chief Solicitor
Chris Little, Chief Finance Officer
Noel Adamson, Head of Audit and Governance
Sandra Shears, Head of Finance (Corporate and Schools)
Joan Stevens, Scrutiny Manager
David Cosgrove, Democratic Services Team

55. Apologies for Absence

Councillor Stephen Akers-Belcher.

56. Declarations of Interest

Councillor Thompson declared a personal interest in Minute no. 58.

57. Minutes of the meeting held on 21 August 2014

Confirmed.

58. Internal Audit Plan 2014/15 Update (*Head of Audit and Governance*)

The Head of Audit and Governance submitted a report updating the Committee on progress made to date completing the internal audit plan for 2014/15. The Head of Audit and Governance highlighted the audit completed on the Procurement Quick Quote System which had received a 'Limited' assurance level. This had been due to a mismatch in information between systems though actions had been agreed and implemented to

resolve this problem.

A Member referred to one of the school audit's and the comments in relation to the storage of computer back-ups and the Head of Audit and Governance confirmed that such back-ups should be stored in a fire proof safe on site.

Recommended

That the report be noted.

59. National Fraud Initiative National Report 2014/15

(*Head of Audit and Governance*)

The Head of Audit and Governance submitted a report informing Members of the Audit Commissions National Report detailing the outcomes from the National Fraud Initiative (NFI), the Audit Commission's data matching exercise to help prevent and detect fraud, overpayment and error. A copy of the full report had been placed in the Members' Library.

Recommended

That the report be noted.

60. Local Audit and Accountability Bill Consultation Update (*Chief Finance Officer*)

The Chief Finance Officer reported that in January 2014, the Local Audit and Accountability Act received Royal Assent. Secondary legislation was required to give effect to the new local audit arrangements and the consultation covers the detail of this. New Accounts and Audit Regulations, to be made under Section 32 of the Local Audit and Accountability Act 2014, will play a similar role in the new local audit framework.

The Chief Finance Officer indicated that the majority of the questions posed did not apply to the Council, one of the main proposals being consulted on is to bring forward, from 2017/18, the existing dates of 30 June and 30 September to 31 May and 31 July, for accounts being signed and certified by the Responsible Financial Officer and then approved and published. The Chief Finance Officer commented that these two changes could prove to be extremely challenging and, should the proposal to change the dates remain after the consultation, appropriate planning would be required in advance of their introduction. A copy of the consultation response submitted was included as an appendix to the report.

Recommended

That the response to the consultation on the proposed Accounts and Audit Regulations be noted and that the Committee be kept fully appraised of actions the Council needed to take to comply with the new Regulations when published.

61. The 2013/14 Financial Report (including the 2013/14 Statement of Accounts) (*Chief Finance Officer*)

The Chief Finance Officer reported that the Committee had considered the draft accounts at its meeting on 11th July 2014. The July report indicated the draft Statement of Accounts would be subject to review by the external auditors Mazars. The Audit and Governance Committee would then need to approve the final accounts by 30th September, 2014.

The Chief Finance Officer briefly outlined the main aspects that had been incorporated in the Statement of Accounts reflecting the decisions made by Council in February in regards to the budget and safeguarding the future financial position of the Council.

The Chief Finance Officer stated that the audit process had gone well with Council officers pleased with the final outcome. The Auditors had highlighted the "good standard of working papers and thanked officers and Members for their continued assistance.

The audit identified no significant unadjusted misstatements in the financial statements. A small number of misstatements/ disclosure amendments were identified by the Auditor during the audit and the Chief Finance Officer agreed to amend the Accounts to reflect the issues detailed in Section 4 (pages 9-10) of the Audit Completion Report.

The Auditor had also identified one proposed change which the Chief Finance Officer recommended was not implemented as this issue was not material in accounting terms and therefore did not impact on the position reported in the Accounts, or the level of General Fund Balances. This issue related to two assets which were disposed of but not written out of the Asset Register to the value of £0.810m. The reason for not amending was that the amount was not significant in relation to the overall value of Property, Plant and Equipment of £241.761m and, therefore, the accounts had not been amended. This would be actioned in 2014/15.
This issue and the reason it was proposed it was not implemented was detailed in the Letter of Representation submitted as Appendix B to the report. The detail below had been discussed with Mazars and they would issue an unqualified opinion on the basis of the information provided in the Letter of Representation. The Committee needed to formally consider this issue and the Chief Finance Officer's recommendation that this issue does not need to be amended.

Members commented that while in percentage terms the sum was 'insignificant', £810,000 was a significant value. The Chief Finance Officer stated that he was not trivialising the sum concerned only that when measured against the total value of the assets (£274,834,000) it was then seen as small. Officers did appreciate that it was a significant accounting valuation .

The representatives from Mazars presented their Audit Completion Report which was submitted as Appendix A to the report. The Mazar's representatives highlighted the following key points to Members –

- The audit opinion on the financial statements is an unqualified opinion on the accounts (subject to the receipt and consideration of the assurance the auditor had requested from the Pension Fund auditor and checking the revised Statement of Accounts).

- The Auditors highlighted the "good standard of working papers; which was invaluable in allowing them to carry out the audit as efficiently and effectively as possible, and the representatives from Mazars thanked officers and Members for their continued assistance and specifically thanked the Chief Finance Officer and the Head of Finance (Corporate and Schools).

- An unqualified Value for Money conclusion had been issued as the Council was making good progress in agreeing detailed plans to achieve the savings required for 2015/16, with reports already being taken to the relevant Committees and the Council had proper arrangements in place to secure economy, efficiency and effectiveness.

- the following significant matters remain outstanding: -
  Pension Fund Auditor assurance - consideration of the findings of the Pension Fund auditor. When this is received would be added to the final report.
  Revised financial statements - checking the amendments made to the financial statements

- The report highlighted the significant risks to the authority which had been highlighted earlier in the year. In relation to the risk around the potential for management override of controls, the representatives from Mazars commented they had approached this with appropriate professional scepticism and the audit showed there were no issues arising. In relation to both revenue and expenditure recognition the audit had provided the assurance sought and had not highlighted any material issues to bring to Members' attention.

- Similar assurance was given in relation to pension entries (IAS19), which was highlighted for Members as the calculation of these pension figures, both assets and liabilities, could be subject to significant volatility and included estimates based upon a complex interaction of actuarial assumptions. This results in an increased risk of material misstatement.

- Key areas of management judgement around property, plant and equipment – depreciation, revaluations and impairments; and fair values were highlighted.

- Current year internal control recommendations in relation to outturn

revenue and capital budget reports, manual adjustments and school bank reconciliations were set out in the report. In relation to bank reconciliations the representatives from Mazars had previously commented that they would wish to see bank records reconciled precisely. There had been some limited issues last year in relation to school bank accounts but none in this year's accounts.

- In relation to manual adjustments the representatives from Mazars commented that they would wish to see greater emphasis on resolving manual adjustments as they led to greater risks.

- Reference was made to the adjusted and unadjusted misstatements and there were no material adjustments impacting on reserves.

- There were very few disclosure amendments which was reflective of the work done to get the accounts to this stage.

- The representatives from Mazars indicated that in their Audit Strategy Memorandum they had not identified any significant risks that were relevant to the Value for Money (VfM) conclusion. Since the Audit Strategy Memorandum had been issued a significant risk in respect of the financial resilience criterion had been highlighted, as reported to the July Audit and Governance Committee. There are no matters arising from our VfM conclusion work and no recommendations we would wish to highlight to you; the Council is already well aware of the significant challenges facing it and is taking appropriate action.

Members questioned the significance of the outstanding assurance from the Pension Fund Auditor. The representatives from Mazars indicated that if the assurance was not received by 30 September there would be a delay in the issuing of the audit opinion on the Council's accounts. Assurances had been received from Middlesbrough Borough Council that the audit of the pension fund would be completed in time though no explanation for the delay had been given. The representatives from Mazars indicated that once the assurance had been received, they would inform the Chair. The Chief Finance Officer added that this was an issue affecting all the Tees Valley authorities. While the figures would be significant in terms of the accounts, they would not have any impact on the Council's reserves.

Members questioned the write-down of capital equipment through depreciation and asked what percent of capital value was accounted for each year. The Chief Finance Officer indicated that the depreciation of capital equipment varied depending on the expected life span of the specific equipment. Officers did review assets against their depreciation period regularly.

The Chair thanked officers for the work undertaken to complete the accounts and then referred to the five specific recommendations set out within the Chief Finance Officer's report and sought the committee's approval to each individually. All were agreed unanimously.

Recommended

1. That the matters raised in Mazars' Audit Completion Report detailed in Appendix A to the report be noted;

2. That the adjustments to the financial statements set out in Section 4 of Mazars' Audit Completion Report be noted;

3. That the reason detailed in the Letter of Representation (Appendix B to the report) for not amending the Statement of Accounts to reflect the unadjusted misstatement in the accounts be approved;

4. That the Chair be authorised to sign the Letter of Representation attached at Appendix B to the report;

5. That the final 2013/14 Statement of Accounts attached at Appendix C to the report be approved.

62. Code of Conduct for Employees (*Chief Solicitor*)

The Chief Solicitor submitted for the Committee's consideration a draft 'Code of Conduct for Employees' as part of its standards function *'to assist in making recommendations through the better governance of the Council insofar as it relates to the maintenance and promotion of high ethical standards.'* The report included as an appendix the existing Code as agreed with Trade Unions as part of the Single Status Agreement and a suggested revision covering the expanded themes and principles behind such a Code.

The draft Code had been considered and approved by the Joint Local Consultative Committee. The draft Code would be considered further by the Trade Unions at their Single Table meeting in September. Subject to any additional comments from the Trade Unions the draft Code would be presented to the Finance and Policy Committee owing to its 'workforce' content and that a report thereafter be taken to Council for the meeting on 30 October, 2014, to formally adopt the amended Code and incorporate it into Part 5 of the Constitution ('Codes and Protocols'). Following its adoption all employees would be signposted to the new Code.

Members welcomed the revised Code of Conduct for Employees as providing clarity for officers. Members suggested that the code of conduct for Councillors may also need to be reviewed alongside the new Officers' Code. The Chief Solicitor indicated that the Members Code had been reviewed in April.

Members queried some of the terminology in the new Code, particularly the reference to 'inappropriate relationships' with Councillors. The Chief Solicitor indicated that this was an all encompassing definition and covered such things as canvassing.

The reference to the register of gifts and hospitality was also raised by an Independent Member who queried if this had been an issue within the Authority. The Chief Solicitor commented that it had not been an issue. The Members' Code of Conduct required them to declare any gifts or hospitality with a value of £25 or more and while a value was not included in the Officers' Code it was anticipated that a similar approach should be taken to avoid issues that could compromise an officer.

Recommended

That the Code of Conduct for Officers, as submitted be noted and approved by the Committee and that the Finance and Policy Committee be informed as such when it considered the Code for approval and referral to Council.

63. Department of Health Gateway Review (*Scrutiny Manager*)

The Scrutiny Manager reported that that there was to be a Health Gateway Review of the Momentum Project between 29 September 2014 and 1 October 2014. The gateway Review would be undertaken by the Office of Government Commerce (OGC), an independent office of HM Treasury who works with central government and public sector organisations to help them improve their efficiency, gain better value for money from their commercial activities and deliver improved success from programmes and projects. One of the ways in which OGC achieves this is through conducting OGC Gateway Reviews of programmes/projects at defined stages (gateways).

The Review Team had approached the Chair of the Audit and Governance Committee and asked for an Overview and Scrutiny representative to be interviewed as part of the review. The Chair has indicated that he considered he would be unable to participate in this review as he was not involved in the Momentum process and, as such, did not have the background knowledge necessary to express a well-informed view.

In addition, the Chair has expressed his disappointed that the timescale for the review also precluded the Vice-Chair from participating, and that its outcome will not be made public. The Chair's disappointment that the Committee was unable to participate and his concerns were relayed to the Gateway Review Team.

The Chair informed the meeting that he had received a telephone call from the Chief Executive of the Hartlepool and Stockton NHS Foundation Trust in which he expressed his disappointment that neither the Chair nor Vice-Chair could take part but fully understood the reasons.

Recommended

That the report be noted.

64. Minutes of the recent meeting of the Health And Wellbeing Board

The minutes of the meeting held on 11 August, 2014 were received.

65. Minutes of the recent meeting of the Finance and Policy Committee Relating to Public Health (*Scrutiny Manager*)

No items.

66. Minutes of recent meeting of Tees Valley Health Scrutiny Joint Committee

No items.

67. Minutes of recent meeting of Safer Hartlepool Partnership

The minutes of the meeting held on 18 July 2014 were received

68. Regional Health Scrutiny Update

No items.

69. Any Other Items which the Chairman Considers are Urgent

No items.

The meeting concluded at 2.45 pm.

CHAIR

AUDIT AND GOVERNANCE COMMITTEE

16 October 2014

Report of: CHIEF SOLICITOR

Subject: APPOINTMENT OF PARISH COUNCIL REPRESENTATIVES FOR STANDARDS ISSUES

1. PURPOSE OF REPORT

1.1 To propose two Parish Council representatives to be appointed to the Committee to form part of the Committee membership when Standards issues relating to Parish Councils are being considered.

2. BACKGROUND

2.1 Under the terms of the Localism Act 2011, the Borough Council needs to have in place 'arrangements' whereby allegations that a Member has not complied with the Code of Conduct can be investigated. The Borough Council are obliged to facilitate these arrangements on behalf of Parish Councils' in its area.

To reflect this, the Council's Constitution allows for the appointment of Parish Council Representative's to the Audit and Governance Committee when considering Standards issues relating to Parish Councils and Parish Councillors.

This Audit and Governance Committee has within its remit the 'standards' responsibilities assigned under the Localism Act 2011 and that the Committee should compose '*Parish Council representatives when dealing with standards' functions*.' Where a matter relates to a Parish Council, a representative from another Parish Council should sit on the Committee (or any hearing sub- committee) to assist in the determination of that complaint.

2.2 The specific functions of the Audit and Governance Committee as set out in Part 3 of the Constitution that are affected are –

STANDARDS

9. Promoting and maintaining high standards of conduct by Members and Co-opted members of the Authority.
10. Assisting Members and Co-opted members to observe the requirements of the Council's Code of Conduct.
11. To advise and offer guidance to Members and Co-opted members on the adoption or revision of the Code of Conduct.
12. To delegate to a Hearing Sub-Committee, the conduct of a hearing upon a complaint and to make recommendations and report findings, as appropriate.
13. To grant dispensations to Members and Co-opted members (including Parish Council representatives) from requirements relating to interests as set out within the relevant Code of Conduct.
14. Powers to make payments or provide other benefits in cases of maladministration etc.
15. To assist in making recommendations through the better governance of the Council insofar as it relates to the maintenance and promotion of high ethical standards.

2.3 Parish Council representatives will only be involved in those matters that specifically relate to Parish Council business or during the investigation of Parish Council complaints.

2.4 In the past, the Council had been heavily reliant on a single Parish Councillor, Alan Bell, who served upon the previous statutory Standards Committee and thereafter the Audit and Governance Committee with some distinction. As Mr Bell is no longer a Parish Councillor the Committee presently has no 'parish presence' on the Committee and more importantly an absence when dealing with any complaints involving a Parish Council.

2.5 Ideally, the Committee should have at least two parish representatives, to safeguard against any conflict of interests arising. Clearly, attendance at the meetings of the Audit and Governance Committee will be dependent upon business relating to a Parish Council and a complaint arising thereon. Over the summer, the Parish Councils were consulted on two options for appointing parish representatives. They were –

Option 1 – That each Parish Council provides one representative (nominated each year by the Parish Council) and the Monitoring Officer would approach at least one of those individuals from that 'list' to sit on any Committee/Sub-Committee hearing.

Option 2 – That the Parish Councils' agree a rotation of parish representation (a system operated previously), with a term of appointment of at least a year, potentially two years, from two parishes, on a rotational basis.

2.6 The feedback received supported the second option with a two year term of office.

3. PROPOSAL

3.1 Following the consultation it is proposed, therefore, that Parish Council representatives are appointed for a two year period and rotated around the Parish Council's in the Borough.

3.2 It is intended that the rotation of appointments be as follows –

Greatham PC / Headland PC – 2014/15 and 2015/16
Dalton PC / Elwick PC – 2016/17 and 2017/18
Hart PC / (etc.,) - 2018/19 and 2019/20

3.3 Nominations have been sought from Greatham and Headland Parish Councils. Headland PC has nominated Parish Councillor John Cambridge and Greatham PC will make their appointment at a meeting on 3 November, 2014.

4. RECOMMENDATIONS

4.1 That the Committee notes the report and the responsibilities assigned under the Localism Act 2011;

4.2 That two Parish Council representatives be appointed to the Committee for a two year term with following the rotation of nominations applying –

Greatham PC / Headland PC – 2014/15 and 2015/16
Dalton PC / Elwick PC – 2016/17 and 2017/18
Hart PC / (etc.,) - 2018/19 and 2019/20

4.3 That for the remainder of 2014/15 and 2015/16

(i) the nomination of Parish Councillor John Cambridge from Headland Parish Council be approved as a Co-opted Member of the Committee.
(ii) that, subject to confirmation of the nomination, a Parish Councillor from Greatham Parish Council be approved as a Co-opted Member of the Committee.

5. REASONS FOR RECOMMENDATIONS

5.1 So that the Borough Council complies with the terms of the Localism Act 2011, to have in place 'arrangements' whereby allegations that a Member has not complied with the Code of Conduct can be investigated and so that it can facilitate these arrangements on behalf of Parish Councils' in its area.

6. BACKGROUND PAPERS

None.

7. CONTACT OFFICER

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Audit and Governance Committee

16 October 2014

Report of: Scrutiny Support Officer

Subject: SCRUTINY INVESTIGATION INTO CARDIOVASCULAR DISEASE: SETTING THE SCENE PRESENTATION - COVERING REPORT

1. PURPOSE OF REPORT

1.1 To inform Members that representatives from the Tees Valley Public Health Shared Service and the Public Health Team have been invited to attend this meeting to provide information in relation to the investigation into Cardiovascular Disease (CVD).

2. BACKGROUND INFORMATION

2.1 Members will recall that at the meeting of this Committee on 21 August 2014, Members agreed the Scope and Terms of Reference for their forthcoming investigation into CVD.

2.2 Subsequently, officers from the Tees Valley Public Health Shared Service and the Public Health Team have agreed to attend this meeting to provide a presentation on the following:-

-. What is CVD
-. Epidemiology of CVD in Hartlepool
- Lifestyle and prevention services (stop smoking, weight management, healthy eating, exercise)

2.3 The National Cardiovascular Intelligence Network has produced a CVD profile, the introduction and risk factors from this profile are attached as **Appendix A** for Members Information. Further chapters from the CVD profile are listed below and can be accessed via the weblinks:-

Heart disease. http://www.yhpho.org.uk/ncvincvd/pdfs/Heart/00K_Heart.pdf
Diabetes. http://www.yhpho.org.uk/ncvincvd/pdfs/Diabetes/00K_Diabetes.pdf
Kidney http://www.yhpho.org.uk/ncvincvd/pdfs/Kidney/00K_Kidney.pdf
Stroke http://www.yhpho.org.uk/ncvincvd/pdfs/stroke/00K_Stroke.pdf

3. RECOMMENDATION

3.1 It is recommended that the Members of the Audit and Governance Committee consider the evidence presented at this meeting and seek clarification on any relevant issues where required.

Contact Officer:- Laura Stones – Scrutiny Support Officer
Chief Executive's Department
Hartlepool Borough Council
Tel: 01429 523087
e-mail: laura.stones@hartlepool.gov.uk

BACKGROUND PAPERS

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

(i) Report of the Scrutiny Support Officer entitled 'Scrutiny Investigation into CVD – Scoping Report' presented to the Audit and Governance Committee on 21 August 2011.

(ii) Minutes of the Audit and Governance Committee held on 21 August 20114

Public Health England

Cardiovascular disease profile

Introduction

August 2014

NHS Hartlepool and Stockton-On-Tees CCG

Background

The Cardiovascular disease profiles are produced by the National Cardiovascular Intelligence Network (NCVIN). The profiles are available for each clinical commissioning group (CCG) in England. Each profile is made up of five chapters which look at risk factors, coronary heart disease (CHD), diabetes, kidney disease and stroke. Each profile compares the CCG with data for England, a group of similar CCGs and its strategic clinical network (SCN).

The profiles for all CCGs are available at www.ncvin.org.uk NCVIN produces many other tools and data resources which will inform the work of commissioners of cardiovascular disease (CVD) services and health and social care professionals with an interest in CVD. These can also be found on the NCVIN web pages.

In addition, an interactive version of these profiles has been developed on the PHE Fingertips website and is available at http://fingertips.phe.org.uk/ The Fingertips tool includes information for strategic clinical networks.

Key facts	England
Under 75 mortality from CVD	**81.1 per 100,000 people**
Under 75 mortality considered preventable from CVD	**53.5 per 100,000 people**

Source: Public Health Outcomes Framework 2010/12. These figures include deaths from heart disease stroke and vascular disease only (ICD10 codes) I00-I99. Deaths from diabetes and kidney disease are not included in this total

Key information

CVD is an overarching term that describes a family of diseases (including stroke, heart attack and peripheral vascular disease) sharing a common set of risk factors. Chronic kidney disease and diabetes are also included in the CVD family of diseases as they have similar risk factors and are associated with a greater risk of CVD.

Deaths from CHD have been falling since the early 1970s, and dropped by 62% for men and 64% for women between 1995 and 2012.

In 2013 the total prevalence of diabetes in adults in England was estimated to be 7.4%, and approximately 508,000 of the estimated 3,211,000 adults with diabetes in England have not been diagnosed.

In 2013 there were 1,881,631 adults aged 18 and over on GP lists in England with diagnosed and recorded chronic kidney disease stage 3 to 5; however, it is estimated that there are approximately a further one million people with CKD stage 3 to 5 in England who are undiagnosed.

Between 1995 and 2012 there were 56% fewer stroke deaths in men, down from 76 per 100,000 people in 1995 to 34 per 100,000 in 2012.

Produced by the National Cardiovascular Intelligence Network (NCVIN)
PHE publications gateway number 2014130

Public Health England

Cardiovascular disease profile

Cardiovascular risk factors

August 2014

NHS Hartlepool and Stockton-On-Tees CCG

Background

This chapter of the Cardiovascular disease profiles focuses on risk factors for cardiovascular disease and is produced by the National Cardiovascular Intelligence Network (NCVIN). The profiles are available for each clinical commissioning group (CCG) in England. Each profile is made up of five chapters which look at risk factors, coronary heart disease (CHD), diabetes, kidney disease and stroke. This profile compares the CCG with data for England, a group of similar CCGs and the Northern England strategic clinical network.

Lifestyle and behavioural risk factors (such as smoking, physical inactivity, poor diet and obesity) reflect an individual's circumstances and choices. There are also a number of risk factors for cardiovascular disease (CVD) which are not dependant on how people behave but biological and social aspects of their lives, such as age, sex, ethnicity and deprivation. In addition, physical risk factors (including hypertension) reflect changes to body systems that are also reversible or preventable in their early stages but may require medical treatment.

Key facts	Local	Comparator CCGs	SCN	England
Population aged 65 and over	**16.7%**	**17.3%**	**18.7%**	**16.9%**
Estimated smoking prevalence	**25.2%**	**23.6%**	**22.4%**	**19.5%**
Current smokers offered support and treatment	**84.7%**	**83.1%**	**82.9%**	**82.2%**
Observed prevalence of hypertension	**15.0%**	**15.2%**	**15.5%**	**13.7%**
Expected prevalence of hypertension	**25.6%**	**25.8%**	**26.7%**	**24.9%**

Key information

The total population of NHS Hartlepool and Stockton-On-Tees CCG is 284,500 and 47,500 of these people are aged 65 and over, a lower proportion than across England as a whole.

In NHS Hartlepool and Stockton-On-Tees CCG, 35.5% of people live in the most deprived fifth of areas in England.

In 2012 it was estimated that 25.2% of adults in NHS Hartlepool and Stockton-On-Tees CCG smoked.

In 2012 it was estimated that 66.1% of adults in NHS Hartlepool and Stockton-On-Tees CCG were classified as overweight or obese.

In 2013 there were 43,658 people diagnosed with hypertension in NHS Hartlepool and Stockton-On-Tees CCG. This was lower than the expected number and 10.6% of adults could have hypertension that has not been diagnosed.

In 2013/14 28.0% of the eligible population of NHS Hartlepool and Stockton-On-Tees CCG were offered an NHS Health Check. Of those people offered a Health Check, 36.0% received a Health Check.

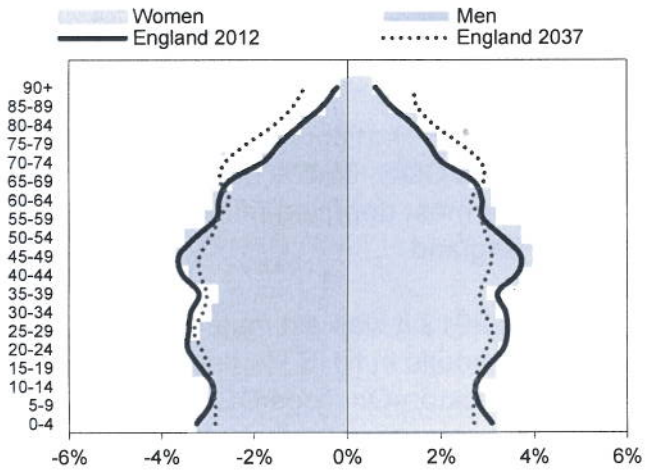
Risk factors for cardiovascular disease August 2014

NHS Hartlepool and Stockton-On-Tees CCG

Quantifying non-behavioural risk factors

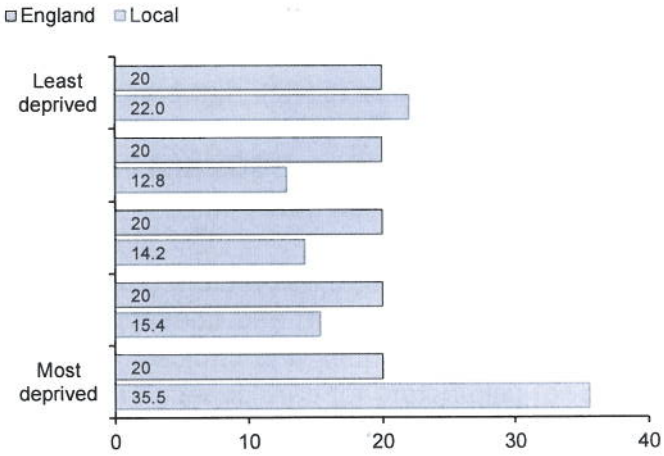
The prevalence of CVD increases with age which is important in the light of an ageing population. In 2012 the proportion of people aged 65 and over in NHS Hartlepool and Stockton-On-Tees CCG was 16.7% which is lower than across England as a whole, where 16.9% of the population were aged over 65 years.

Age profile and population projections, 2012/13 (percentage)



Source: 2012 Mid-year population estimates

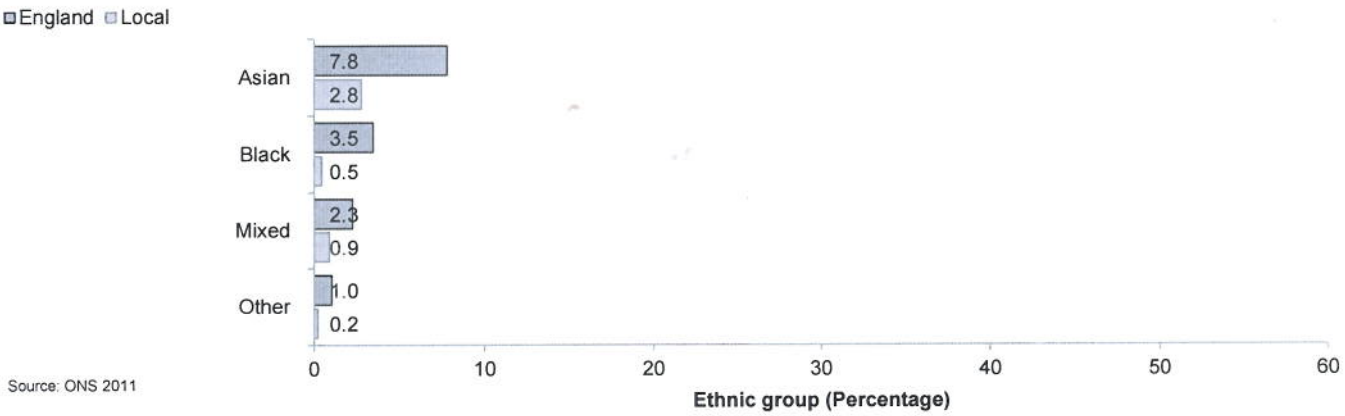
Deprivation, 2012/13 (percentage)



Source: IMD 2010 and 2012 mid year population

People from a more deprived background are at greater risk of CVD than the general population. In NHS Hartlepool and Stockton-On-Tees CCG, 35.5% of the population are in the most deprived national quintile and 22% of the population in the least deprived.

Minority ethnic groups, 2011 (percentage)



Source: ONS 2011

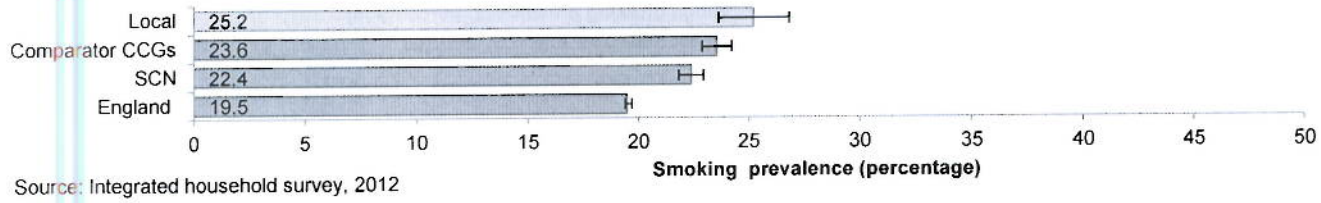
England has become more ethnically diverse with rising numbers of people identifying with minority ethnic groups in the 2011 Census. The relationship between ethnic group and CVD prevalence is complex. For example, the risk of stroke is higher in south Asian, African or Caribbean populations living in England. In NHS Hartlepool and Stockton-On-Tees CCG an estimated 4.4% of the population are from black, Asian, mixed or other groups, compared to 14.6% across England.

NHS Hartlepool and Stockton-On-Tees CCG

Behavioural risk factors - prevalence

A number of common risk factors are recognised as increasing the likelihood of individuals developing CVD. These include smoking, obesity, physical inactivity, poor nutrition and drinking too much alcohol.

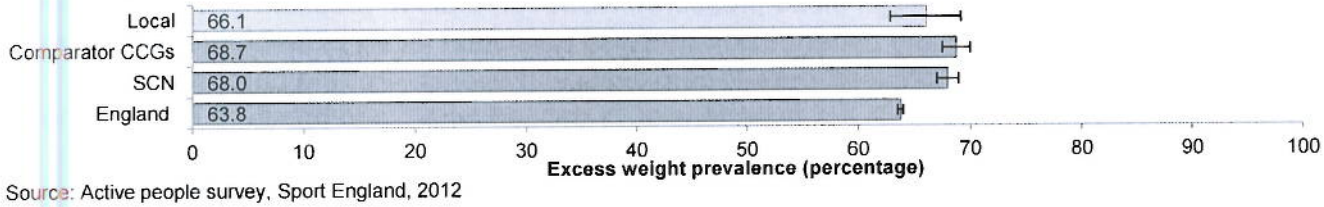
Smoking prevalence, 2012 (percentage)



Source: Integrated household survey, 2012

In 2012 it was estimated that 25.2% of adults in NHS Hartlepool and Stockton-On-Tees CCG smoked.

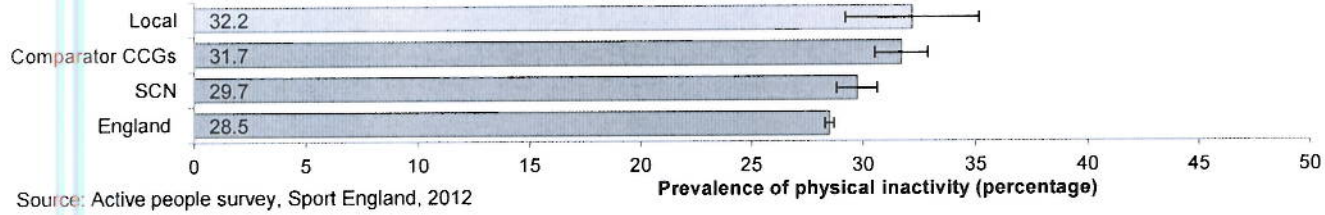
Excess weight in adults, 2012 (percentage)



Source: Active people survey, Sport England, 2012

In 2012 it was estimated that 66.1% of adults in NHS Hartlepool and Stockton-On-Tees CCG were classified as overweight or obese.

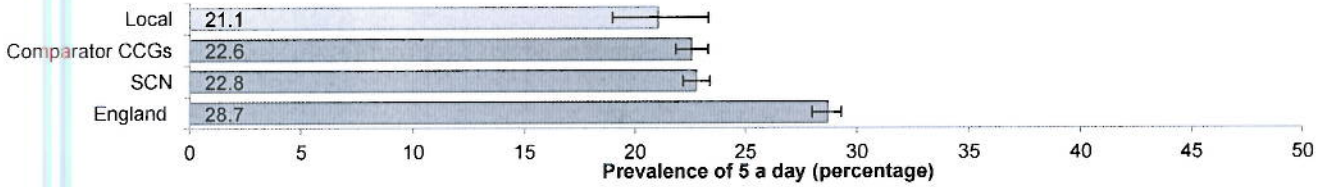
Physical inactivity, 2012 (percentage)



Source: Active people survey, Sport England, 2012

In 2012 it was estimated that 32.2% of adults in NHS Hartlepool and Stockton-On-Tees CCG were classified as 'inactive'.

Healthy eating (estimated proportion of adults who consume 5 or more fruit or veg), 2006-08 (percentage)

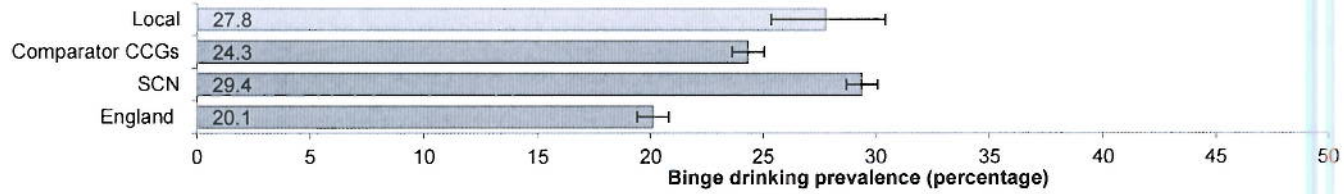


Source: Model-based estimates (based on invidual level data from the Health Survey for England), 2006-08

In 2006-08 it was estimated that 21.1% of adults in NHS Hartlepool and Stockton-On-Tees CCG ate five or more portions of fruit and vegetables a day.

NHS Hartlepool and Stockton-On-Tees CCG

Binge drinking, 2007/08 (percentage)



Source: Model-based estimates (based on individual level data from the Health Survey for England), 2007/08

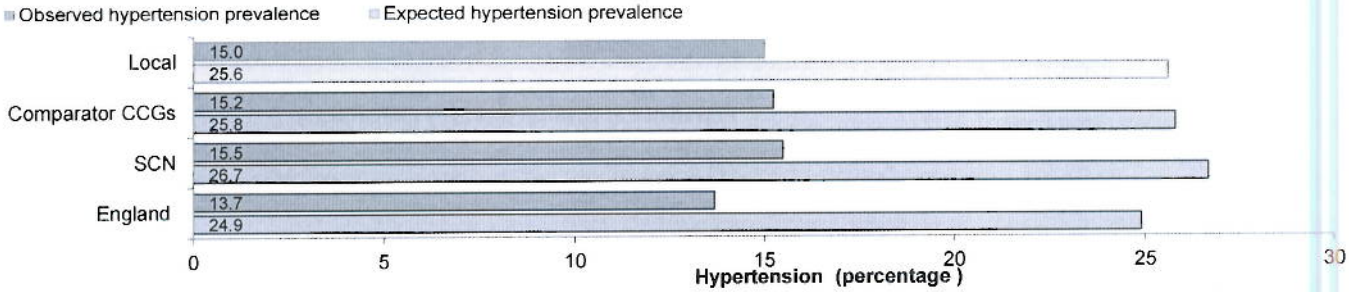
In 2007/08 it was estimated that 27.8% of adults in NHS Hartlepool and Stockton-On-Tees CCG engaged in binge drinking.

Hypertension - prevalence

Blood pressure measurements indicate the pressure which the circulating blood puts on the walls of blood vessels. Blood pressure is measured in millimetres of mercury (mmHg) and is usually written as the systolic blood pressure/diastolic blood pressure. Blood pressure measurements are on a continuous scale and therefore there is no specific point at which normotension (normal blood pressure) becomes hypertension (high blood pressure). However, a blood pressure of 140/90 mmHg or greater is usually used to indicate hypertension because persistent levels of blood pressure above this start to be associated with increased risks of cardiovascular events. For the purpose of the Quality and Outcomes Framework (QOF), hypertension is defined as a blood pressure measurement of 150/90. Hypertension is important because when uncontrolled it is a major risk factor for stroke, heart attack, heart failure, aneurysms and chronic kidney disease.

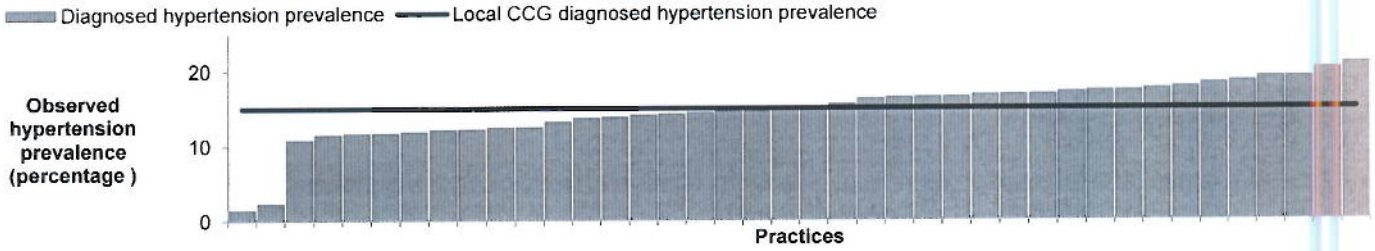
In 2013 there were 43,658 people on GP lists in NHS Hartlepool and Stockton-On-Tees CCG with diagnosed hypertension. This equated to 15.0% of the population registered with a GP. However, it was estimated the expected prevalence of hypertension in the CCG was 25.6%, meaning that 10.6% or 30,000 adults could have hypertension that has not been diagnosed.

Diagnosed and estimated prevalence of hypertension, 2012/13 (percentage)



Source: Quality and Outcomes Framework (QOF), 2012/13, Copyright © 2014, Re-used with the permission of the Health and Social Care Information Centre. All rights reserved. National general practice profiles 2011

Variation by general practice of diagnosed hypertension prevalence, 2012/13 (percentage)



Source: QOF 2012/13 (practices censored at 25%)

Risk factors for cardiovascular disease August 2014

NHS Hartlepool and Stockton-On-Tees CCG

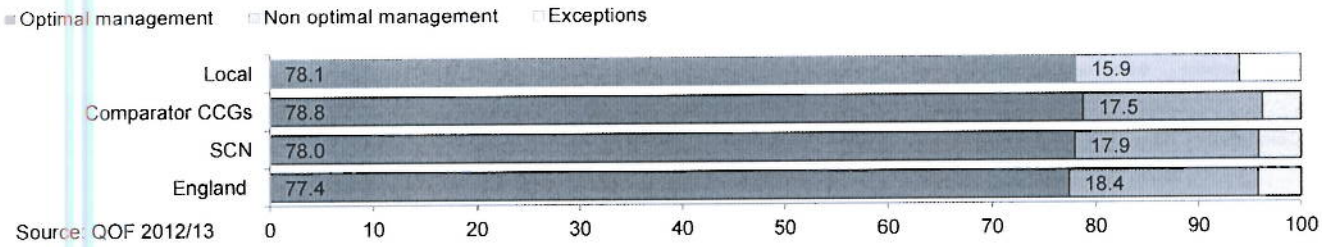
Care processes and treatment indicators

The Quality and Outcomes Framework (QOF) rewards practices for the provision of quality care and helps to standardise improvements in the delivery of clinical care. The risk of developing cardiovascular disease can be reduced in patients with hypertension by careful management of blood pressure and other cardiovascular risk factors such as physical inactivity and smoking.

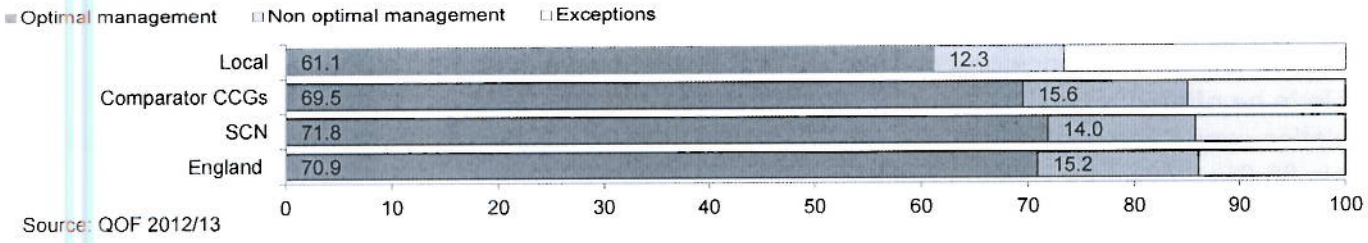
The graphs below show achievement against QOF hypertension and primary prevention of cardiovascular disease clinical indicators for the CCG as a whole.

Hypertension

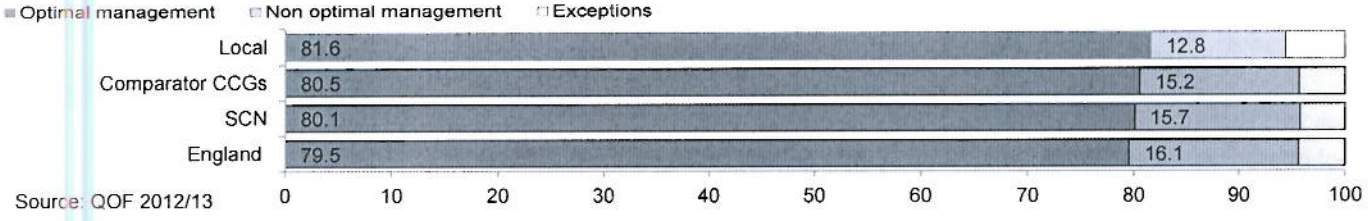
Patients with hypertension in whom the last blood pressure is 150/90 or less, 2012/13 (percentage)



In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients aged 30 to 74 years who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within 3 months of the initial diagnosis) using an agreed risk assessment tool, 2012/13 (percentage)



Patients diagnosed with hypertension (diagnosed after 1 April 2009) who are given lifestyle advice in the preceding 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet, 2012/13 (percentage)

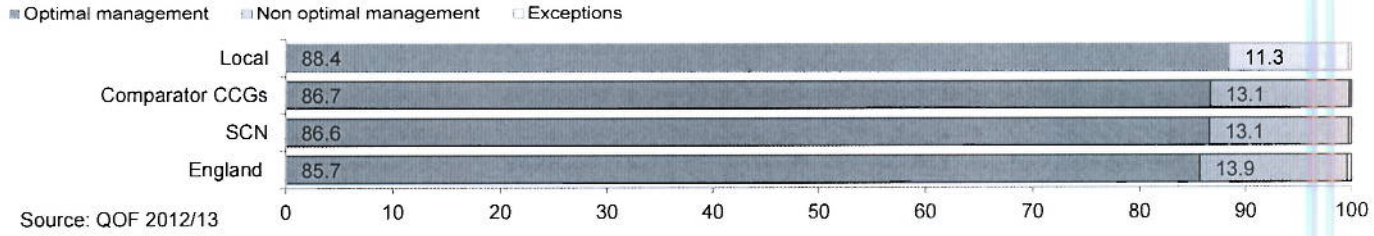


NHS Hartlepool and Stockton-On-Tees CCG

Smoking

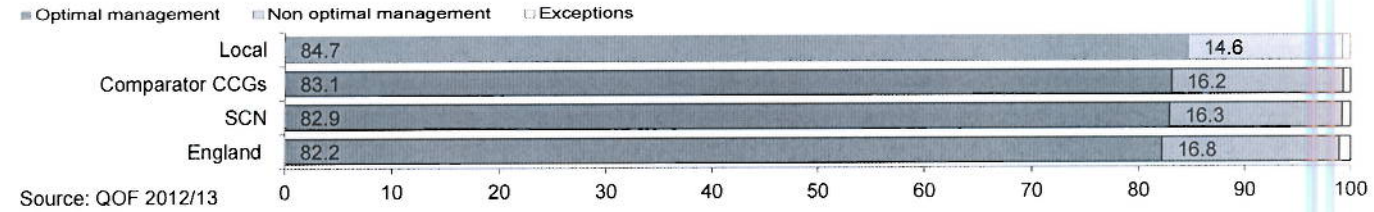
QOF includes information on the percentage of patients with a smoking status recorded and whether those identified as smokers are offered support or treatment to stop smoking.

Patients aged 15 years and over whose notes record smoking status in the preceding 27 months, 2012/13 (percentage)



Source: QOF 2012/13

Patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months, 2012/13 (percentage)



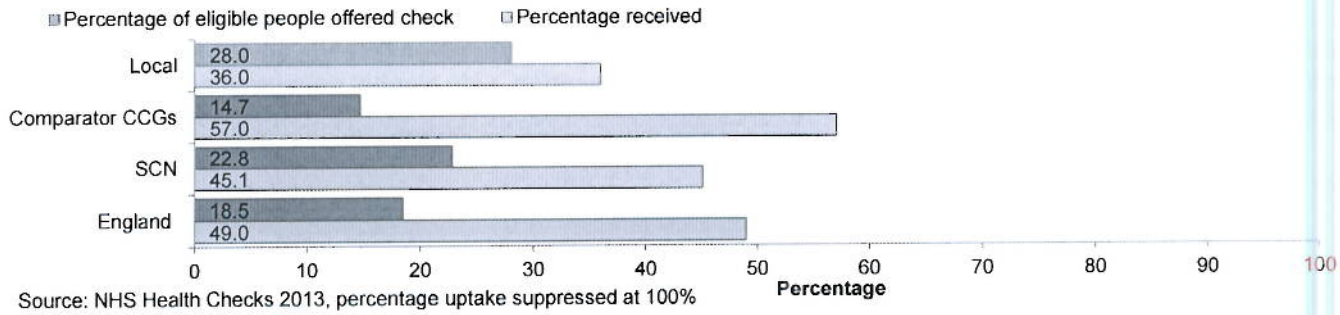
Source: QOF 2012/13

NHS Health Check Programme

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited once every five years to assess their risk of developing these conditions. They are given support and advice to help them reduce or manage that risk.

In NHS Hartlepool and Stockton-On-Tees CCG in 2013/14 an estimated 74,000 residents were eligible to be offered a Health Check. Local authorities offer the programme to all the eligible population over a five year period. During 2013/14, 28.0% of eligible residents were offered a Health Check, 36.0% received a Health Check.

Proportion of eligible people who were offered and received a Health Check, 2013/14 (percentage)



Source: NHS Health Checks 2013, percentage uptake suppressed at 100%

A list of references for each chapter is given in the indicator guide for the profiles.

AUDIT AND GOVERNANCE COMMITTEE

16 October 2014

HARTLEPOOL BOROUGH COUNCIL

Report of: Director of Public Health

Subject: DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

1. PURPOSE OF REPORT

1.1 The purpose of this report is to present for information to the Committee the Director of Public Health Annual Report for 2013/14 (attached as **Appendix A**).This report was presented to full Council in August 2014.

2. BACKGROUND

2.1 The requirement for the Director of Public Health to write an Annual Report on the health status of the town and the Local Authority duty to publish it is specified in the Health and Social Care Act 2012.

2.2 Director of Public Health Annual Reports are not a new requirement, as prior to 2012, Directors of Public Health in the National Health Service (NHS) were expected to produce annual reports.

2.3 Historically, the equivalent of the Director of Public Health Annual Report was produced by the Local Authority Chief Medical Officer.

2.4 Since the transfer of public health to the Local Authority in April 2013, this is the first time a Director of Public Health Annual Report has been produced since the last time the Local Authority had responsibility for public health back in 1973. Therefore the look back at the health status of the population over the past forty years provides the theme for the 2013/14 report.

3. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

3.1 Comparing and contrasting the health status of Hartlepool over the past 40 years required consideration of the Chief Medical Officer Report of 1973. The then Chief Medical Officer, Dr Milligan's report focused on infectious diseases, maternity and child welfare and environmental health. These priorities are still very relevant today to ensure the health of the public is protected.

3.2 Forty years on and the focus for the Director of Public Health Annual report is on improving the health of the population and reducing health inequalities by addressing non communicable disease such as cancer, cardiovascular disease, respiratory disease. To reduce incidence and prevalence of these diseases action must be taking to reduce associated risk factors for disease such as addressing smoking, excessive alcohol use and increasing numbers of people who are overweight or obese.

3.3 Forty years on and the evidence base regarding the inextricable link between poverty, social and economic deprivation and health inequalities is well understood and largely accepted. This is very clearly demonstrated by the gap in life expectancy of 14 years for men and 8 years for women in Hartlepool between the more affluent and the more socially and economically deprived communities.

3.4 The 2013/14 Director of Public Health Annual Report focuses not so much on diseases but on the risk factors for developing diseases, hence the focus on the three key priority areas of smoking, alcohol and obesity. The three priority areas provide an opportunity to improve health as they are amenable to change. However, change will not be achieved solely by individual behaviour change but through education, accessible services, and local and national policy changes.

4. RECOMMENDATIONS

4.1 Members receive this report for information.

5. REASONS FOR RECOMMENDATIONS

5.1 Ensures compliance with the statutory duties under the Health and Social Care Act 2012 for the Director of Public Health to produce a report and the Local Authority to publish it.

6. CONTACT OFFICER

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Director of Public Health Report

HARTLEPOOL
BOROUGH COUNCIL

Public Health - Then and Now 1973 - 2013

Contents

Foreword

As a long-term employee of Hartlepool Borough Council, I can recall the last Medical Officer for Health, Dr Milligan. His last report in 1974 forms the starting point of this report from the Director of Public Health for Hartlepool, Louise Wallace. The Director of Public Health is the equivalent post in 2014 and it is interesting that at the time of Dr Milligan's report, Public Health as a discipline was leaving the Council's remit for the NHS. At the time of writing, after 40 years, Public Health has returned to the fold. In the intervening years many things have changed in Hartlepool – politically, economically and geographically – and this report touches on them all. However, in terms of the population of Hartlepool, one thing remains constant – health and wellbeing is of fundamental importance to leading a fulfilled and not just a tolerable life. On this basis, I am happy to extend a warm welcome to Public Health because it presents us with an opportunity to work more collaboratively to ensure that the people of Hartlepool live as happy and fulfilled a life as possible.

The challenges have also changed somewhat. Whilst the need to protect the public from infectious disease and environmental hazard remains, we also need to ensure that quality of healthcare is acceptable, and that public health services such as smoking cessation, and drug and alcohol services are in place. In addition, the last 40 years have seen a change in population structure, meaning that we have an increasingly ageing population where the challenge is now the long-term health effects that are related in large part to lifestyle. This reports highlights that challenge comprehensively by focusing on the issues of tobacco, alcohol and obesity, and also puts the spotlight on possibly the biggest challenge we face – how to tackle the issue of unjust health inequality. These challenges will be solved in one fell swoop or in a matter of months. This report recommends that we attend to the need to plan and implement interventions for the short, medium and long-term to embed these fundamental priorities at the heart of the Council's work. I endorse this approach and look forward to watching the progress that we make in improving the health and wellbeing of Hartlepool.

Dave Stubbs
Chief Executive
Hartlepool Borough Council

Introduction

In 2010, the Coalition Government decided that public health should be located within Local Government (as it was pre-1974). The Health and Social Care Act (2012) made this possible, along with many other changes to the structure of the NHS and social care system. For public health, this meant the physical relocation of many staff and a complete rethink about how public health functions would be delivered. When the responsibility of public health became that of the NHS, environmental health remained in local government. In the intervening years there have been many changes within the theory and practice of public health. [1] [2]

The Director of Public Health

In 1973, when last in local government, this leader was the Medical Officer for Health. In more recent times within the NHS, a Director of Public Health held this key role. In Hartlepool Borough Council, there is a Director of Public Health who is a statutory chief officer of the Council and a member of the Council's Corporate Management Team. This role encompasses a range of responsibilities including being the principal adviser on all health matters to elected members and officers, with a leadership role spanning all three domains of public health: health improvement, health protection and healthcare public health. [1]

The public health transition

Due to the wide ranging determinants of health, no single organisation can tackle public health alone. The transition of public health into local authorities ensures that there is an opportunity to create integrated and systematic solutions to Hartlepool's most pressing public health challenges.

In Hartlepool, a new Public Health Department has been established. The Regulatory Services, including Environmental Health and Trading Standards functions, and the Sport and Recreation Services within the Council, have now become part of the Public Health Department. This will ensure that efforts to support the protection and improvement of the health of the people of Hartlepool, and the quality of healthcare available to them, will be more seamless. These efforts will be in line with the Strategy approved by the Health and Wellbeing Board and will address the key priorities for Hartlepool as informed by the Joint Strategic Needs Assessment.

Revisiting the past

The public health transition provides an opportunity to consider how Hartlepool has changed in the last 40 years. The 1973 equivalent to this report provides a starting point for us to consider the changes over time. The report was produced by the then Medical Officer for Health, Dr H. C Milligan, while this report is produced by me. Over the last century we have seen a change in focus for public health, from infectious diseases (e.g. cholera and typhoid) to focusing on chronic illness (e.g. heart disease and cancer) and behaviours (e.g. smoking and alcohol use). In 1973, the concept of improving health by promoting healthy behaviour was in its infancy, whereas the 2013 report will focus on these challenges and the major changes that have been made since the 1973 report.

The Health and Social Care Act created the Health Wellbeing Board which focused on improving the health of the population. In 2013 - 2014 the board was chaired by Councillor Carl Richardson.

Councillor
Carl Richardson

Louise Wallace
Director of Public Health
Hartlepool Borough Council

Hartlepool Then and Now

Population

The population of Hartlepool has decreased by about 4,500 people in the last 40 years. This may be due to a number of reasons, such as a lower birth rate and urban decline & unemployment in the 1970s and 1980s because of the outward migration of businesses and people.

1973

MALES: 47,417

FEMALES: 49,353

TOTAL: 96,770

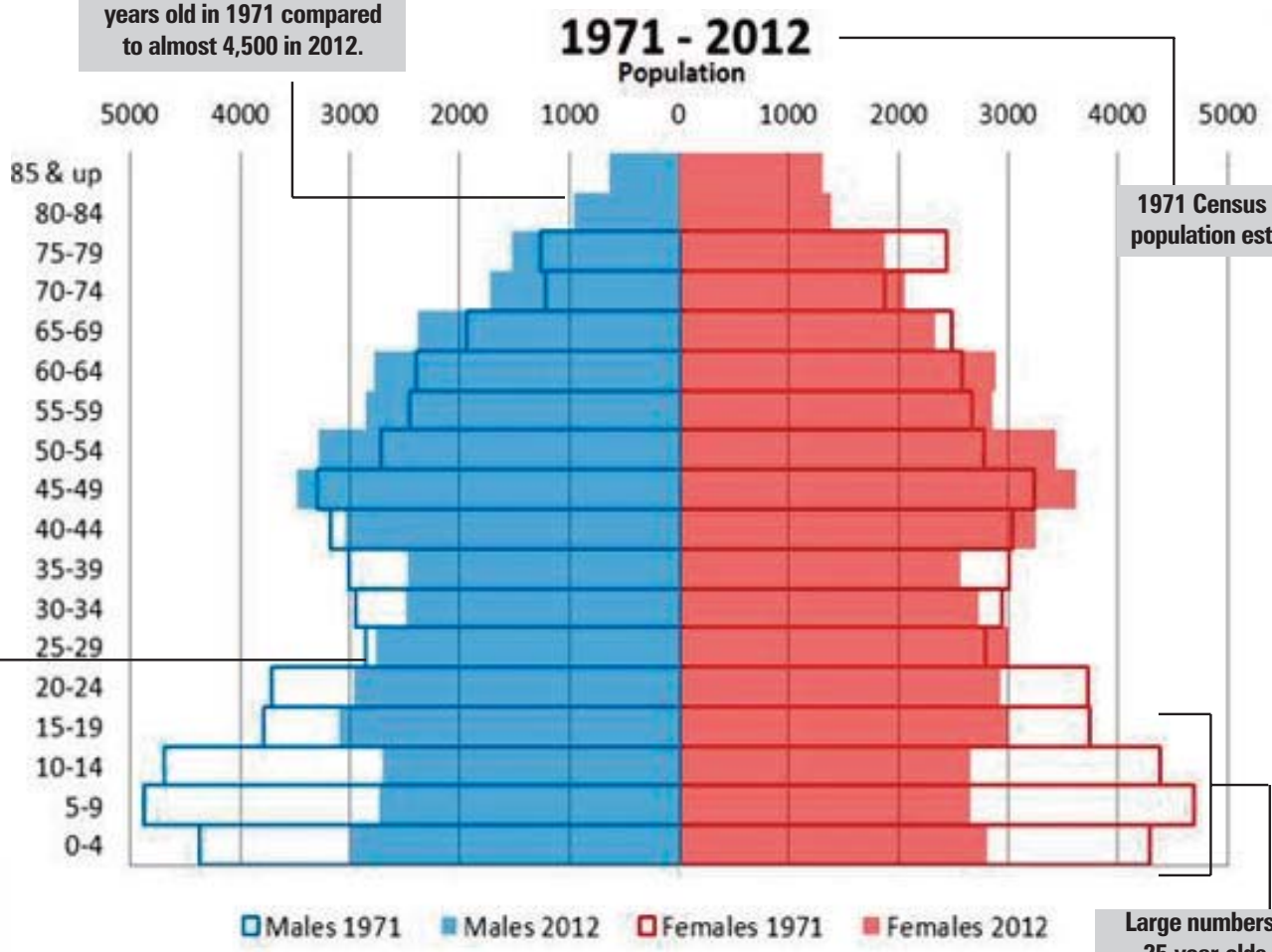
2013

MALES: 44,855

FEMALES: 47,383

TOTAL: 92,238

Very few people over 80 years old in 1971 compared to almost 4,500 in 2012.



1971 Census v 2012 population estimates.

Huge decline in numbers from (20-24) to (25-29) year olds. Perhaps due to fewer births during World War II

Large numbers of under 25-year-olds in 1971 (post-war 'baby boom') compared with 2012.

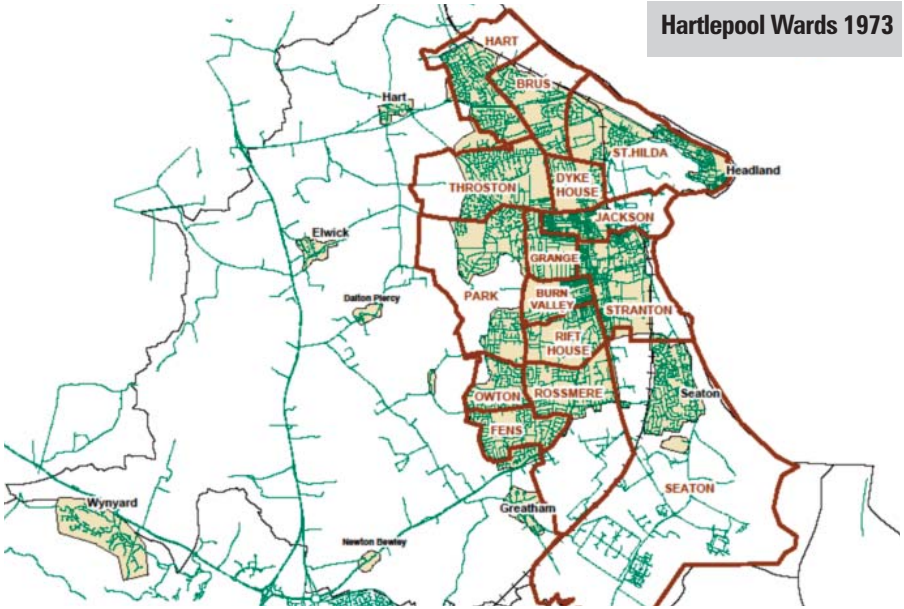
Reference: Office for National Statistics

Hartlepool Then and Now

Geography

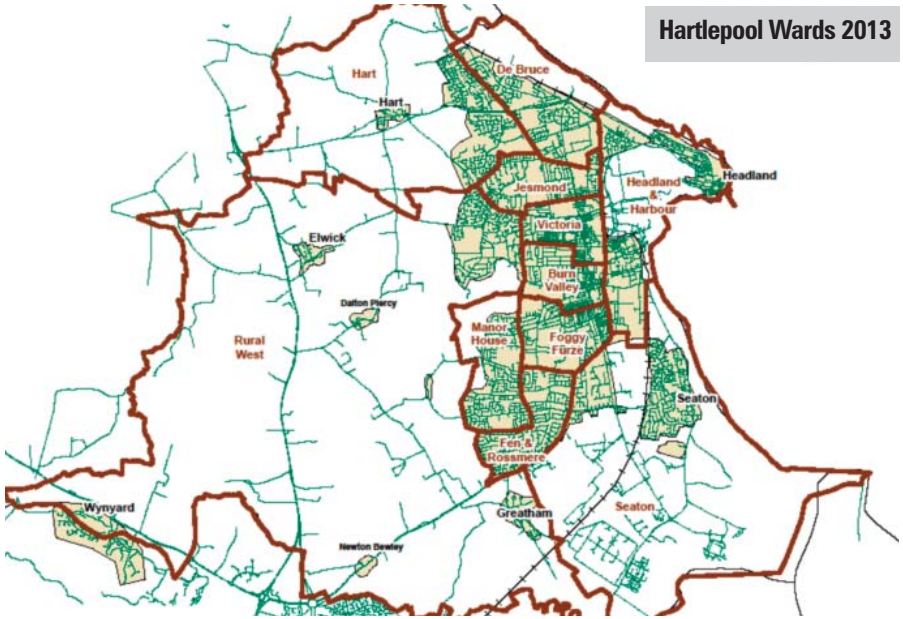
Hartlepool has grown from the original early settlement on the Headland. In more recent times, the young town of West Hartlepool expanded in the 1960s. In 1973, the town covered a smaller geographical area than it does today.

Hartlepool Wards 1973



In 1973 there were 15 electoral wards: Brinkburn, Brus, Dyke House, Fens, Grange, Hart, Jackson, Owton, Park, Rift House, Rossmere, St. Hilda, Seaton Carew, Stranton and Throston.

Hartlepool Wards 2013



In 2013 there are 11 electoral wards: Burn Valley, De Bruce, Fens & Rossmere, Foggy Furze, Hart, Headland & Harbour, Jesmond, Manor House, Rural West Seaton and Victoria.

Hartlepool Then and Now

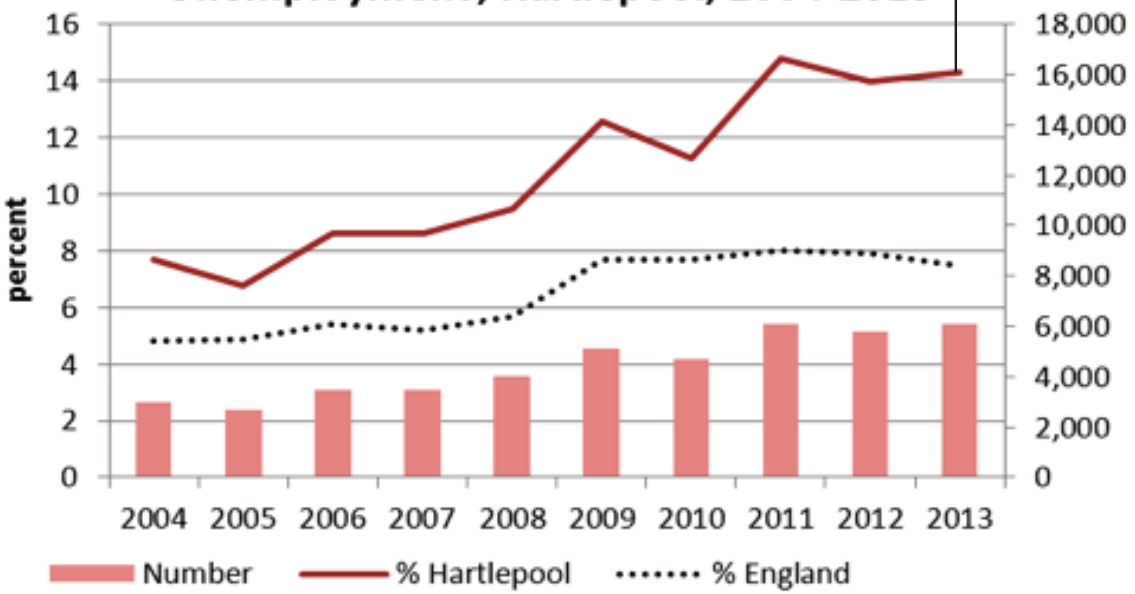
Economy

In 1973, it was reported that unemployment in Hartlepool was falling, and many new industries were applying for permission to locate in the area. In the late 1970s and the 1980s there followed a period of increasing unemployment of up to 30%, and an increase in poverty, which continued until the 1990s when a major investment and re-development began. In 2013 the unemployment rate was 14.3% (twice the national average).

Middleton Grange Shopping Centre was opened by Princess Anne in 1970.

Throughout all the changes in economy, Cameron's Brewery, founded in 1852, has remained in the centre of town.

Unemployment rates in Hartlepool are the highest they have been in over 9 years (14%+).



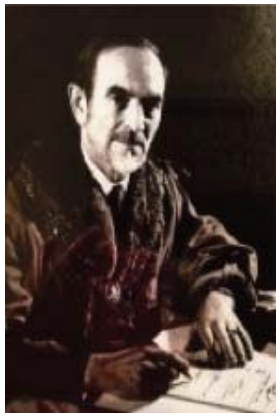
Source: Nomis

Hartlepool Then and Now

Hartlepool Borough Council

Although there have been many structural changes to local government in Hartlepool, the post of Mayor represents a civic link to 1973; however. For instance, the County Borough ceased to exist on 1 April 1974, as the Local Government Act 1972 came in to force.

1973



Mayor of the County Borough of Hartlepool was Councillor W.O. Mann.

List of past and present mayors of Hartlepool

2013

Mayor of Hartlepool is Councillor Stephen Akers-Belcher.

Hartlepool Civic Centre

Hartlepool Then and Now

Public Health

In assessing public health, measurement is a key activity to be able to make comparisons between different outcomes. One of the most common of these measures is the mortality rate. The rates are adjusted to take account of the age structure of the population.

1973

Mortality (All Causes)	Number	Percentage %
Number - All	1,155	100.0%
Number - Male	634	54.9%
Number - Female	521	45.1%
Rate (per 1,000)	14.7	-

Cause of death	Number	% of all deaths
Circulatory Disease	560	48.5%
Cancer	245	21.2%
Respiratory Disease	178	15.0%

2013

Mortality (All Causes)	No.	%
Number	905	100.0%
Number - Male	440	48.6%
Number - Female	465	51.4%
Rate (per 1,000)	6.0	-

Cause of death	Number	% of all deaths
Circulatory Disease	236	28.4%
Cancer	279	32.9%
Respiratory Disease	52	4.4%

- Almost half the deaths in 1973 were due to circulatory disease. In 2013, circulatory disease accounted for less than one-third of all deaths.
- In 2013, cancer is the cause for 33% of deaths in Hartlepool. In 1973, cancer only accounted for 21% of deaths.
- In 2013, the proportion of deaths from mortality from respiratory disease is three times less than in 1973.

A higher proportion of men (than women) died in 1973 compared to 2013.

The mortality rate in 2013 is less than half the 1973 rate (and 250 fewer people died). However, in 2013 the mortality rate is still higher than the national average (5.3).

Infant mortality has significantly reduced. There were five times more infant deaths in 1973 than 2013.

Hartlepool Then and Now

Living in Hartlepool

In 1973, the Corporation built 70 houses and private industry built 252 houses. In 2013, the Council is on target to build 60 houses, while the private sector target is 320. These figures reflect the changing patterns in housing as the Council stock has reduced, and private ownership and private rentals have become more common. Average household size has reduced with the trend towards smaller family size and more people living alone.

1973

Total Households: 31,900
Owner Occupied: 14,700 (46%)
Council/Town Rented: 13,000 (41%)
Privately Rented: 4,200 (13%)
Average Household Size: 3.0 people

1970's style housing in Easington Road prior to re-development (HBC)

2013

Total Households: 40,400
Owner Occupied: 24,400 (60%)
Council/Town Rented: 9,500 (24%)
Privately Rented: 6,500 (16%)
Average Household Size: 2.3 people

Easington Road 2013 (HBC)

Hartlepool Then and Now

Then & Now

The population of Hartlepool has decreased by about 4,500 people in the last 40 years. This may be due to a number of reasons, such as a lower birth rate and urban decline and unemployment in the 1970s and 1980s because of the outward migration of businesses and people.

1973

2013

Images reflecting popular & cultural issues at the time

Milk 1973 6p

Milk 2013 43p

Hartlepool Then and Now

Public Health Priorities

The increase in the prevalence of long-term conditions (such as diabetes and asthma) has led to a change in focus in public health activity from predominantly health protection in relation to infectious disease. Attention now includes quality health care and health improvement activities. It has become increasingly recognised that these long-term conditions are often linked to particular behaviours that threaten our health.

1973

The 1973 Medical Officer's report focussed on:

Infectious Diseases

Such as: measles, scarlet fever, whooping cough, food poisoning, jaundice, malaria and various venereal diseases.

Maternity and Child Welfare

Such as: ante-natal care, dental treatment, health visiting and vaccination & immunisation.

Environmental Health

Such as: housing, chemical sampling & testing of milk, noise, slaughter house & meat inspections and water supply.

2013

The 2013 Director of Public Health report will focus on the following:

Tobacco Control

Since 1973 there have been significant reductions in the prevalence of smoking in the UK. However, it is clear that smoking rates remain high in those areas and populations that suffer greater levels of deprivation.

Nutrition and Obesity

There has been a significant increase in obesity in the last 40 years. This carries an increased risk for a number of diseases and is therefore a major concern for public health.

Alcohol Misuse

Attitudes towards alcohol have changed in the last 40 years. During this time the availability of alcohol has increased partly because its relative cost has reduced.

Tobacco Control

Introduction

Smoking is a significant public health threat and is responsible for a major burden of disease, including cardiovascular and respiratory conditions. Smoking disproportionately affects the health of deprived communities and vulnerable groups such as children, young people and pregnant women.

If there is one example of where Public Health as a discipline has made the biggest impact, it is in the approach to reducing tobacco use and protecting people from its harmful effects. In 1973, the health risks were starting to be communicated to people. Then smoking was still very popular, but over the last 40 years many things have changed. There has been a cultural shift, largely led by Public Health, involving actions by a mix of different organisations and individuals. In 2011, the Coalition Government launched its Tobacco Control Plan for England in which it set out an ambition to reduce adult smoking prevalence to 18.5% or less by 2015.

Smoking prevalence		
	1973	2013
Men	50%+	21%
Women	40%+	19%

HSCIC [5]

In England, smoking causes 80,000 premature deaths each year. This makes smoking the largest preventable cause of ill-health.

The cross-cutting nature of tobacco

Professor Sir Michael Marmot made the following recommendation in his independent review into health inequalities:

'Tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups. Smoking-related death rates are two to three times higher in low-income groups than in wealthier social groups.'[4].

Hartlepool Borough Council is fully committed to the Marmot Principles. To signify their support to tobacco control they have signed the Local Government Tobacco Control Declaration as a means of acknowledging the importance of the agenda, welcoming the opportunity to lead local action to tackle smoking. They fully endorse the annual action plan of the Smoke Free Hartlepool Alliance, with an overall aim of reducing smoking prevalence, and thereby health inequalities in the town.

Tobacco Control

Tobacco control - what it is and why it's important

In 1973, people were fooled into thinking cigarettes were a normal part of life. People smoked them in large numbers, but they were also starting to kick the habit too, particularly amongst the more affluent professional middle classes. The health education on smoking was basic and largely consisted of telling smokers to stop smoking without being given any specific help or support. The only reference to smoking in Dr Milligan's report was a reference to 'anti-smoking education campaigns' which seemed to be having some success with older smokers.

It was in 1974 that the Health Field Concept was proposed by Lalonde,[6] suggesting for the first time that health and wellbeing of individuals and populations was determined not just by traditional medical approaches, but was also influenced by lifestyle, biology and the environment. This was the first step in a series of developments which looked to prevent as well as to cure. It would be many years however, before the UK government published a white paper entitled "Smoking Kills" in 1998, in which it outlined its plans to reduce the massive toll of death and disease caused by smoking.

Smoking Kills

Smoking Kills has the distinction of being the first White Paper to focus on tobacco, and sets out the clear evidence that the most effective means of controlling tobacco involve taking a multi-faceted and comprehensive approach at several levels.

The persistence of public health professionals before and since the landmark "Smoking Kills" White Paper has resulted in a number of key changes to legislation that have had a positive impact on the health of the public. [7]

Stop Smoking Services

Stop smoking services ensure that every smoker in the country who wanted help with stopping would have access to evidence-based behavioural support (along with a prescription for a smoking cessation medication). Services in Hartlepool have consistently performed as either best or second best in England and are the best in the North East for 4-week quitters.

Second - hand Smoke

In 1973, little consideration was given to the implications of second-hand smoke. Smoking was a habit carried out at home, at work, the cinema, restaurants and on transport. It wasn't until the early 2000s that new evidence was published [8].

A range of research papers concluded that the immediate effects of exposure to secondhand smoke include eye irritation, headache, cough, sore throat, dizziness and nausea. Adults with asthma can experience a significant decline in lung function when exposed, while new cases of asthma may be induced in children whose parents smoke. Short-term exposure to tobacco smoke also has a measurable effect onthe heart in non-smokers. In the longer term, passive smokers suffer an increased risk of a range of smoking-related diseases. In 2004 a report from the Scientific Committee on Tobacco and Health found that secondhand smoke is a cause of lung cancer and ischaemic heart disease in adult non-smokers and a cause of respiratory disease, cot death, middle ear infections and asthma attacks in children.

On July 1st 2007, in a landmark public health moment, England introduced a new law to make virtually all enclosed public places and workplaces in England smokefree. The legislation ensures a healthier environment, so everyone can socialise, relax, travel, shop and work free from secondhand smoke. Despite opposition from the tobacco industry, this legislation has proven to be universally popular, not just with non-smokers, but also with those who still smoke or are trying to quit.

Tobacco Control

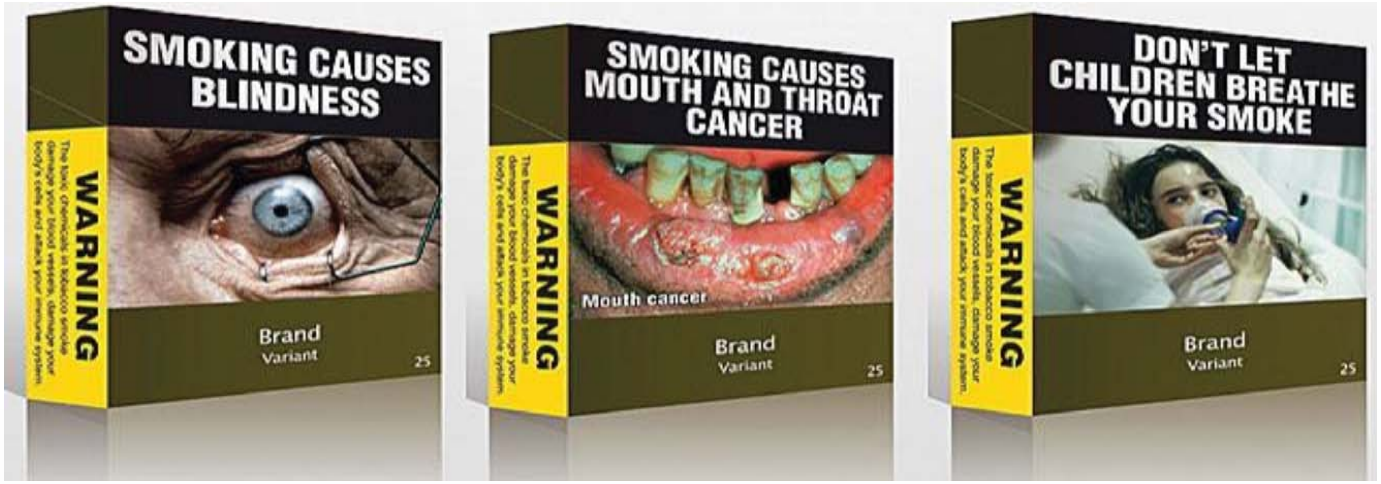
Marketing

In 1973, the marketing of tobacco was an important factor in ensuring that smoking remained popular and the tobacco industry invested heavily in this. From Hollywood stars to doctors, from sport to music - all have been a vehicle for marketing tobacco. The Tobacco Advertising and Promotion Act (2003) introduced a ban on tobacco direct marketing and sponsorship within the UK. [9-12]

Tobacco packaging

In 1973, cigarette manufacturers put a mild health warning on the packets. In 2013, it is compulsory for tobacco products to include graphic health warnings. However, two-thirds of regular smokers start before the age of 18 and two-fifths before 16. Due to the restrictions on advertising, tobacco packaging has become one of the tobacco industry's leading promotional tools, and innovative packaging and branding designed to appeal to young people continues to be a key element in maintaining smoking uptake.

Standardised packs were introduced in Australia on 1st December 2012 in a bid to make smoking less attractive to their children and young people. In April 2014, the Government announced that it is minded to introduce standardised packaging subject to a short consultation. The proposed standardised packaging can be seen right. [13]



Proposed standardised cigarette packaging (FRESH)

Tobacco Control

Hartlepool	Number	Percentage %
Smokers	17,200	23.5%
Deaths due to smoking	159	17.6%
Smoking during pregnancy	259	22.7%

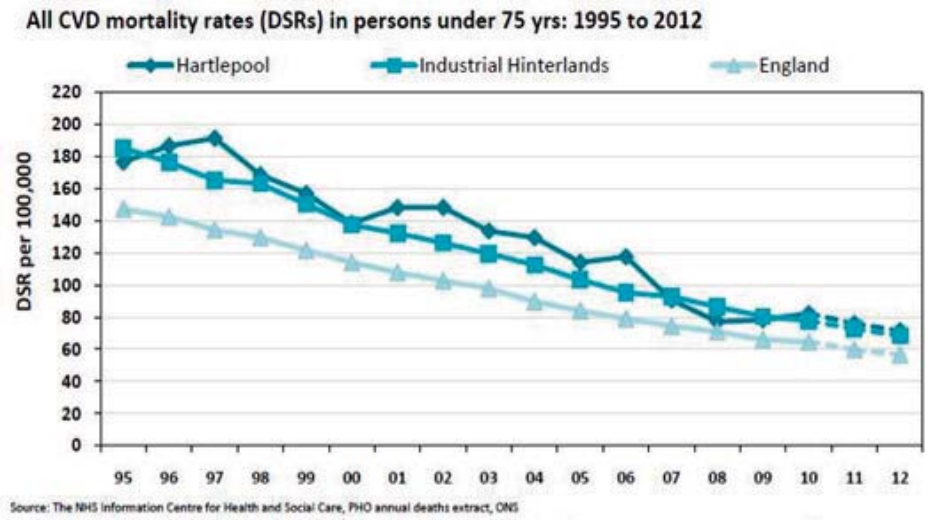
The local challenge

Although there is a lot of work on tobacco education for young people in the school setting, there is currently no stop smoking advice and support specifically for young people. This is now being addressed.

Numbers accessing stop smoking services are showing a decline (possibly due to getting down to the most hardened smokers or the availability of electronic cigarettes). These are not yet licensed as a medication and therefore unable to be prescribed through services.

Tobacco control impact - reduction in cardiovascular disease (CVD)

One of the major causes of mortality in the UK is CVD, a disease that is caused in large part by smoking. There has been a considerable reduction in deaths due to CVD since 1973. The gap between Hartlepool mortality rates and England rates is reducing and therefore impacting on health inequalities.



% Decrease 1995 to 2010

Hartlepool: 53.4% Industrial Hinterlands: 58.0% England 56.1%

Summary

Hartlepool has made much progress in establishing tobacco control. There is an effective stop smoking service, an active Smoke Free Alliance co-ordinating wider activity on tobacco control and strong support from the local authority. However, to reduce inequalities, more targeted work on smoking cessation is required to support residents from the most disadvantaged areas, unemployed people, young people and pregnant women. For tobacco control, there remains the regular monitoring of legislation and the ongoing lobbying of government (e.g. standardised packaging and smoke-free cars). Progress could be jeopardised if we do not actively maintain our efforts.

Nutrition and Obesity

Introduction

Being overweight or obese increases the risk of diabetes, high blood pressure, heart disease and some cancers, which are among the biggest contributors to premature mortality. The concept of a balanced diet is relatively recent, and it was only in the post-war years that the new science of 'nutrition' was born. Today's food environment is quite different to 1973 and an extensive variety of food and drink products is now available and offers palatability, convenience and novelty [14].

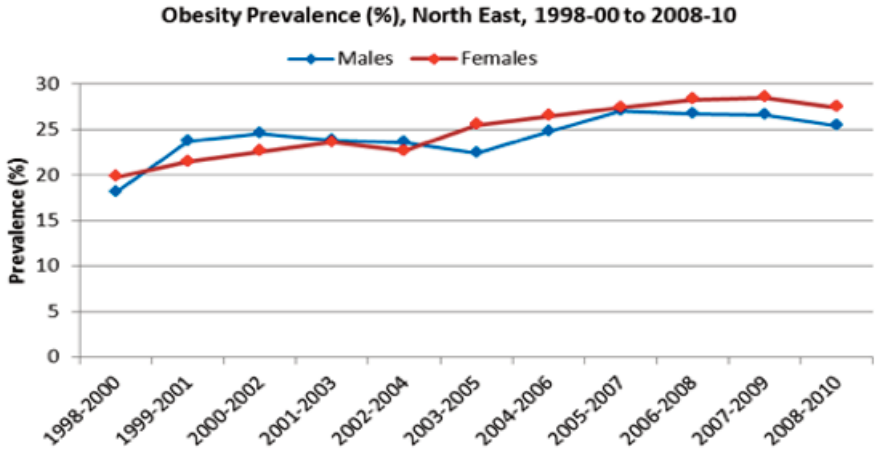
People were generally more active in 1973, so there was less education about being overweight and obese at the time. Dr Milligan's report recognises the importance of nutrition in its careful listing of the cost of welfare foods for infants, though there is perhaps a sign of things to come with a single reference to health visitor involvement in a 'weight reducing clinic' at a local hospital.

In 1973 the health education was basic. It was centred on home economics or domestic science, teaching people how to prepare and cook food, but not necessarily focusing on healthy eating or weight management. The prevailing culture at that time meant that there was little need for intervention in respect of obesity. The relative lack of technology at work and at home meant that work (employment and domestic), was more likely to be manual in nature, while television and video games were less common and so children tended to be more active. In addition, food was more likely to be prepared and cooked from scratch and there was much less processed food.

The need to intervene

It was not until 1980 that obesity rates started rising steadily in the UK.

In 2013, approximately 28% of females and 25% of males in the North East are obese. Private weight loss companies such as Weightwatchers and Slimming World are thriving and the NHS is spending around £5 billion each year [16] on treating the health effects that are associated with overweight and obesity. Being of an above-average weight is now the norm, with 68.5% [17] of Hartlepool residents having a Body Mass Index (BMI) >25.



Source: Health Survey for England [15]

A BMI of 30 or higher indicates a person has very high body fat or is obese

A BMI of 25 - 29.9 indicates a person has high body fat or is overweight.
A BMI of 18.5 - 24.9 indicates a person is within the recommended range of body fat.

A BMI of < 8.5 indicates a person has low body fat or is underweight.

Nutrition and Obesity

The World Health Organisation (WHO) points to a number of factors that have contributed to a reduction in the amount of physical activity. [18] These include:

- A reduction in occupational exercise. The extra physical activity involved in daily living in 1973 compared with today, has been estimated to be the equivalent of running a marathon a week.
- Greater use of the car and wider car ownership.
- An increase in energy-saving devices in public places, such as escalators, lifts and automatic doors.
- Fewer opportunities for young people to take physical exercise.
- The substitution of physically active leisure with sedentary pastimes such as television, computer games and the internet.

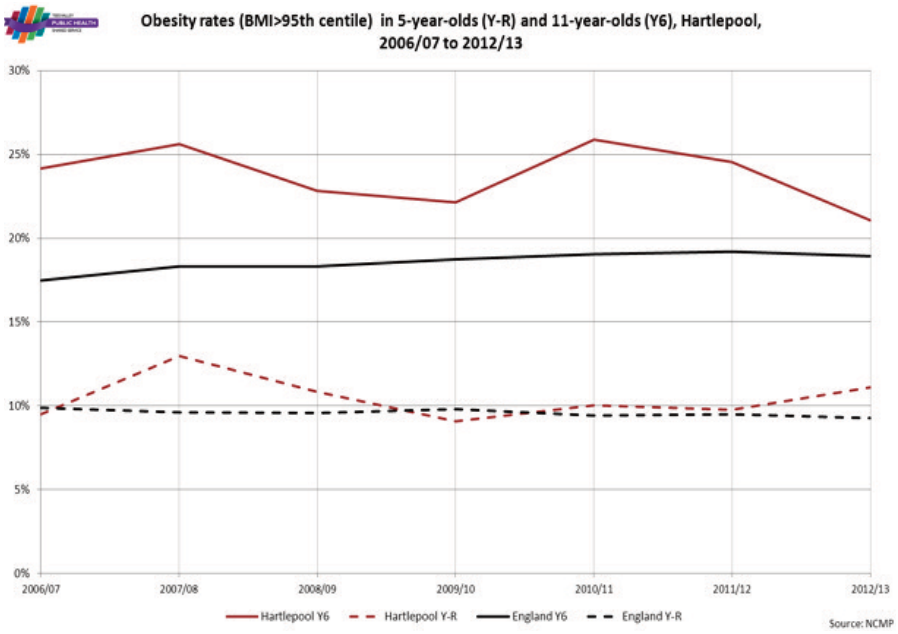
Aims of Public Health intervention

There are 5 key strands with supporting actions to support obesity management in Hartlepool, aligned to the national Healthy Weight, Healthy Lives Strategy [19]. They are:

1. Children: Healthy Growth and Healthy Weight;
2. Promoting healthier food;
3. Building physical activity into our lives;
4. Creating incentives for better health; and
5. Personalised support for people who are overweight and obese.

Local Challenge

In Dr Milligan's School Medical Officers Report of 1973, the measurement of children was restricted to routine medical inspections. In 2013, children in Reception (4-5 year olds) and year 6 pupils (10-11 years old) are weighed and measured each year in school as part of the National Child Measurement Programme (NCMP). There is much more information about the growth patterns of today's children. In 2011/12, 10% of reception children and 24% of year 6 pupils in Hartlepool were obese [20].



Nutrition and Obesity

Retail food and drink outlets

Since 1973, Hartlepool, like many other areas in the UK, has seen a major decline in the more traditional trades such as butchers, bakers, fishmongers and greengrocers, which typically supplied fresh food including fruit and vegetables. These would be taken home and prepared as home-cooked meals. General dealers, smaller supermarkets and newsagents have also decreased in number and been replaced by larger stores and supermarkets supplying a much wider range of products including convenience foods, which can be consumed inside or outside the home. [21] [22] [23] [24]

TYPE	1973	2013	% change
Newsagent/Confectioner	66	37	- 44%
Bakeries/Bakers Shops	42	20	- 52%
Butchers	62	16	- 74%
Café/Restaurant	32	104	+325%
Fish & Chip Shop	49	20	- 60%
General Dealer	134	82	- 39%
Greengrocers	35	11	- 69%
Takeaways	0	112	-
Off Licence	29	5	- 83%
Supermarket	51	20	- 61%
Petrol Stations	0	7	-
Health & Sports Clubs	0	8	-
Ice Cream	4	7	+75%

In 1973, there were 0 takeaway establishments, in 2013 there are 112!!

Early example of take-away food (HBC)

Supermarkets – a new innovation (HBC)

There has been a 300%+ increase in the number of cafés/restaurants in Hartlepool since 1973.

Nutrition and Obesity

Food marketing

Advertising and other forms of marketing are a significant contributor to childhood obesity [25]. The extensive variety of food and drink products now available and the marketing of these products (especially those with a high content of fat, sugar or salt) challenge efforts to eat healthily. Studies have shown a relationship between weight gain and television exposure [26], and that television advertising influences children's food preferences and consumption patterns [14]. The National Institute for Health and Care Excellence (NICE) recommends that measures to protect children from the dangers of a poor diet should be given serious consideration [27].

New television advertising rules were introduced in the UK in 2007 (fully implemented in 2009), which restricted the advertising of high fat, sugar or salt products to children. It has been suggested that this has reduced this type of advertising for children and young people by 37%, although, some recent research has indicated that the amount seen by children has actually increased [28]. This is because the regulation applies only to children's TV, not programmes for older audiences. These are recognised as having a powerful influence on children and young people [27].

Many techniques are used to market food products, not just through television, but also through social media and the Internet. There are no codes or regulations that address these integrated marketing communications across the range of different marketing platforms now available.

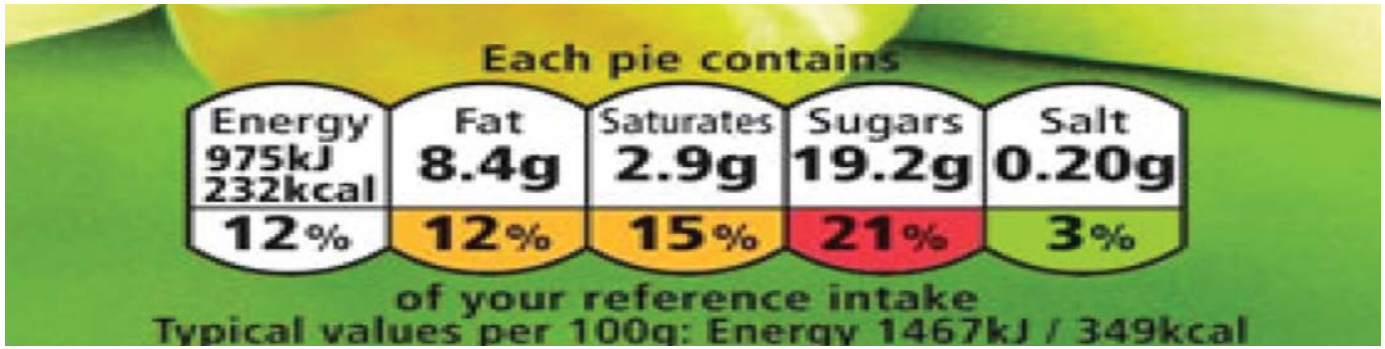
Food labelling

The law in the UK on food labelling is multifaceted and is spread over many reforms and parliamentary acts, making the subject complex. In 1970, the first large scale review of food labelling since the early 1950s was published as the Labelling of Food Regulations. This was in response to the continual consumer demand for pre-packed foods which left previous measures outdated and now required new design of packaging and modifications to labelling. From 1973, these regulations came into force and saw nutritional labels used for the first time on processed food to provide consumers with nutrient information. Today nutrition labels provide even more useful product information. In 2013, after consultation, agreement was reached on a voluntary scheme to inform food choices through a 'traffic light' system to make it easier for consumers to know the nutritional content of food [29].

Red - high = enjoy it once in a while

Amber - medium = ok most of the time

Green - low = go for it



Nutrition and Obesity

School meals

School meals are an important way of promoting healthy eating habits in children and young people (more so for children living in areas of deprivation). Good nutrition is also beneficial for concentration, so encouraging and increasing the uptake of school meals may help improve both the health and education of school children in Hartlepool. There have been some interesting changes in both numbers of school children and the patterns of their school dinner consumption in the years since 1974.

The uptake of school meals, generally, decreases when children move from primary to secondary school and in many cases secondary school pupils are allowed to leave the school premises at lunchtime.

In 2007 the Government introduced set nutritional standards for school dinners [30], which have introduced more fresh ingredients and less processed foods. The options on the menu have also changed greatly over the years, reflecting the availability of prepared foodstuffs, cultural changes and recognition of the need for a balanced diet

	1974	2012
Children on school roll	22,570	13,136
Children receiving school dinners	10,597 (47%)	7,220 (55%)
Children receiving free school dinners	2,733 (26%)	2,883 (40%)
Children having paid dinners	7,864 (74%)	4,337 (60%)
Children having school milk	5,710	Unknown

	1973	2013
Main Meal Options	Liver & onions Spam fritter Mashed or boiled potatoes Cauliflower Beetroot Peas	Sweet potato and vegetable curry, Naan bread & mixed salad Fish fingers, chips and garden peas Salad bar option with jacket potato and fillings Selection of sandwiches, wraps and pitta bread
Dessert Options	Chocolate concrete cake and pink custard Tapioca Ice cream and toffee sauce	Chilled berry mousse or fresh fruit

School Meal Prices

1973: 14p

2013: £1.90 to £2.10

Nutrition and Obesity

Travel and transport

Car ownership in Hartlepool has increased significantly in the last 40 years. In 1973, 40% of households owned a car, whereas in 2011, 65% of households in Hartlepool have at least one car or van (416 cars per 1000 people). Improved transport links and car ownership mean residents often make just one weekly journey to a large supermarket which provides everything a family needs, rather than making multiple shorter journeys to a number of local stores several times a week. As a result, people are less physically active.

The most popular method of travel to work in Hartlepool is by car/van, or as a passenger (over 40% of journeys), with fewer than 8% of journeys made on foot or bike. [31]

Breastfeeding

It is widely known that the best start in life for a new baby is to breastfeed. A baby who is breastfed is less likely to become obese in later life and therefore less likely to develop type 2 diabetes and/or other illnesses.

Breastfeeding rates in Hartlepool (43.9%) are among the lowest in England (73.9%) and the gap between Hartlepool and England is widening. Breastfeeding rates vary considerably within Hartlepool. In Rift House, Brus and Owton wards, less than one-third of mothers initiated breastfeeding, compared with more than three-quarters in Elwick, Park and Greatham wards.

In Hartlepool, there are several initiatives to improve the uptake of breastfeeding:

- Peer support;
- Training & guidance to staff & biological nurturing feeding position;
- More support during pregnancy;
- Health visitor teams trained in motivational interviewing for breastfeeding; and
- Breastfeeding Welcome Award.

Breastfeeding rates in Hartlepool are one of the worst in England.

Method of travel to work in Hartlepool	Percentage
Working from home	1.6%
Train	0.7%
Bus	3.9%
Taxi	1%
Motorcycle / scooter	0.3%
Car / van	35.7%
Passenger in car / van	4.8%
On foot	6.8%
Bicycle	1.1%
Other	0.6%

Nutrition and Obesity

Welfare food and healthy start vitamins

In 1973, welfare food was available at the infant welfare clinics which were located across the town. The products included national dried milk, concentrated orange juice, cod liver oil, vitamin A and D tablets, and children's vitamins. These were offered for sale and for free (depending on family circumstance). In 2013, welfare food support is through the 'Healthy Start' scheme which aims to support low-income families to eat more healthily by providing them with vouchers to spend on cows milk, fresh or frozen fruit and vegetables and infant formula milk. The scheme also provides pregnant women, new mothers and young children with free healthy start vitamins, which can reduce the risk of health problems associated with vitamin deficiencies, e.g. rickets and spina bifida.

Currently, 80% of eligible women and children claim their healthy start vouchers, but very few claim their healthy start vitamins.

Local interventions

Hartlepool Borough Council currently operates a multi-partnership Healthy Weight Healthy Lives Steering Group which aims to address rising levels of overweight and obesity among adults and children. The group includes representation from Public Health, Social Care, Sport & Recreation, Dietetics, School Meals Service, NHS, Transport and the voluntary services among others, and has a strong emphasis on joint working.

Did you know that…

- **8% of children under five in the UK don't have enough vitamin A in their diet;**
- **Families in lower-income groups tend to have less vitamin C in their diet; and**
- **Pregnant and breastfeeding women are at risk of vitamin D deficiency.**

Healthy start vitamins help with all of these issues.

Summary

It is widely acknowledged that obesity is a threat that continues to rise, with rates showing little sign of easing in the next 5-10 years.

The 2007 Foresight Report [32] stated that almost half of the UK population could be obese by 2050, and that the total cost could reach £50 billion a year. [33]

The most recent figures published by the Health & Social Care Information Centre [34] have shown a fall in the number of obese and overweight children in their final year of primary school in England for the first time in six years - although the levelling off in obesity rates tends to be amongst the children of more affluent families. Levels of obesity amongst children in deprived areas remain high.

Alcohol Misuse

Introduction

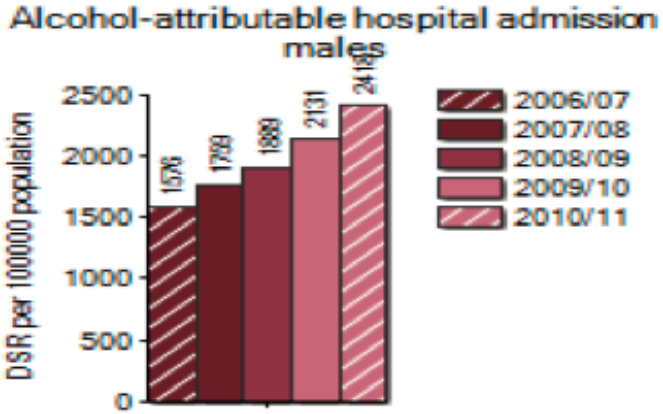
Alcohol use has long been seen as a deep rooted part of the culture of the industrial north east. Excessive use is not only extremely dangerous to health, but also causes injuries and domestic violence. Patterns of alcohol use have changed over time, as have the types of alcohol available. Dr Milligan's report for 1973 had nothing to say about alcohol harms. There was reference to Health Education in 1973 and the need to meet the needs of older students, and short talks on human relationships were provided by the Local Authority in schools and colleges, but whether these touched on alcohol use as a health or social issue is not recorded. Given that it was written before the advent of health improvement and promotion as we know it today, this seems unlikely. The only area that hints at the problem is within the section on causes of mortality in Hartlepool, where the reference to deaths from cirrhosis of the liver shows us that the problem was there, if not the means to tackle it. [35-37]

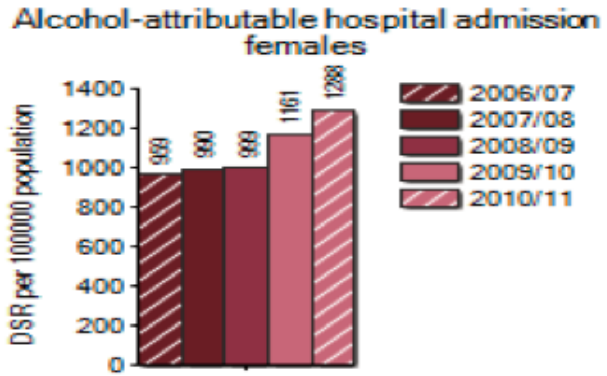
The impact

Alcohol kills around 2.5 million people globally each year and is responsible for almost 4% of all deaths. [45] In the UK, recent statistics show a rise in alcohol-related and primary alcohol-attributable hospital conditions. In 2011, alcohol-related admissions increased by 11% on the previous year, including a 2.1% rise in admissions for conditions where the primary diagnosis was attributable to alcohol consumption [39].

It is estimated that in a community of 100,000 people (Hartlepool population 92,000) each year:

- **1,000 people will be a victim of alcohol-related violent crime;**
- **Over 400 11-15 year olds will be drinking weekly;**
- **Over 13,000 people will binge drink;**
- **Over 21,500 people will be regularly drinking above the lower risk levels;**
- **Over 3,000 will be showing some signs of alcohol dependence; and**
- **Over 500 will be moderately or severely dependent on alcohol [41].**





The estimated the cost of alcohol-related harm to the UK is £21 billion per year. HSCIC [44]

Alcohol Misuse

Changing trends

Patterns of alcohol consumption in the UK have changed over the last 40 years. Some key developments include:

- A rise in drinking at home and a decline in the amount of alcohol consumed in pubs.
- A significant increase in wine consumption.
- The emergence of supermarkets as leading providers of alcohol for home consumption.
- The development of new alcohol products and brands, including 'ready to drink' beverages (often known as 'alcopops') and strong white ciders [42].

Policy level responses include a recent report from the House of Commons Science and Technology Select Committee which advised that people should have at least two alcohol free days per week [40]. In addition, the Coalition Government has recently published an Alcohol Strategy to deal with 'the scourge of violence caused by binge drinking' [41].

The Licensing Act 2003, provided for flexible opening hours for licensed premises, with the potential for up to 24 hour opening, seven days a week; wider availability of and reduced prices for alcohol through off licence sales in supermarkets; and the development of a range of new alcohol products. [42]

Marketing

Alcohol is marketed through an integrated mix of strategies including TV, radio and print advertising, point of sale promotions, and the association of brands with a variety of sporting and cultural events [50]

Binge drinking is defined as drinking more than 8 units (male) or 6 units (female) in one day.

In 1994, research into the knowledge, beliefs and attitudes of schoolchildren in relation to beer advertising was published [51]. This showed that those who were aware of advertising held more favourable beliefs about drinking, intended to drink more as adults, and had more knowledge of brands and slogans. [43] The WHO Global Strategy [38] considers action on alcohol marketing as one of ten key policy areas, and states that reducing the impact of marketing, particularly on young people and adolescents, is an important consideration in reducing harmful use of alcohol.

Alcohol Misuse

Minimum unit pricing

The Governments' Alcohol Strategy in 2012 committed to consider the introduction of a minimum unit price for alcohol. This is a targeted measure that will link the price of alcohol to its strength - the more units of alcohol, the higher the price. It is designed to increase the price of the most harmful alcohol and therefore to protect vulnerable younger and heavier drinkers.

In 2012/13, Hartlepool Public Health Department was actively working with partners to introduce a minimum unit price for alcohol, which was high on the Government's agenda. However, after the national consultation, the Government announced that it had been listening to powerful arguments on both sides and was deciding not to introduce this measure. [53]

Licensing

In 1973, there were fewer licensed premises which also had shorter opening hours. Most pubs were serving last orders at 10.30pm (and closed between 3.00pm and 5:00pm) and nightclubs closed at 2:00am. In 2013, there are approximately 36 premises with a midnight closing time and approximately 35 more licensed premises that will stagger closing between 1am and 4am (depending on the terms of the license).

A rise in the number of outlets which have licenses to sell alcohol increases availability to access alcohol. Some supermarkets are open on a 24-hour basis and sell alcohol at competitive prices providing the consumer with choice and availability. [54]

Alcohol strength and labelling

The labelling of alcohol products in 1973 was subject to limited legislative requirements and there was no pressure to include health messages. Labels were limited to details of the manufacturer and brand and contained logos and brand identifiers. Indications of alcoholic strength were limited to brand descriptions such as 'Brown Ale' or 'Pale Ale'. [57]

Spirit-based drinks had an indication of strength included on the labelling which was based on the historical test for the quality of British Navy Rum rations (this was based on proving that the rum had not been tampered with by soaking gunpowder in a sample of rum and then seeing if it would still explode). This was labelled as '100% Proof' and indicated that the rum had not been watered down and was of a guaranteed strength which is the equivalent of approximately 57% alcohol by volume (ABV). Subsequently, spirit drinks manufactured to lesser strengths were given indications of degrees of proof, with 70 degrees proof being the equivalent of today's 40% ABV. [52]

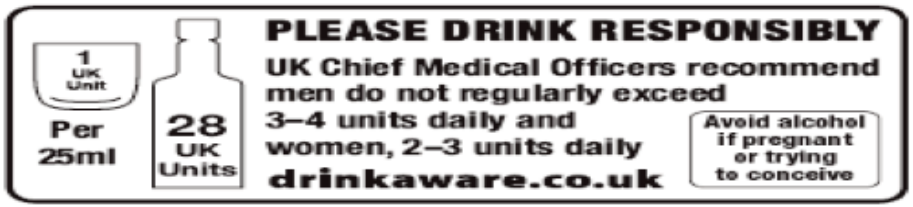
Since 1980, UK alcoholic drinks have been required to be labelled with their alcoholic strength in percentage, which gives a more easily understandable indication of the strength of the drink. As part of the Government's responsibility deal, alcohol producers and sellers have been encouraged to commit to a range of pledges, including health-related labelling. [55]

Alcohol Misuse

New alcoholic drinks

The drinkers of 1973 had a relatively limited choice of products such as beers, wines and spirits. In recent years there has been a proliferation in the types of alcohol that have become available. There are now alcoholic drinks such as alcopops, which are arguably aimed directly to the younger age groups. Alcopops, as the name implies, often resemble and taste like soft drinks and can therefore mislead as to the high alcohol content.

Lager has become much more popular in the UK which has resulted in the availability of much stronger international brands (not available in 1973). In effect, the strength of the beers and lagers has increased, as well as the amount that people drink. More recently, there has been a resurgence in the cider market, and a further expansion of brands using a variety of other fruits.



Alcohol Misuse

Local challenge

Hartlepool faces the challenge of dealing with the range of short-term and long-term health risks caused by excessive alcohol consumption. The immediate effects often result from binge drinking and include:

- Unintentional injuries, including traffic injuries, falls and drowning.
- Violence, including domestic partner violence and child abuse.
- Risky sexual behaviours.
- Offenders under the influence of alcohol;
- Miscarriage and stillbirth among pregnant women, and a combination of physical and mental birth defects among children.
- Alcohol poisoning.

Longer-term effects include the development of chronic diseases, neurological impairment and social problems. These include:

- Neurological problems, including dementia and, stroke;
- Cardiovascular problems, including heart attacks, heart flutters and high blood pressure;
- Psychiatric problems, including anxiety, depression and suicide;
- Social problems, including unemployment, lost productivity, and family disruption;
- The risk of mouth, throat, oesophageal, liver and colon cancer;
- Liver disease including cirrhosis, alcoholic hepatitis; and
- Gastrointestinal problems such as pancreatitis and gastritis.

Hartlepool initiatives

Alcohol is a major part of the Hartlepool Substance Misuse Strategy and Action Plan, and work is underway with partner agencies. There has been a significant increase in the last decade in awareness raising campaigns to tackle alcohol for the population of Hartlepool.

Hartlepool is investigating alcohol in pregnancy to raise awareness of the dangers of drinking alcohol during pregnancy. When a pregnant woman drinks, the alcohol in her blood passes freely through the placenta into the developing baby's blood. Because the foetus does not have a fully developed liver, it cannot filter out the toxins from the alcohol. Instead, the alcohol circulates in the baby's blood system. It can destroy brain cells and damage the nervous system of the foetus at any point during the nine months of pregnancy. The effects can be mild or severe, ranging from reduced intellectual ability and attention deficit disorder to heart problems and even death. This work is in partnership with Balance, the North East Regional Alcohol Office.

Alcohol Misuse

Specialist treatment

The number of dependent drinkers has increased in recent years leading to the development of specialist treatment services in Hartlepool. Hartlepool Journey 2 Recovery delivers a combination of structured psychosocial interventions, relapse prevention and aftercare, harm minimisation and recovery and reintegration. There is a wide range of support for service users and their families, including strong links to education, training and employment. For those clients who need a more structured medical intervention, Hartlepool has a clinical service to deliver this structured treatment in partnership with the services listed above. Regionally, at the end of 2011/12, it was estimated that 5.5% of dependent drinkers had accessed specialist alcohol treatment services.

Summary

Alcohol dependency continues to be a problem in Hartlepool. This risk is underpinned by a number of issues, from changes in drinking patterns and culture over the last four decades to current price and availability. The understanding of the harmful effects of excessive alcohol consumption, while known for many years, has only recently come to the attention of society and therefore become a priority area for action. Progress is being made due to the efforts on awareness raising, education in schools and youth settings, and work with parents to highlight the dangers of alcohol, but further work remains to be done to ensure that both stakeholders and the general public are fully aware of the effects.

There is increasing demand for support services in Hartlepool (evident from the rise in people entering treatment and subsequent successful completions).

Public Health has a role in continuing to advocate for minimum unit pricing of alcohol, which was recently put on hold by the Government, but is seen as a positive step on the way to a healthier future approach to alcohol.

Conclusion

This report demonstrates how Hartlepool has changed over the last 40 years, both in terms of the town itself and, more importantly, how local people have progressed in terms of their health. Public Health has a key role in helping many different organisations to ensure that health improvement is planned systematically.

This report focuses on several issues of particular concern for Hartlepool, which fall largely within the health improvement domain. The rationale is that these risk factors (smoking, high blood pressure, inactivity, poor diet and alcohol) apply in almost all long-term conditions (cancer, cardiovascular disease, diabetes and dementia).

Complex issues such as smoking, alcohol consumption and obesity are not amenable to short-term and easily managed programmes. They are deeply rooted within the social circumstances and cultural norms of a population and closely linked to inequalities and require systematic action between organisations and political parties to deliver benefits for the people of Hartlepool.

Inequalities

People with higher socioeconomic position in society have more life chances and better health and wellbeing [4]. In Hartlepool about 5,400 children live in poverty and life expectancy is below the England average. In Hartlepool, men in the most deprived areas can expect to live around 12 years less than in the more affluent areas [56].

Sir Michael Marmot suggested that Public Health focuses less on treating what has gone wrong, but more about the choices people have. This would be best achieved by action on six policy objectives:

- Give every child the best start in life;
- Enable all children, young people and adults to maximise their capabilities and have control over their lives;
- Create fair employment and good work for all;
- Ensure healthy standard of living for all;
- Create and develop healthy and sustainable places and communities; and
- Strengthen the role and impact of ill health prevention.

Success in reducing health inequalities and improving and protecting health and wellbeing relies on policy, planning, practice and review that includes effective evidence. Examples of action that can tackle health inequalities include [58]:

- Prioritise disadvantaged groups (e.g. multiply deprived families and communities, unemployed people, those living in fuel poverty, rough sleepers, and homeless people).
- Provide services universally, but with a scale and intensity that are proportionate to the level of disadvantage.
- Provide accessible services (e.g. easily accessible locations, services that are affordable with good transport links).
- Offer intensive support (e.g. systematic and tailored approaches involving face-to-face or group work, home visiting, good quality pre-school day care).
- Do not only target geographical areas defined as deprived. Targeting only these areas will not include vulnerable people living elsewhere. Neighbourhoods that are considered as being well-off overall with good health outcomes can still include individuals and families that are experiencing health inequalities.
- Local policy should not be discriminatory. Discrimination can lead to and perpetuate health inequalities.
- Ensure local agencies work together with common aims and actions to reduce health inequalities.

Using our intelligence

Health profiles are produced by Public Health England [56] and provide details of how Hartlepool compares with England for a range of public health indicators. For example:

- The health of people in Hartlepool is generally worse than the England average.
- In Year 6 (11-year-olds), almost 1-in-4 children are classified as obese, this is worse than the England average.
- The rate of alcohol-specific hospital stays among those under 18 is worse than the England average.
- The rate of mothers smoking during pregnancy is worse than the England average.
- The estimated levels of adult 'healthy eating', smoking, physical activity and obesity are worse than the England average.
- The rates of smoking related deaths and hospital stays for alcohol related harm are worse than the England average.
Hartlepool Health Profile 2013[56]

Conclusion

The electoral ward health summaries that accompany this report together with a recently published 'benchmarking' analysis can be used to make better informed decisions about health priorities, resource allocation, and targeting of actions. These tools should also be used as part of the wider intelligence contained in the Joint Strategic Needs Assessment for Hartlepool **www.teesjsna.org.uk/hartlepool.**

Asset based approach

It is important to recognise that the basis of Hartlepool is its communities. Flourishing communities are those where everyone has someone to talk to, neighbours look out for each other, and people have pride and satisfaction with where they live and feel able to influence decisions about their area. Residents are able to access green and open space, feel safe going out and there are places and opportunities that bring people together. A good place to start is by looking at where communities are already flourishing [60]. There are considerable positive features within Hartlepool's communities such as services, groups, advocates and champions, enthusiasm and a desire to achieve the best that is possible. By mapping these resources it is possible to engage with local communities to allow participation in decision-making. This asset-based approach can empower individuals and communities to facilitate local solutions to health inequalities.

Hartlepool Health and Wellbeing Board

Health and Wellbeing Boards were established as a forum where key leaders from the health and social care system work together to improve the health and wellbeing of their local population and reduce health inequalities. The boards are a key part of broader plans to:

- Ensure stronger democratic legitimacy and involvement;
- Strengthen working relationships between health and social care;
- Encourage the development of more integrated commissioning of services.

Board members are expected to collaborate to understand their local community's needs, agree priorities, based on the Joint Strategic Needs Assessment, and encourage commissioners to work in a more integrated way. As a result, patients and the public should experience better services from the NHS and local councils. The Board will help give communities a greater say in understanding and addressing their local health and social care needs. The Health and Wellbeing Board has the aspiration that the people of Hartlepool will be 'Healthy people and will live longer, healthier lives'. [61]

The Health and Wellbeing board has been in operation since 1st April 2013. The was chaired by Cllr Carl Richardson and has had a very successful first year.

In 2014 the board is now being chaired by Cllr Christopher Akers-Belcher, leader of the Hartlepool Council.

Hartlepool Public Health Department

Since September 2013, the Public Health Department manages the additional functions of environmental health, licensing, trading standards and sports & recreation. Hartlepool is also considering the reconfiguration of a health improvement service for children aged under 20-years-old including school nursing, health visiting and breast feeding services. These additional functions ensure that the Department is well placed to tackle the key issues of tobacco, alcohol and obesity-related harm, and will be better placed in future to work with partners through the Health and Wellbeing Board to address the health inequality challenge in the medium and long-term.

Public Health initiatives come to fruition at different points and have an impact that is difficult to measure in the short-term. It is important to ensure that the desire to see immediate results should not undermine the determination to tackle Hartlepool's medium and long-term public health challenges. This requires commitment to effectively 'future-proof' such approaches to avoid short-term funding, and reactive decision making.

The Future of Public Health

The forthcoming year 2014/15 is seen to be a transformation year for Public Health in the Council. Staff are settled into the Council and commited to forming new alliances and spreading the influence of public health both inside and outside of the local authority.

I am committed to reducing health inequalities and protecting the health of all people in Hartlepool.

I am driven to contribute to make Hartlepool a great place to be born, live, learn, work and grow older and look forward to reporting progress in my 2014/15 Director of Public Health Annual Report.

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Bengali

এই ডকুমেন্ট অন্য ভাষায়, বড় প্রিন্ট আকারে এবং অডিও টেপ আকারেও অনুরোধে পাওয়া যায়।

Cantonese

本文件也可應要求，製作成其他語文或特大字體版本，也可製作成錄音帶。

Hindi

अनुरोध पर यह दस्तावेज़ अन्य भाषाओं में, बड़े अक्षरों की छपाई और सुनने वाले माध्यम पर भी उपलब्ध है

Kurdish

ئەم بەلگەیە هەروەها بە زمانەکانی کە، بە چاپی درشت و بە شریتی تەسجیل دەس دەکەویت

Arabic

هذه الوثيقة متاحة أيضا بلغات أخرى والأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

Polish

Dokument ten jest na życzenie udostępniany także w innych wersjach językowych, w dużym druku lub w formacie audio.

Urdu

درخواست پر یہ دستاویز دیگر زبانوں میں، بڑے حروف کی چھپائی اور سننے والے ذرائع پر بھی میسر ہے۔

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AUDIT AND GOVERNANCE COMMITTEE

16 October 2014

Report of: Director of Public Health

Subject: SUBSTANCE MISUSE STRATEGY GROUP – UPDATED SUBSTANCE MISUSE TREATMENT PLAN 2014/15

1. PURPOSE OF REPORT

1.1 To inform and update the Audit and Governance Committee on the progress and process taken to produce a Substance Misuse Treatment Plan 2014/15.

2. BACKGROUND

2.1 In order to support the delivery of the local Substance Misuse Strategy, the Safer Hartlepool Partnership is required to produce an annual Substance Misuse Treatment Plan **(Appendix 1).**

2.2 After a number of national drug strategies that promoted maintenance in treatment, the latest strategy launched in December 2010 changed the focus to the three key areas of:

- Reducing demand
- Restricting supply
- Building recovery in communities

The new focus on recovery encompassed alcohol as well as drugs. It stressed that recovery is individual and person centered, and requires an effective 'whole systems' approach working with education, training and employment, housing, family support services, wider health services and criminal justice agencies where appropriate.

2.3 The strategic direction and lead for substance misuse in the town is the Safer Hartlepool Partnership which includes key stakeholders such as the CCG, Local Authority, Police, Probation and Fire Brigade, and a number of additional special interest task groups and forums, e.g. Night Time Economy (Police and Licensing interests), and Community Alcohol Partnership.

2.4 The previous Substance Misuse Treatment Plan came to an end in March 2014.

3. PROPOSALS

3.1 To inform the development and subsequent annual refresh of the Substance Misuse Treatment Plan the SHP Strategic Assessment and the Joint Strategic Needs Assessment will assist us to understand the issues that are affecting the local community and identify key priorities that will inform the Substance Misuse Treatment Plan for 2014/15.

3.2 JSNA for Drugs and Alcohol has informed the new Treatment Plan.

3.3 The first Draft Substance Misuse Treatment Plan 14/15 was presented to SHP in May 2014 for consideration by Safer Hartlepool Partnership. This has been a complete refresh on the original document that includes a framework to include the governance structure, substance misuse data, with key objectives and actions for the coming year. This new plan also includes a RAG reporting mechanism that forms the structure of the new Substance Misuse Treatment Plan for 2014/15 and the future contract monitoring of the treatment providers, in addition to other Partnership activity.

3.4 The draft plan was consulted upon in accordance with the Voluntary and Community Sector Strategy undertakings (this contains the former consultation codes of the Hartlepool Compact) for an 8-week period. The results of the consultation on the first draft of the Plan were considered and used to inform the production of the final working document that is being presented today.

3.5 The Substance Misuse Treatment Plan is currently being delivered with partners including Child & Adult Services, Community Safety Services, Licensing and Criminal Justice Intervention Team (CJIT), Police and Balance.

4. EQUALITY AND DIVERSITY CONSIDERATIONS

4.1 The JSNA (Drugs & Alcohol) ensured the needs of all substance misusers within our community were considered when formulating and implementing the Substance Misuse Treatment Plan 2014/15

5. RECOMMENDATIONS

5.1 Following on from the first draft and formal consultation it is recommended the Audit and Governance Committee note the progress taken to refresh the Substance Misuse Treatment Plan.

5.2 To accept this as an ongoing document that will show updates on the Action Plan (starting on page 10 on attached Treatment Plan) on a quarterly basis, with a final annual update given after quarter 4 (ready in April 2015).

6. REASONS FOR RECOMMENDATIONS

6.1 Partners involved in delivering the plan are Responsible Authorities and it is a statutory duty to develop an annual Substance Misuse Plan to reduce substance misuse and the issues that are linked to it.

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Substance Misuse Treatment Plan 2014-2015 (Drugs & Alcohol)

Introduction

In order to support the delivery of the local Substance Misuse Strategy, Hartlepool Borough Councils' Public Health Department have produced an Annual Substance Misuse Treatment Plan.

Public Health has contributed to a Joint Strategic Needs Assessment (JSNA) throughout 2013. JSNA included analysis of treatment data, performance compared against regional and national best practice, and consultation with service users and families. This has informed the Substance Misuse Plan for 2014/15 for Hartlepool.

Background

After a number of national drug strategies that promoted maintenance treatment, the strategy launched in December 2010 changed the focus to that of recovery as the central goal and encompassed alcohol as well as drugs. It stressed that recovery is individual and person centred, and requires an effective 'whole systems' approach working with education, training and employment, housing, family support services, wider health services and criminal justice agencies where appropriate

PHE suggests the principles for commissioning a treatment system that promotes successful recovery journeys are:-

- To maintain or improve access to ***early and preventative interventions*** and to treatment.
- Ensure treatment is ***recovery-orientated, effective***, high-quality and protective.
- Ensure treatment delivers continued benefit and ***achieves appropriate recovery-orientated outcomes***, including successful completions.
- Ensure treatment supports people to ***achieve sustained recovery.***

The strategic direction and lead for drug and alcohol activity in the town is Safer Hartlepool Partnership a multi agency partnership that ensures an integrated approach with membership that includes key stakeholders such as the NHS, Local Authority, Police, Probation, Balance and Fire Brigade. In addition Safer Hartlepool Partnership involves a wider range of stakeholders through a number of additional special interest task groups and forums.

In addition to the activity illustrated below there are additional supplementary plans and programmes developed in SHP task groups that focus on a particular aspect of drug and alcohol activity e.g. Night Time Economy (Police and Licensing interests), Community Alcohol Partnership and Community Safety Plan.

Delivery Structure

The responsibility for delivery of each of the priorities has been allocated to a dedicated theme group of the Safer Hartlepool Executive Group.

Local Context

Hartlepool is the smallest unitary authority in the North East region and the third smallest in the country comprising of some of the most disadvantaged areas in England. Issues around Substance Misuse can be understood by a number of contextual factors:

Population

- Hartlepool has a stable population rate, maintained by low levels of migration.
- Hartlepool has become more diverse in recent years, although a very small proportion of the population are from the Black Minority Ethnic (BME) community.
- 46% of the population in Hartlepool live in five of the most deprived wards in the country, where crime and anti-social behaviour rates are high.

Housing

- Strong links exists between the occurrence of anti-social behaviour and the location of private rented housing.
- The percentage of long term empty properties in Hartlepool is higher than the regional average.

Health & Wellbeing

- The health of people in Hartlepool is generally worse than the England average.
- There is a higher prevalence of long term health problems, including mental health.
- The number of alcohol related hospital admissions and hospital stays for self-harm in Hartlepool are significantly worse than the England average.
- The number of Class A drug users in Hartlepool is more than double the national average.

Geography

- Substance misuse issues are not evenly spread and tend to be concentrated in geographic hotspots, particularly in the most deprived wards in Hartlepool.

Deprivation

- Hartlepool has pockets of high deprivation where communities experience multiple issues: higher unemployment, lower incomes, child poverty, ill health, low qualification, poorer housing conditions and higher crime rates.
- Residents living in more deprived and in densely populated areas have high perceptions of crime and anti-social behaviour and feel less safe.

Unemployment

- Unemployment rates in Hartlepool are above the regional average and more than double the national average.
- 14.5% of young people aged 18-24 years are unemployed.
- Hartlepool has high rates of people incapable of work due to disability and ill health.

Strategic Objectives: Reduce Harm caused by Substance Misuse

From April 2013 the Public Health Department became part of Hartlepool Borough Council.

The SHP, Substance Misuse Strategy Group (SMSG) oversees the implementation of the National Drug & Alcohol Strategies at a local level and ensures a comprehensive response and services for substance misuse issues, treatment and support.
The drug and alcohol treatment services in Hartlepool, including the Criminal Justice Integrated Team (CJIT), is a responsibility of the (SMSG) facilitated by the Health Improvement Practitioner (Drugs & Alcohol), who reports to the Director of Public Health who in turn reports to the SHP Executive Board.

It is the responsibility of the Commissioning and Clinical Quality Section of PH to develop and implement commissioning strategies and monitor contract performance and clinical quality. Recently included - April 2014 is the Clinical Prescribing Service.
There is the need for robust relationships and pathways for strategic direction/decisions and resource allocation.

Going forward the objectives for this plan is to focus on the Recovery Agenda within Substance Misuse. The plan will enable all individuals (Adults & Young People) who have been identified with drug or alcohol issues to be supported throughout their recovery journey to achieve best possible outcomes.

The Joint Strategic Needs Assessment (JSNA) for Hartlepool summarises the efforts of many people through a range of different mechanisms to identify, define, and address the wider health and wellbeing needs of the people of Hartlepool. The work we do in partnership is guided by plans, strategies, and policies that have been developed after needs assessment, data analysis and research, through consultation with professionals and residents across the area.

Drugs
Drug misuse refers to the use of a drug for purposes of which it is not intended, or using a drug in excessive quantities.

All sorts of different drugs can be misused, including illegal drugs (such as heroin or cannabis), prescription medicines (such as tranquilisers or painkillers) and other over the counter medicines (OTCs - such as cough mixtures etc).

People who misuse drugs often have a range of health and social problems, which may have led to misusing drugs or maybe a consequence of their addiction.

For the people who take them, illegal drugs can be a serious problem. National Programme on Substance Misuse Deaths for 2012 shows 1,757 deaths per year in the UK. Deaths from Substance Misuse destroy thousands of relationships, families and careers.

Within Hartlepool we have six elements of treatment to support Recovery:

- Clinical Prescribing Service
- Recovery & Reintegration
- Psychosocial Interventions
- Harm Minimisation and Needle Exchange
- Service User & Family Support
- Education Training & Employment

Our Services address the four corners of addiction which are the following:

- Neurological – Which is addressed via our Clinical Prescribing Service
- Biological - Which is addressed via our Clinical Prescribing Service
- Psychological – Which is addressed via our treatment providers – Lifeline & DISC
- Sociological - Which is addressed via our treatment providers – Lifeline & DISC

Recovery

Within drug and alcohol services, the recovery model recognises that there are a variety of routes into problematic drug and alcohol use and a variety of routes out of it. This emphasises the need for personalised pathways that support an individual's recovery journey and for treatment to deal with all relevant issues in holistic way. In the recovery model, treatment outcomes are emphasised over process and are being defined in terms of recovery, employment and reintegration rather than the historical focus on offending and health. The aim of recovery is to become free of problematic drug and/or alcohol use.

Alcohol

Alcohol misuse is defined as consuming more that the Governments/DH recommended limits of alcohol. Many people are able to keep their alcohol consumption within their recommended limits, so their risk of alcohol-related health problems is low. However, for some, the amount of alcohol they drink could put them at risk of damaging their health.

Types of Alcohol Misuse:

Risk	Men	Women
Lower Risk	No more than 3-4 units per day on a regular basis	No more than 2-3 units per day on a regular basis.
Increasing Risk Drinkers who are at an increased risk of alcohol-related illness (which would also include binge drinking).	More than 3-4 units per day on a regular basis.	More than 2-3 units per day on a regular basis.
Higher Risk Drinkers who have a high risk of alcohol-related illness	More than 8 units per day on a regular basis or more than 50 units per week	More than 6 units per day on a regular basis or more than 35 units per week

Long-term alcohol misuse is a major risk factor for a wide range of serious conditions, such as:

- Heart disease
- Stroke
- Liver disease
- Various Cancers

The short-term risks of alcohol misuse include:

- Alcohol poisoning
- Head injury
- Violent behaviour
- Unprotected sex, unplanned pregnancies or sexually transmitted infections (STIs)

Young People – Drugs & Alcohol

In Hartlepool we have a specialist substance misuse team provided by DISC that provides a range of support to young people affected by substance misuse.

Young people and their needs differ greatly from adults. The majority of young people that access the specialist substance misuse team have problems mainly with alcohol and cannabis. There has been an increase in the use of Benzodiazepines and other prescription medication and anecdotal information regarding Novel Psychoactive Substances. The young people that access the service require psychosocial, harm reduction, pharmacological, multi-agency and family work interventions. Young people who use

drugs or alcohol problematically are likely to be vulnerable and experiencing a range of problems, of which substance misuse is just one of them. This means that the delivery of the specialist substance misuse interventions for young people also need to address additional needs and not just address the substance misuse in isolation. This can only be achieved with effective practice between the specialist substance misuse team and other key agencies such as YOS, education, social care, CAF, locality teams, VEMT, the youth service etc.

Cannabis misuse continues to be the most prevalent drug used by young people in Hartlepool, where adjunctive use with alcohol is high.

Early identification is a key element to the young people's specialist substance misuse team and a vast amount of work is carried out to support this agenda.

Early Intervention Delivery and Support
There are several elements in delivering and supporting early intervention:

- Workforce development to train and support universal and education staff in identification, assessment and brief intervention delivery
- Extensive work to develop and increase referral pathways with universal services
- Provide targeted interventions to individuals or groups of young people
- Provide drop-in services within education settings and community settings

Young people who require structured care planned support will engage with the service and undergo a comprehensive assessment and will receive a care planned package of support that can include the following interventions;

Structured Interventions
- Psychosocial Interventions (ITEP, CBT, MI, SFT, NLP, CPI)
- Pharmacological Interventions (medical support such as prescribing)
- Harm Reduction Interventions (risk and resilience, relapse prevention)
- Family Support (family sessions, parent sessions, family therapy)

Domestic Violence
Domestic violence continues to be a key factor in the occurrence of violence offences, with more than half of offences being domestic related. Domestic violence has a devastating impact on individuals, families and communities. Tackling this issue requires a significant amount of resources from all public sector agencies.

Housing
Three-quarters of single homeless people have a history of problematic substance misuse (rising to more than 80% of rough sleepers). More than 40% of single homeless people sight substance misuse as the main reason for homelessness, while two-thirds report increasing problem substance misuse after becoming homeless. Substance misusers felt that having appropriate housing was one of the most important support services required to help them stay free of substance misuse.

CJIT/Crime
Clear links are evident between substance misuse and violent crime. Drug misuse continues to be a contributory factor in offending behaviour, specifically in regard to acquisitive crime and high rates of re-offending.

Substance Misuse Priorities 2014-2015

Our focus for the Substance Misuse Treatment Plan will concentrate on the following areas of concern:

Annual Priorities 2014 - 2015
Substance misuse – reduce the harm caused to individuals, their family and the community, by illegal drug and alcohol misuse
Domestic violence and abuse – reduce the risk of serious harm and provide the right response to safeguard individuals and their families from violence and abuse
Anti-social behaviour – ensure effective resolution of anti-social behaviour, divert perpetrators and identify and support vulnerable individuals and communities
Re-offending - reduce re-offending through a combination of prevention, diversion and enforcement activity

Action Plan

RAG Status Key:

LAVENDER	Actions not yet planned or underway
RED	Unsatisfactory progress – targets and timescales not being met
AMBER	Good progress being made against targets
GREEN	All targets being met

Planning Section 1: PREVENTION AND EARLY INTERVENTION

- To promote early interventions to reduce the incidence of dependency in all sections of the population
- To liaise and work effectively with Children's Services and other relevant organisations to safeguard vulnerable adults and children
- To provide advice and information to address drug misuse and promote responsible drinking
- To prevent harm to children, young people and families affected by drug and alcohol misuse
- To ensure families are supported through effective multi agency working

Key Actions	By When	By Whom	Baseline	RAG Status & Comments
Promote early interventions to reduce the incidences of dependency in all sections of the population through increased use of effective screening and IBA	Ongoing	Planning & Commissioning Officers (as part of the monitoring). All Agencies	All admissions data from Balance. ARHA data. HYPED data. CJIT from follow-up assessments. (KC)	**Quarter 1 Update** All treatment providers are gathering data on screen. HYPED will also know how many people have been trained to do screening around Audit C and IBA as they gather this information on their database. Work continues into Q2.

Young Peoples services to continue to work in partnership to deliver prevention initiatives are built into the 'Healthy Child Programme' 5-19.	Ongoing	HYPED	Last years end of year data of YP worked with to demonstrate if targets are being met.	**Quarter 1 Update** HYPED are working towards this target as part of their daily work programme. However further work is needed to see how we want this recording. SR will check with Deborah Gibbin to update at Q2.
Reinstate the Hidden Harm Forum to strengthen safeguarding families.			Number of Children in need Number in children child protection Look at number of clients within Troubled Families and THAT KC to gather figures from Lisa Oldroyd this will then demonstrate the need for this to happen	**Quarter 1 Update** SR & KC need to instigate the reforming of this group and further updates will be given at Q2.

Ensure families, especially those with more complex needs are supported to give the best start in life.			Look at number of referrals to children's centres Numbers of children seen by the centres (John Scadden) Lifeline stats for referrals	**Quarter 1 Update** It has been identified that Mel Calvert maybe a useful link to this group as Early Years Co-ordinator. SR will invite her to the next meeting once actions have been assigned to people. This would also be a good link into Locality Teams.
Work with The Community Alcohol Partnership (CAP) to deliver a range of preventative, educational and enforcement activity to address the issue of alcohol misuse amongst young people in our most disadvantaged communities.		HYPED	Nil – pilot (area) Collate numbers over the coming year.	**Quarter 1 Update** CAP is a pilot in Owton Manor area for one year. HYPED and Lifeline have an active input in this group and in the delivery of the work CAP are aiming to achieve with regards to education for young people drinking on the streets and parenting sessions. This work continues and further updates will be available in Q2.
Joint delivery with Balance of preventions messages in relation to FASD	Ongoing	Sharon Robson and Providers	From our providers point of view regarding previous promotion	**Quarter 1 Update** Work has commence in partnership with Balance on promoting the awareness of FASD. This is a regional target to produce consistent

			what are the numbers of people engaged? SR questionnaires	messages for all around FASD that can then be used within our locality. Preparation is well underway for the national FASD Awareness Day to be held on 9th September 2014. Lifeline will be leading on this event with stalls and promotional work taking place in Middleton Grange Shopping Centre. Further updates on how the event was received will be given in Q2.

Planning Section 2: DELIVER RECOVERY-ORIENTATED, EFFECTIVE, HIGH QUALITY APPROACHES TO TREATMENT AND SOCIAL INTEGRATION WHILST MONITORING PROGRESS

- To ensure a 'recovery model' of treatment that responds to individual needs and is based on identified best practice.
- To improve performance and outcomes against national targets and for the benefit of Hartlepool
- To ensure that partnership working provides streamlined and effective pathways between specialist and non specialist services
- To specifically concentrate on developing a clear, needs led integrated care pathways between alcohol, community and specialist support services
- To improve the coordination of services to ensure that existing provision is most effectively and efficiently used and best practice is widely shared thus reducing duplication of effort and maximising the use of resources
- To deliver continued benefit and achieve appropriate recovery-orientated outcomes, including successful completions
- To expand understanding of recovery and reintegration across staff, service users, and stakeholders
- To establish robust arrangements for joint recovery and care coordination for complex cases

Key Actions	By When	By Whom	Baseline	RAG Status & Comments
Increase access to Harm Reduction measures:- • Greater numbers receiving Hep B vaccinations and Hep C testing. • Increase screening for BBV • Establish and monitor numbers attending Needle Exchange programmes in pharmacies			DOMES Q3 BBV, harm Min annual figures from E.O.Y Nil – KC to chase	**Quarter 1 Update** Work continues through our harm minimisation service to raise awareness within the centre and surrounding community venues through awareness raising campaigns to increase the numbers.
Monitor and improve transitional pathway for those clients 18+ transferring into adult services.			Numbers transferred from HYPED to Adult services	**Quarter 1 Update** There is a pathway in place at the moment for those clients who are eligible for transition from young peoples services into adult services. However, there is a need for this pathway to be refreshed and updated. HYPED currently hold the pathway and will be working with Treatment Manager to update the pathway.
Providers to complete checklists for Treatment Effectiveness Meetings, to address improving outcomes for groups who are less likely to leave treatment successfully.		All Agencies	DOMES data Exit by reason and time in treatment	**Quarter 1 Update** All providers will complete checklist for Treatment Effectiveness Meeting (TEM) to address improving

				outcomes especially for those leaving treatment. KC will then report back to the action plan and SMSG on a quarterly basis.
Monitor links with Mental Health and Social Care Services to improve access and recovery for Dual Diagnosis and High Demand Families.		All Agencies	TOPS/ mental wellbeing less than 10 reported (See Dean)	**Quarter 1 Update** SR has set up multi-agency meeting with Mental Health & Social care to address some issues and build on relationships in order to improve service provision for all clients & high demand families.
Update on the pilot project with Harbour from a Child, Victim and Perpetrator perspective, which addresses incidences of Substance Misuse relating to Domestic Violence.			Nil	**Quarter1 Update** There is not update on this pilot in Q1. SR to gain more information for Q2.
Monitor and develop options for Tier 4 provision including: • Community/Residential Detoxification, to meet the level of need. • Increase opportunities for rapid community detoxification with associated wraparound services.	Ongoing	Marie Shout	Last year's numbers from MS Last year's numbers from IntraHealth	**Quarter 1 Update** This work is ongoing with no issues at this time.

Monitor and develop the use of Audit C for all services, as a priority for those services with direct contact with our clients, for example: Hospital Staff, Providers, Job Centre Plus, etc.			Providers/how many have done Audit C? Hospital/ SR to check with Donna SR to Monitor CQUIN	**Quarter 1 Update** Audit C is currently delivered within all our treatment providers as routine. However, there may be the need to offer additional training to staff to enhance the numbers of organisation and therefore enhance the numbers into treatment after assessment. Some members of our partner organisations have already been trained in delivery Audit C and IBA however there is the need to roll this out further, focusing on the organisations listed within the action. Online training has been sourced and can be accessed by individuals wanting to complete the training for IBA and our provider services can deliver training on Audit C for those in need. This will also be reflected in the training section of this plan and the training programme.

Planning Section 3: ACHIEVE OUTCOMES AND SUSTAINED RECOVERY

- To provide additional supportive measures that complement treatment
- To build opportunities for recovery capital for substance misusers i.e. housing, education, employment and family
- To ensure robust pathways and processes for social reintegration

Key Actions	By When	By Whom	Baseline	RAG Status & Comments
To monitor and improve successful outcomes and take necessary action to address areas of underperformance. To monitor and reduce unplanned discharges and take necessary action to address areas of underperformance.	Ongoing	All Agencies	Effective Treatment Successful Completions Non re-presentations Unplanned discharges	**Quarter 1 Update** Commissioning Officers will be pro-active when working with services to address issues of under performance if needed
To track and ensure provision for complete wraparound service is available for those individuals leaving specialist treatment.	Ongoing	All Agencies	Aftercare stats as baseline Treatment map - Referrals	**Quarter 1 Update** Work is ongoing through Commissioning Officers and treatment providers to monitor those referrals to/and from others.
Enhance access for Substance Misuse clients to emergency, move on and sustainable accommodation.			Negative – Looking at clients with housing need Monitor - TOPS on a monthly basis.	**Quarter 1 Update** No update for Q1 at present.

Encourage/improve family involvement in Treatment Planning, as evidence shows better outcomes for those clients where families have had an input.			Ali's Stats using highest Families who have been through CRAFT	**Quarter 1 Update** HYPED are currently delivering Systemic Family Therapy within their service and will continue to do so. Adult treatment services also deliver programmes to encourage family involvement and this will be ongoing.
Improve numbers accessing reduction regimes with additional psychosocial support.	Ongoing	All Agencies	DOMES report 2-4, 4-6 years and 6 years +	**Quarter 1 Update** There is a new pathway being set to address this. Further updates will be given in Q2.

Planning Section 4: PROMOTE PUBLIC PROTECTION THROUGH LAW, ENFORCEMENT AND POLICY

- To tackle drug supply, drug and alcohol related crime and anti-social behaviour through robust enforcement
- To use Licensing powers and other legislation to effectively manage the night time economy
- To introduce measures and initiatives that focus on specific issues
- To target interventions at groups/ individuals in the community causing most harm to themselves and others
- To work with leisure and entertainment industry to promote responsible drinking e.g. challenge cost of soft drinks.
- To continue to monitor sales of alcohol through regular underage test sales to young people and prosecute those retailers who fail to heed warnings and advice.
- To extend Pub Watch and Best Bar None and similar schemes to raise quality standards.

Key Actions	By When	By Whom	Baseline	RAG Status & Comments
ACTIONS IN THIS SECTION STILL TO BE AGREED				• SR to see IH re the targets • SR to ask IH to check blue area above. • KC will feed in some actions based on CJIT targets

Planning Section 5: ACCOUNTABILITY AND PARTNERSHIP WORKING

- To have robust treatment systems with effective safeguarding measures in place, geared to meet the needs of vulnerable adults, as well as parents and carers with responsibility for children.
- To ensure clear pathways and protocols are in place between treatment, children's services and adult social care services to improve safeguarding, joint working and information sharing.

Key Actions	By When	By Whom	Baseline	RAG Status & Comments
How many protocols we are developing? Joint working and formalising pathways				
Links with the Police – KC				

Planning Section 6: WORKFORCE DEVELEOPMENT TRAINING & CAMPAIGNS

WORKFORCE DEVELOPMENT TRAINING				
Key Actions	**By When**	**By Whom**	**Baseline**	**RAG Status & Comments**
Annual Training Programme to be developed that links to all actions below around training: • Hidden Harm & Think Family • Harm Minimisation • Drug & Alcohol Awareness Training – Level 1,2 & 3 • Hep B & Hep C Training & BBV Training • Overdose Prevention • Safer Injecting Training • IPED's Training • Parental Substance Misuse • Alcohol Champions • FASD Champions • IBA Training • Audit (Alcohol) • CAF Training • NBPS Training (Addiction Training) -see note in Drugs paragraph • Safeguarding Training Ensure Substance Misuse Training Programme links to HBC Workforce Development Training.	Quarter 1			**Quarter 1 Update** Further work needs to be done by SR to establish who will be responsible for developing and delivering on the Training Programme. Further updates will be given in Q2. HYPED already link in with Workforce Development & LSCB.

Needs Assessment to be undertaken to indentify knowledge gaps across Hartlepool organisations to inform the training matrix	Quarter 2		Training Needs Assessment	**Quarter 1 Update** Training Needs Assessments needs to be undertaken across Hartlepool services to identify priorities for training.
CAMPAIGNS				
Key Actions	**By When**	**By Whom**	**Baseline**	**RAG Status & Comments**
All providers to coordinate and work together to deliver an annual campaigns timetable to encompass all aspects of Substance Misuse. This timetable will include the use of social marketing approaches to target specific groups with tailored messages in a variety of formats, using all available opportunities to promote support by using consistent prevention messages.	Quarter 1			**Quarter 1 Update** A full 12 month Campaigns Timetable has been produced with awareness raising campaigns set for a number of issues relating Substance Misuse. All treatment providers are playing an active part in the timetable to deliver the messages.
To continue to drive forward campaigns to promote responsible drinking and highlight the dangers of substance misuse - campaigns including: Substance Misuse Week.	November 2014		Nil	How many people we have reached
Continue to support Balance to drive forward campaigns to promote responsible drinking and highlight the dangers of alcohol misuse - campaigns	November 2014		Nil	How many people we have reached

including: Alcohol Awareness Week.				
Targeted work to address alcohol related issues throughout the World Cup 2014. • Links with Morning After Campaign (Police). • Links to local workplaces via Steven Carter. • Local promotion of sensible drinking during this period. • Work with HBC licensing department.	June/July		Nil	How many people we have reached
Support FASD Awareness Day by promotional campaign to raise awareness of the dangers of alcohol during pregnancy	September 2014		Previous	How many people we have reached

Measuring Performance

Performance monitoring will be undertaken monthly and quarterly, assessing progress against key priorities and identifying any emerging issues.

The following key performance indicators will be monitored over the next 12 months:

Reduce the harm caused by drug and alcohol misuse	Increasing the number of Problem drug users /Opiate and Cocaine users PDU/OCU in effective treatment (sustaining 12 weeks +)
	Increasing the number of individuals successfully completing treatment (leaving in a planned way)
	Reducing the numbers of PDUs /OCUs returning to treatment within 12 months
	Increasing the number of individuals who have reduced their Drug/Alcohol use and reduced their criminal activity?
	Increasing the number of individuals being vaccinated / tested
	Reducing drug related deaths
	Reduce the number of alcohol related hospital admissions rate per 100,000 population
	Number of young people known to substance misuse services

In addition we work closely with PHE who supply information around NDTMS, NATMS & DOMES that will inform the treatment plan. This partnership is an essential part of the treatment reporting mechanism helping us deliver a robust service for our clients and their families.

END OF SUBSTANCE MISUSE TREATMENT PLAN

Glossary of Terms

Appendix 1

BBV	Blood Bourne Viruses
CAF	Common Assessment Framework
CAP	Community Alcohol Partnership
CBT	Cognitive Behavioural Therapy
CJIT	Criminal Justice Intervention Team
CPI	Community Psychosocial Intervention
DOMES	Diagnostic Outcomes Monitoring Executive Summary
FASD	Foetal Alcohol Spectrum Disorder
HBC	Hartlepool Borough Council
HEP B	Hepatitis B
HEP C	Hepatitis C
IBA	Identification & Brief Advice
IPED's	Image Performance Enhancing Drugs
ITEP	International Treatment Effectiveness Project
JSNA	Joint Strategic Needs Assessment
MI	Motivational Interviewing
NATMS	National Alcohol Treatment Monitoring System
NBPS	Neurological, Biological, Psychological & Sociological
NDTMS	National Drug Treatment Monitoring System
NHS	National Health Service
NLP	Neuro Linguistic Programme
OTC's	Over the Counter
PDU	Problem Drug Users
PHE	Public Health England
SFT	Solution Focused Therapy
SHP	Safer Hartlepool Partnership
SMSG	Substance Misuse Strategy Group
VEMT	Vulnerable Exploited Missing Trafficked
YOS	Youth Offending Service

AUDIT AND GOVERNANCE COMMITTEE

16 October 2014

Report of: Report of Health and Wellbeing Board

Subject: HEALTH AND WELLBEING BOARD'S RESPONSE TO THE INVESTIGATION INTO CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

1. PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide Members of the Audit and Governance Committee with feedback on the recommendations from the investigation into Chronic Obstructive Pulmonary Disease (COPD), which was reported to the Safer Hartlepool Partnership on 10 September 2014.

2. BACKGROUND INFORMATION

2.1 The investigation into COPD conducted by this Committee falls under the remit of the Public Health Department and within the remit of the Health and Wellbeing Board.

2.2 On 10 September 2014, the Health and Wellbeing Board considered the Final Report of the Audit and Governance Committee into COPD. This report provides feedback from the Health and Wellbeing Board's consideration of, and decisions in relation to this Committee's recommendations.

2.3 Following on from this report, progress towards completion of the actions contained within the Action Plan will be monitored through Covalent; the Council's Performance Management System; with standardised six monthly monitoring reports to be presented to the Committee.

3. SCRUTINY RECOMMENDATIONS AND DECISION

3.1 Following consideration of the Final Report, the Health and Wellbeing Board approved the recommendations and actions, subject to a response being received from Hartlepool and Stockton-on-Tees Clinical Commissioning Group and North Tees and Hartlepool NHS Foundation Trust, in response to recommendations A to C. A 12 week timescale is provided for such responses, therefore when the response is received, the action plan will be

updated and re- circulated to this Committee and to the Health and Wellbeing Board.

3.2 Details of each recommendation and proposed actions to be taken following approval by the Health and Wellbeing Board are provided in the Action Plan, attached as **Appendix A.**

3.3 The Health and Wellbeing Board requested that the impact/progress on the Action Plan be reported to the Board in March 2015 along with the Public Health report in relation to COPD screenings (recommendation f refers).

4. RECOMMENDATIONS

4.1 That Members note the proposed actions detailed within the Action Plan and seek clarification on its content where felt appropriate.

Contact Officer:- Laura Stones – Scrutiny Support Officer
Chief Executives Department –Legal Services
Hartlepool Borough Council
Telephone: 01429 523087
E-mail – laura.stones@hartlepool.gov.uk

BACKGROUND PAPERS

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

(i) The Audit and Governance Committee's Final Report into COPD considered by the Health and Wellbeing Board on 10 September 2014

(ii) Decision Record of the Health and Wellbeing Board held on 10 September 2014

AUDIT AND GOVERNANCE SCRUTINY ENQUIRY ACTION PLAN

NAME OF COMMITTEE: Audit and Governance Committee

NAME OF SCRUTINY ENQUIRY: Chronic Obstructive Pulmonary Disease (COPD)

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION+	FINANCIAL / OTHER IMPLICATIONS	LEAD OFFICER	COMPLETION DATE*
(a) That the Health and Wellbeing Board develop a strategic approach to COPD to ensure that inequality is not worsened by:- (i) monitoring the review of the single point of access to establish whether the changes have had a positive impact on COPD patients and their families (ii) ensuring that any changes to service provision are appropriately evaluated to provide assurance that these changes are effective from an evidence and cost perspective	This action has been forwarded onto North Tees and Hartlepool NHS Foundation Trust and Hartlepool and Stockton on Tees Clinical Commissioning Group to provide a response			

(b) That the Health and Wellbeing Board explores ways to promote COPD support programmes, such as the pulmonary rehabilitation programme, to encourage people to attend	This action has been forwarded onto North Tees and Hartlepool NHS Foundation Trust and Hartlepool and Stockton on Tees Clinical Commissioning Group to provide a response			
(c) That the Health and Wellbeing Board, through an integrated and co-ordinated approach, work in partnership with relevant organisations and groups to promote a consistent message on COPD through the use of a single questionnaire	This action has been forwarded onto North Tees and Hartlepool NHS Foundation Trust and Hartlepool and Stockton on Tees Clinical Commissioning Group to provide a response			
(d) That the Health and Wellbeing Board raises community awareness of COPD by placing the COPD questionnaire in community and health venues across Hartlepool to find those people with undiagnosed COPD	Public Health has already taken the lead on behalf of the Board over the past year to promote the questionnaire. Public Health will build on this previous activity during 2014/15 to ensure the questionnaire is circulated across a range of settings to find those people with undiagnosed COPD.	N/A	Louise Wallace	Mach 2015

(e)	That the Health and Wellbeing Board explores the development of a targeted COPD awareness campaign for young people to raise awareness of the long term implications of smoking;	Public Health has led this activity on behalf of the Board and will continue to do so through activities such as theatre in education and schools. This approach has proven successful in raising awareness amongst young people of the short and long term healthy implications of smoking.	N/A	Louise Wallace	March 2015
(f)	That the Health and Wellbeing Board explores whether the number of COPD screenings taking place at various GP surgeries across Hartlepool can be publicised, as it would be valuable for the community to be aware of the variations in practices in order to aid patient choice and help to alleviate variations across GP surgeries.	Public health are responsible for commissioning the COPD screening programme in primary care. This requires practices to ensure that patients most at risk of developing COPD i.e those that smoke, are made aware of this service. Public Health will provide a report on uptake, impact and variation of this service provided by GP's to the Health and Wellbeing Board by March 2015.	N/A	Louise Wallace	March 2015

[+] please detail any risk implications, financial / legal / equality & diversity / staff / asset management considerations

* please note that for monitoring purposes a date is required rather than using phrases such as 'on-going'

Extract from the minutes of the Finance and Policy Committee on 18 August 2014 relating to Public Health

37. Drug and Alcohol Recovery Support Services (*Director of Public Health*)

Type of decision
Key Decision tests (i) and (ii) apply - Forward Plan Reference No PH 07/14.

Purpose of report
The purpose of the report was to seek approval from the Finance and Policy Committee to secure a Drug and Alcohol Recovery Support Service, funded through the ring fenced Public Health Grant, to commence 1st April 2015.

Issue(s) for consideration
The Chief Executive reported that the existing contracts for Adult Drug and Alcohol Recovery and Reintegration, Harm Minimisation, Psychosocial Interventions, Education Training and Employment, Family and Carer Support and the Criminal Justice Interventions Team alongside Young People's Drug Treatment Services all come to an end on 31st March 2015. There was no further opportunity to extend existing arrangements and therefore a review of services was required in order to ensure that identified need was still being met and a new recovery model was developed to continue to meet that need.

A full service review was being conducted alongside consultation with stakeholders, providers and service users in order to shape future service provision, the outcome of which will support the development of the new recovery model beyond April 2015. Following final outcome of the review and consultation it was proposed to secure a new Drug and Alcohol Recovery Support Service designed to meet the continuing need of service users, their families and carers.
The Chief Executive highlighted that any successful bidder may be subject to TUPE regulations with regards to staff. There were 53 members of staff employed by the current service providers, with varying working hours.

Members referred to the periodic reports to other bodies, such as the Health and Wellbeing Board on the effectiveness of the service. There was concern that more recent admissions to the programme were progressed from drugs to methadone and then off methadone in a controlled but relatively quicker manner than in the past yet there were still significant numbers who had almost moved to prescribed methadone, another addictive drug, as a life choice rather than being weaned off drugs altogether. The new contract needed to take cognisance of this problem and ensure the programme tackled these users. The Head of Health Improvement commented that long term users were a problem as they saw methadone as a crutch rather than a means to an end. Work within the

service was tackling these users and this would be seen through the statistics reported in the coming months.

Decision
1. That the development of a new service specification during 2014/15 taking into consideration current local needs and views from the engagement process be approved.
2. That the securing of a provider for the Drug and Alcohol Recovery Support Service to be funded by the ring fenced Public Health Grant 2015/16 be approved.

38. Stop Smoking Service (*Director of Public Health*)

Type of decision
Key Decision test (i) and (ii) applies - Forward Plan Reference No PH/06/14

Purpose of report
The purpose of the report was to seek approval from the Finance and Policy Committee to secure a Stop Smoking Service, funded through the ring fenced Public Health Grant, to commence 1st April 2015.

Issue(s) for consideration
The Chief Executive reported that on 1st April 2013, under the statutory transfer order, the Council inherited a contract for Stop Smoking Services provided by North Tees and Hartlepool Foundation Trust. On 29th November 2013 the Finance and Policy Committee agreed to place a one year contract from April 2014 with the existing provider of Stop Smoking Services, North Tees and Hartlepool Foundation Trust. In the spirit of openness and transparency it was also agreed that the Local Authority would publish a Voluntary Ex-Ante Transparency Notice (VEAT) in relation to this proposed contract award.

The current service operates a community-based drop in model providing clinics in a community setting using a wide variety of venues across the town on a range of days and times ensuring easy access. They also support the delivery of a structured one to one delivery of stop smoking service in a selection of pharmacies in the town. Closed groups in workplace settings are offered by arrangement, family/couple home visits for pregnant women and a combination of home and telephone support for the housebound.

The original target set by the Strategic Health Authority was based on achievement over a 3-year period. As Hartlepool had always performed well – being ranked as either best or second best in the Country (per 100,000 population) – an extremely high 4-week quit target, which is the number of people who set a quit date and remain stopped smoking for 4 weeks, was set. In line with regional and national trends it was only in the last year that the high target had not been reached with less quitters accessing services, therefore less 4-week quits. For future service delivery

it was expected that more emphasis should be placed on accessing harder to reach groups such as routine and manual workers, pregnant women, those with mental health problems, those from most disadvantaged wards rather than chasing a high 4-week quit rate.

The Chief Executive indicated that it was proposed to plan and implement the review of smoking cessation services through a joint approach between Hartlepool and Stockton on Tees Local Authorities. This joint approach would allow us to compare and contrast our service provision with another local authority who was procuring a very similar service at exactly the same time. It would provide an opportunity to determine whether there was any best practice that could be shared, economies of scale that could be identified and utilised and whether there were any options available for more efficient ways of procuring, especially if future service provision requirements were effectively delivered in the same manner. This did not mean, however, that the service would be commissioned with Stockton as the service would be commissioned on the most economic and efficient means possible for the residents of Hartlepool.

Members noted that there was a reported increase in the numbers of women smoking when pregnant. The Head of Health Improvement that there was a new programme being delivered to pregnant women by midwives which was starting to show some positive results. It was considered that the surveys now being undertaken were including a greater number of respondents so were giving a more accurate number of smokers. Members acknowledged that the service provided in Hartlepool had, for some time, been one of the best smoking cessation services in the UK and Europe in terms of results which was a credit to the staff involved. Members did question which community locations were being utilised and the Head of Health Improvement commented that they included council premises where available and other local venues including a pub – mainly chosen in areas of greatest smoking prevalence. Members proposed that the service should be required under the new contract to utilise the community buildings operated by the Council to provide a wider range of services through these venues. This proposal was seconded in the meeting.

Members also questioned the growing use of e-cigarettes and what controls there were on the sale of these products and if their users were still considered to be smokers as many claimed to use them as a means of helping them quit smoking. The Head of Health Improvement stated that users of e-cigarettes were presently classified as non-smokers. This did cause the service an issue when e-cigarette users came forward to the cessation service seeking help to quit. They were offered help by the programme but couldn't be included in the statistics of those helped to quit as they wouldn't be classes as 'smokers'. One of the major issues with smokers switching to e-cigarettes was that it didn't break the physical habit of smoking. The problem with illegal cigarettes was raised by a member of the public and the Head of Health Improvement indicated that the numbers of illegal cigarettes in the town were falling. An officer in the Public

Protection Team was working specifically on the issue of illegal tobacco products/non-duty paid cigarettes.

The Chair commented that one of the remaining issues to be tackled through the smoking cessation service was the number of businesses whose employees could be seen smoking around the entrances to businesses. The Head of Health Improvement indicated that work with businesses on these issues was being undertaken by the Workplace Health Improvement Specialist in the Health Improvement Team.

Decision

1. That the development of a new service specification for stop smoking services during 2014/15 be approved to be designed to meet the needs of local people and based on their views gained through the consultation and service review process.
2. That the service specification include the requirement for the services to utilise Council Community facilities as far as was possible, in particular, the three remaining community centres, in order to safeguard their future and make them more viable.
3. That that securing of a provider for a Stop Smoking Service, funded by the ring fenced Public Health Grant in 2015/16 be approved.

SAFER HARTLEPOOL PARTNERSHIP
MINUTES AND DECISION RECORD
18 July 2014

The meeting commenced at 1.00 p.m. in the Civic Centre, Hartlepool

Present:

Councillor Christopher Akers-Belcher, Elected Member, Hartlepool Borough Council ((In the Chair)
Councillor Chris Simmons, Elected Member, Hartlepool Borough Council
Dave Stubbs, Chief Executive, Hartlepool Borough Council
Denise Ogden, Director of Regeneration and Neighbourhoods, Hartlepool Borough Council
Clare Clark, Head of Community Safety and Engagement, Hartlepool Borough Council
Louise Wallace, Director of Public Health, Hartlepool Borough Council
Chief Inspector Lynn Beeston, Chair of Youth Offending Board
John Bentley, Voluntary and Community Sector Representative, Chief Executive, Safe in Tees Valley
Andy Powell, Director of Housing Services, Housing Hartlepool

Also present:
Dr Neville Cameron, Office of Police and Crime Commissioner for Cleveland
Kevin Parry, Durham Tees Valley Probation

Officers: Joan Stevens, Scrutiny Manager
Amanda Whitaker, Democratic Services Team Manager

93. Apologies for Absence

Apologies for absence were submitted on behalf of Chief Superintendent Gordon Lang, Cleveland Police and Karen Hawkins, Hartlepool and Stockton on Tees Clinical Commissioning Group

94. Declarations of Interest

None

95. Minutes of the meeting held on 9 May 2014

The minutes were confirmed.

96. Safer Hartlepool Partnership Reducing Re-Offending Strategy 2014-17 (*Director of Regeneration and Neighbourhoods*)

Purpose of report

To seek approval of the second draft of the Reducing Re-offending Strategy 2014-17 and to the proposed consultation process.

Issue(s) for consideration

Following the Safer Hartlepool Partnership Development Day held in April 2013, the Safer Hartlepool Partnership had agreed that there was a need to develop a local Reducing Re-offending Strategy. In September 2013 the first draft of the Strategy had been approved by the Safer Hartlepool Partnership. It had been acknowledged that finalisation and consultation on the strategy should be delayed pending findings from the Audit & Governance Committee's investigation into the level, complexities and impact of re-offending in Hartlepool.

Following the conclusion of the Committee's investigation in May 2014, the strategy had been revised as appended to the report. Tribute was paid to the work which had been undertaken by the Audit and Governance Committee which had enriched the Strategy. Although the overall aim of the strategy had remained unchanged, the three supporting objectives had been revised to strengthen the Strategy as set out in the report: In addition an action plan, appended to the report, had been developed by the Safer Hartlepool Partnership Reducing Re-offending Theme Group, taking into account key findings from the Audit and Governance Committee's investigation, recommendations from the Offender Housing Needs Event held in December 2013 and the ongoing work to develop a Tees-wide single IOM scheme. The draft Reducing Re-offending Strategy and action plan would be subject to an eight week consultation exercise, details of which were set out in the report. It was anticipated that the finalised strategy would be presented to the Partnership in October 2014 for final approval.

Whilst expressing their support of the Strategy, members of the Partnership recognised that it was essential to ensure delivery of the action plan. Reference was made to progression of St Paul's housing scheme and it was suggested that specific consultation associated with that scheme should be undertaken once the final details were known. The Council's Head of Community Safety and Engagement responded to concerns expressed in relation to information omitted from the action plan and provided reassurance that the information was included in the strategy and regular updates would be provided to the Partnership. Partnership Members provided also clarification on treatment of drug users in terms of improvements to approaches adopted previously and in the context of the Strategy.

Decision

The consultation process for the Reducing Re-offending Strategy 2014-2017, in line with the Hartlepool 'Community Compact', was approved.

97. Teesside Sexual Violence Strategy 2014-2016 (*Director of Public Health*)

Purpose of report

To seek comments from the Safer Hartlepool Partnership on the Teesside Sexual Violence Strategy 2014 – 2016.

Issue(s) for consideration

The report set out the background to the Teesside Sexual Violence Strategic Group (TSVSG) and to the development of a Teesside Sexual Violence Strategy 2014-2016 which was appended to the report together with the terms of reference for the TSVSG. The strategy set out a vision 'for a society in which no person, child or adult, has to live in fear of sexual abuse, sexual violence or sexual exploitation'. The strategy acknowledged that the prevalence of sexual violence was difficult to quantify due to victims being reluctant to report such matters although estimates based on the British Crime Survey were detailed in the report. A variety of agencies currently provided sexual violence services across Teesside and evidence collated by the Teesside Sexual Violence Co-ordinator, jointly funded by Northern Rock and Public Health, demonstrated the demand for these services. A table included in the report highlighted that 11% of victims accessing sexual violence services were subject to sexual violence in Hartlepool. The strategy recognised the significant and often long term impact that sexual violence could have on its victims and their families, and highlighted the importance of partnership working at a local level accompanied by the provision of accessible and effective support services. Underpinned by an action plan, appended to the report, the strategy set out nine objectives to address the cross cutting issue of sexual violence. Delivery of the strategy would be overseen by the TSVSG with the support of a Sexual Violence Operation Group. At the meeting, the Council's Director of Public Health updated the Partnership on feedback which had been received from Public Health England.

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Decision

(i) The Teesside Sexual Violence Strategy 2014-2016 was noted.

(ii) It was agreed that the Safer Hartlepool Partnership continues to be represented at the TSVSG to ensure links are maintained with local strategy groups, including the Safer Hartlepool Partnership Domestic Violence and Abuse Group.

98. Scrutiny Investigation into Re-Offending – Action Plan (*Director of Regeneration and Neighbourhoods*)

Purpose of report

To agree the Action Plan, appended to the report, in response to the findings and subsequent recommendations of Audit and Governance Committee investigation into Re-Offending.

Issue(s) for consideration

As a result of the Audit and Governance Committee investigation into Re Offending a series of recommendations had been made. An action plan had been produced and was detailed along with the recommendations of the Audit and Governance Committee which was appended to the report.

Decision

(i) The Action Plan was approved in response to the recommendations of the Audit and Governance Committee investigation into re-offending.

(ii) It was agreed that regular update reports would be submitted to future meetings of the Partnership.

99. Potential Topics for Inclusion in the Audit and Governance Committee Work Programme relating to Crime and Disorder (*Scrutiny Manager*)

Purpose of report

To invite suggested topics for inclusion in the 2014/15 work programme for the Audit and Governance Committee in relation to the statutory scrutiny area of crime and disorder.

Issue(s) for consideration

The Audit and Governance Committee would be setting its work programme at its meeting of 7 August 2014 and had invited the Safer Hartlepool Partnership to suggest topics for investigation that may complement their own work programme for the year or be an area of particular interest to help improve the wellbeing of the people of Hartlepool.

Topic suggestions which had been received were presented as follows:

- Hate Crime
- Anti-Social Behaviour Powers
- Restorative Justice
- Domestic Violence

Whilst supporting hate crime as the preferred topic, the referral of the topic of domestic violence for investigation by the Committee was supported also. The rationale for referral of domestic violence to the Committee was highlighted and the importance of dealing with domestic violence was recognised. However, given that domestic violence had been the subject of a fairly recent scrutiny investigation, it was accepted that the topic would not be a suitable scrutiny topic for 2014/15, although it could be potentially a viable topic for consideration as part of the 2015/16 scrutiny work programme.

Decision

The Partnership agreed that hate crime be referred for consideration by the Audit and Governance Committee as the preferred topic for consideration as part of the Committee's 2014/15 work programme but appreciated the importance of dealing with domestic violence and whilst it was agreed that it would not be a suitable scrutiny topic for 2014/15, it was agreed that it could be potentially viable topic for consideration as part of the 2015/16 scrutiny work programme

100. Prevent Silver Group Update (*Director of Regeneration and Neighbourhoods)*

Purpose of Report

To provide an update on the work of the recently formed Cleveland wide Prevent Silver Group, including activity associated with the Counter Terrorism Local Profile (CTLP) 2014.

Issue(s) for consideration

The report set out the background of the Contest Strategy which was

published in 2011 and aimed to reduce the risk to the UK and its interests overseas from terrorism. Incorporated within the revised Contest Strategy was the Government review of the Prevent programme, which had been subsequently refreshed and aimed to prevent people becoming terrorists or supporting terrorism. Changes taking place on a national level coincided with the review of the Counter Terrorism Local Profile (CTLP) which was a statutory requirement. Given the significant reduction in resources available and the review of the CLTP, the role of the Prevent Silver Group had been reviewed also in 2013 to ensure a sustainable way forward. A joint approach across all four Local Authority areas had been agreed in order to avoid duplication of services across Cleveland, to ensure a coordinated approach to the Prevent agenda and to enhance the operational efficiency and effectiveness of all partners. Details of the terms of Reference of the new Cleveland wide Prevent Silver Group were outlined in the report. Whilst recognising the rationale for the joint approach, Partnership Members highlighted potential concerns. Assurances were provided that any issues specific to Hartlepool would be addressed.

It was noted that Hartlepool Borough Council's Head of Community Safety and Engagement is a member of the Group and nominated representative of the Local Authority as the Prevent Lead on a Local Policing Area. In terms of governance, the Prevent Silver Group would be directed by, and would report to the Cleveland Contest Gold Group, and the Local Authority representative on this group was the Council's Director of Regeneration and Neighbourhoods.

The report set out details of the Counter Terrorism Local Profile 2014. In the context of Prevent, the CTLP had identified that the majority of cases that had presented themselves on a local level had been in respect of individuals expressing Far Right views, with limited dealings regarding individuals with an international terrorism perspective. Hartlepool also had one of the lowest levels of racially motivated offences across the Cleveland area.

The Partnership was advised that the CTLP would underpin the development and setting of the Prevent Silver Group's Action Plan, which was due to be finalised in September 2014. This would be undertaken alongside an analysis of the Prevent work that was currently being undertaken on a Local Authority level which included seeking to address any intelligence gaps, assessing training requirements and reviewing engagement with local communities, particularly focussing on the Prevent agenda. An update on progress would be reported at a future meeting of the Partnership.

Decision

The progress of the Silver Group was noted, including activity associated with the Counter Terrorism Local Profile.

101. Safer Hartlepool Partnership Performance *(Head of Community Safety and Engagement)*

Purpose of Report

To provide an overview of Safer Hartlepool Performance for 2013/14.

Issue(s) for consideration

The report provided an overview of the Partnership's performance during 2013/14, comparing the end of year performance to the previous year 2012/13. In presenting the report, the Head of Community Safety and Engagement highlighted salient positive and negative data and responded to a number of queries raised in relation to crime figures by type.

Concerns were expressed by a number of members of the Partnership in relation to the levels of anti-social behaviour in Hartlepool. During discussions, it was highlighted that it was apparent that neighbourhood policing in Hartlepool had changed and the consequences of a reduction in the number of Police Community Support Officers was discussed including public confidence issues and neighbourhoods returning to what they had been prior to the positive introduction of neighbourhood policing. There were increasing concerns raised by residents in relation to anti-social behaviour which was demonstrated by the number of related issues raised at ward councillor surgeries and Neighbourhood Forums. The impact on day to day policing, of cuts in other emergency services, was highlighted. Also discussed was the requirement for increasing meetings in neighbourhoods with key partners to address issues associated with anti-social behaviour.

Decision

It was agreed that a letter should be sent to the Police and Crime Commissioner for Cleveland to convey the Partnership's concerns in relation to the levels of anti-social behaviour in Hartlepool.

102. Any Other Business

(i) Meeting Dates

A schedule of meetings of the Safer Hartlepool Partnership was circulated to the Partnership for information

(ii) Director of Housing Services, Housing Hartlepool

The Partnership noted that Andy Powell, Director of Housing Services, was leaving Housing Hartlepool at the end of the month. Tribute was paid to Mr

Powell's contribution to the Partnership. It was agreed that a letter be forwarded, on behalf of the Partnership, to express appreciation of his contribution and to convey best wishes for his future.

The meeting concluded at 2.10 p.m.

CHAIR

North East Joint Health Scrutiny Committee

Minutes of meeting held on 17 April at South Shields Town Hall

Present:
Councillors: McCabe (Chair)(South Tyneside), Mendelson (Vice Chair)(Newcastle), Simpson (Northumberland), Green (Gateshead),Todd (Durham), Javed (Stockton)

Also in attendance:
Paul Baldasera (South Tyneside), Karen Christon (Newcastle), Paul Allen, Janice O'Hare (Northumberland), Angela Frisby (Gateshead),Jonathan Slee (Durham)
Peter Mennear (Stockton), Sue Appleby (Mental Health Concern), Jane Guppy (Mental Health Concern, Bill Scott (South Tyneside Mental Health User Voice), Martin Barkely (CE, TEWV), Dr Carole Kaplan (NTW), Elizabeth Moody (Group Nurse Director, NTW), Nicola Thackray (Strategic Business Planning and Performance Lead, NEAS), Mark Cotton (Assistant Director Communications, NEAS)

1. **Apologies**
   Cllr Waggott-Fairley (North Tyneside), Cllr Richards (Northumberland)

2. **Minutes of the last meeting**
   The Committee approved the minutes of the last meeting held on 4 November 2013 as a correct record.

3. **North East Ambulance Service – Quality Report 2013/14**
   Nicola Thackray, Strategic Business Planning and Performance Lead delivered a presentation on the NEAS Quality report. The presentation covered

   - What is a quality report?
   - Timetable for consultation and submission
   - What quality metrics are monitored
   - Performance and against 7 priorities in 2013/14
   - Priorities for 2014/15

   Nicola explained that the committee was asked to comment on a voluntary basis on the report on whether it is representative, whether its gives full coverage of services and whether there are any matters of concern that are not adequately addressed.

Members were asked for their comments

Cllr Mendleson (Newcastle) asked whether there were staff reductions this year in the context of the reduction in shifts.

Nicola responded by saying that the hours were being redistributed rather than reduced, resourcing shifts to be based on need. Workforce modelling would be used to ensure that shifts are properly staffed with appropriately skilled people.

She added however that it took 2 years to train a paramedic so it would take some time until the staff were up to full complement.

Cllr Mendleson (Newcastle) then asked how the decision is made to treat someone at the scene rather than transport to hospital.

Nicola said that the response depended partly on the paramedic's skills and what health facilities were within the location. She mentioned that there were two strategic planning events in April in Sunderland and Teesside looking at the greater use of paramedics and increasing their skill levels. These would look at innovative projects such as the use of Community Paramedics in Wooler.

Cllr Javed (Stockton) asked whether 12 hour shifts had always existed and whether this could lead to a dangerous situation where staff are exhausted.

Nicola said that 12 hour shifts had existed for a long time and suited many employees. However, it did not suit certain groups such as women with children and so changes to shift patterns were being developed to provide flexibility. She also agreed that long shifts could lead to people being tired but also logistical problems in organising workloads. The service wanted to look after employees as well as provide an efficient service through more flexible working hours.

Cllr Todd (Durham) asked would it be possible for the 111 service to book appointments directly with GP practices to prevent unnecessary admissions to casualty.

Mark Cotton replied that he was aware that this did happen in at least one area. He said that the 111 service was very new and they were in the process of identifying gaps which can be passed on to commissioners.

Angela Frisby asked about how low morale was being tackled within the service and the fact that there seemed to be no information within the quality report about staff/patient surveys.

Mark said that there was a friends and family test for staff for which there had been a good response rate. It showed that quite a few staff rated the service to patients poorly. As a result, focus groups were held between Christmas and February to

identify the reasons for this. One of the reasons given was GPs tending to book ambulances around the same time of day thus causing logistical problems leading to delays.

He went on to explain that the service did not need to report on this issue in their Quality Report until next year. The systems for capturing patient experience were not fully developed and they were awaiting further guidance as to how the friends and family test should work for ambulance services.

He said they could present patient experience data to the committee or individual Councils should this be requested.

Cllr Mendleson (Newcastle) asked, what back up will there be to ensure practice is safe within the 111 service.

Nicola replied by saying that clinical staff were on hand for help and this was built into the system. Also specialist paramedics can attend a scene in a car if needs be for a second opinion or to provide treatment.

Cllr Mendleson (Newcastle) also asked why some urgent transfers to and from hospital sometimes take a long time.

Mark responded by saying that resources were tight and the red light calls always had to take priority. This sometimes meant delays in other parts of the service.

Cllr Green (Gateshead) asked when the patient survey was issued. He also asked about the staff survey and whether the negative results were due to the reduction in services

Mark responded by saying that the patient survey was undertaken in three ways

- Volunteers undertaking face to face surveys
- Surveys completed via the website
- Annual postal survey

In terms of the outcome of the staff survey, he did not believe that this was unduly affected by service reductions. The main issues were

- Lack of support from managers
- Inappropriate use of 999 service
- Late finishes and arrangements for breaks

In response to the concerns about lack of management support, NEAS has reviewed the Team Leader structure. This means that an individual's manager was always someone who is on the same shift– this would not necessarily be the Station Manager.

Cllr Mendelson (Newcastle) enquired whether the final version of the report would include information which would evidence the growing demand for service.

Mark said that the Operational Plan/Annual Report would provide information on level of demand for 999,111 and booked transport services.

Cllr McCabe (South Tyneside) re-iterated the need to make sure that the valuing the staff was at the heart of any change.

4. North East Ambulance Service – Update on A and E Review

Mark Cotton took Members through a presentation regarding the latest position on the Accident and emergency Review.

He reminded Members that the original work started in 2006 and the aims of the project were

- To support the delivery of NEAS mission – “right care, right place, right time”.
- To deliver the principle of a paramedic at every 999 call that needs one.
- To protect the high standard if our service to patients by continuing to meet increasing activity

This was against a background of an 8% increase in activity over the past three years with the service taking 390,000 calls a year averaging at over 1000 calls per day.

He went on to talk about who had been consulted, and the resulting vehicle change in each area.

The new shift patterns of 6, 8, 10 hours had enabled the service to work more flexibly.

The changes were all put into place by 7 April and the expectation was that performance would remain at the same level.

Cllr Todd (Durham) asked how these changes would affect the Ambulance Service for the Dales

Mark said that the Dales were being looked at as a separate exercise by the CCG. He said that he had passed on Cllr Todd’s concerns about the need to consult on this issue.

Cllr Javed (Stockton) asked how old the data was on which the review was based.

Mark said it was PCT data but it was still pertinent in that there is still widespread inappropriate use of ambulances, in particular “emergency” ambulances taking “urgent” cases.

Mark reminded Members that NEAS were holding a series of workshops looking at how the company was branded and welcomed any Members who wished to take part.

5. The Future of Mental Health Services in the Borough

Northumberland Tyne and Wear NHS Foundation Trust

Elizabeth Moody, Group Nurse Director for NTW NHS Trust, took the committee through the Trusts plans for the development of Adult Care Services.

She explained that the Trust had reviewed their service model and developed new community pathways which would ensure that people were treated quickly and early getting the right help at the right time.

The new pathways would

- Significantly improve quality for the patient
- Double current productive time of community services by redesigning current systems
- Enhance the skills of our workforce
- Improve ways of working and interfaces with partners
- Reduce reliance on inpatient beds and enable cost savings

The aim of the Trust was to reduce the inpatient bed provision for adults and older people from 723 beds to 425. Significant changes would be part of public consultation; such was the case recently in South Tyneside.

Tees Esk and Wear Valleys NHS Foundation Trust

Martin Barkley, Chief Executive of the Trust, took Members through a presentation about how they had developed the service to rebalance the resources between in patient and community services.

He explained that the Trust served 1.6m people and had a workforce of 6000.

The philosophy of the organisation was to protect community based services to help people recover in the community and thus reduce the need for inpatient beds. This

made sense from both service and budget perspectives. Community services provided better value and generally people want to be at home.

He cited the example of Trieste in Italy where the community services were developed to the extent where there was only a need for 6 Inpatient beds for a population of 250,000 people.

He said that the Mental Health index (MINI 2K) suggested that a modern Mental Health Service needs no more that 20 beds per 100k population.

He showed how Trust had steadily been able to reduce their number of beds from 303 in 2007 to 236. In addition they had closed 6 rehabilitation units in this time equating to over 80 beds.

He went on to show a series of graphs how these bed levels were managed across the Trust, and showed that it did prove challenging in certain areas.

This resulted in 1 in 4 patients having to be admitted outside of their local hospital. They way this was being tackled was to try to ensure that community services were effective in these areas in reducing the need for admission.

He also asserted that there was still work to do on reducing the number of beds for people with organic mental illness (ie dementia) as 90% of sufferers could be cared for in a community setting and those that could not for any period of time could be cared for in Care homes with the help of Care Home Liaison Teams.

Cllr Javed (Stockton) asked where the bed pressures came from in TEWV area.

Martin said these were mainly from the Durham and North Yorkshire patches as opposed to the Tees area.

Cllr Mendelson (Newcastle) said that there had been some bed closures in Newcastle without seeing any parallel enhancement of community provision. As a result some residents have had to use out of area inpatient provision.

Elizabeth said that there were some bed reduction based on over provision against demand (eg female wards) but said that there was a need enhance community provision to sustain the changes.

Cllr Mendelson (Newcastle) went on to say that we need to have evidence of outcomes to ensure that the model is working

Elizabeth said that the Trust were looking at a number of metrics such as re-admissions, number of admission, length of stay etc

Cllr Todd (Durham) said that the crisis resolution teams were an absolute vital part of the service which needs to be protected and enhanced.

Elizabeth agreed and said that crisis teams have been developed to be more responsive in that they respond to all calls and run a face to face triage system rather than signpost people to other services

A further question was asked about financial support for patients and their families who had to travel out of area for treatment.

Elizabeth said that there was a budget that lay with the ward manager to meet the costs of travel where this was necessary. There was also the provision of ward cars.

Cllr Mendelson (Newcastle) asked whether there would be a review and consultation in other areas such has happened in South Tyneside.

Elizabeth said that NTW were already talking to Northumberland and North Tyneside on the changes and would be talking to Newcastle and Gateshead towards the back end of the year

The chair thanked the representatives from the two Trusts and said that this would be an issue that would be revisited to see how the revised services were working.

6. Date and time next meeting.

Paul Baldasera said that they had been approach by Christine Keen from NHS England who said that they would like the opportunity to brief the committee on developments within specialised service commissioning. The draft national strategy for specialised services was due to be published for consultation in July, so they said sometime between July and September would be a good time to meet if that would be possible.

The committee agreed to set up a meeting in September to address this issue